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TRANSCRIPT
OF PROCEEDINGS

PRODUCTIVITY COMMISSION

INQUIRY INTO CARING FOR OLDER AUSTRALIANS

MR M. WOODS, Presiding Commissioner
MR R. FITZGERALD, Commissioner

TRANSCRIPT OF PROCEEDINGS

AT HOBART ON THURSDAY, 24 MARCH 2011, AT 8.38 AM

Continued from 23/3/11 in Melbourne

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

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

These hearings represent the next of the inquiry and the final report will be presented to government in June this year. I would like these hearings to be conducted in a reasonably informal manner but remind participants that a full transcript will be taken and made available to all interested parties. At the end of the scheduled hearings for the day, there will be an opportunity for any person present to make an unscheduled presentation should they wish to do so. I welcome to the hearing Southern Cross Care Tasmania. Could you please, for the record, each of you state your name, the organisation you're representing, and any position that hold in that organisation.

MR GROOM (SCC): Ray Groom, I'm chairman of Southern Cross Care Tasmania.

MR SADEK (SCC): Richard Sadek, chief executive officer for Southern Cross Care Tasmania.

MS WALLACE (SCC): Carolyn Wallace, director of clinical services, Southern Cross Care Tasmania.

MR WOODS: Welcome. It's a pleasure to have you. Thank you for your earlier submission and as I was going through it this morning I figured that we ticked off a few of your recommendations in that, but no doubt you'll give us a scorecard on where we're at with the draft report. If you have an opening statement you wish to make, please do.

MR GROOM (SCC): Thank you. We appreciate the opportunity to comment on the draft report prepared by the commission. As you now know, I'm accompanied by Richard Sadek, who is our chief executive officer. Richard has been with Southern

Cross Care in that position for some 15 years - I think a little over 15 years. Carolyn Wallace is our director of clinical care and was director of nursing at one of our major aged care facilities; in fact, the largest in our complex of facilities. Both are very experienced people.

I'll just mention that we're a member of Aged and Community Services Australia and also Catholic Health Australia. We rely very much on those two organisations to look in great detail at your report and to prepare to submissions in response to that report, but we thought we would touch on just a few of the issues that arise from the draft report. Since we're at the coalface of the industry or the sector, we thought that may be helpful to you. We are a not-for-profit organisation; I won't go into all the detail. We operate seven aged care facilities around the state, in the south, north, north-west of Tasmania, and we have 10 retirement villages that we operate in our state, also community services, and we have a training organisation as well. So we are, I think it's fair to say, one of the leading aged care organisations in Tasmania.

MR WOODS: So you are an RTO?

MR GROOM (SCC): We have an RTO, yes.

MR WOODS: Providing cert IIIs for care workers and the like?

MR GROOM (SCC): Yes.

MR WOODS: Excellent, we might discuss that a bit later.

MR GROOM (SCC): We care for an support some 1500 Tasmanians and we have, it's quite surprising, 850 employees or thereabouts. I'll just make the point, it's not really in any sense any criticism of the commission, but we've been involved in making submissions to many inquiries over the years and you've heard this before, no doubt, commissioner, but we just hope that this report, when it's finalised, is not in the too-hard basket. We just see a great need for very real reform of the aged care sector, we see great value in this exercise and your draft report, and we just hope, eventually, the final report is considered very seriously by government and that it's adopted by government, at least largely, if at all possible.

We think that the authors of the draft report have shown a great knowledge of the aged care sector. When you look at that, it's really a good summary of all of the issues that confront both the consumers and the providers in the aged care sector around Australia.

MR WOODS: We too have been in this field for quite a while, trying to get the

reform. So, yes, we're very familiar with many of - - -

MR GROOM (SCC): I understand that you've had previous inquiries and so on that you've been involved in. We do consider that most of the recommendations have a great deal of merit; that's our view. We agree with the overall thrust, which is, as we understand it, giving consumers more choice, freeing up the system to some extent, but also providing reasonable support for providers, that is so essential as we look to the future.

I have to say, we have had some difficulty in fully understanding how some of the recommendations would actually affect our organisation and the people who we care for and support. We're a big organisation in the Tasmanian context, but we don't have the resources, really, at the top level; they're busy people doing their own work and we just don't have those extra resources to look in detail and try to analyse how this will affect our operation, so that's a slight caveat on the comments that we make. We do think if the government does accept the report in its final form, that ongoing consultations will be needed by government to talk to us about how this is going to really operate and affect us, and we may need to make some adjustments accordingly. But a period of consultation will be absolutely essential, we think, following the report's being handed down and considered and, hopefully, accepted by government.

I won't canvass all of the recommendations that I said before. I want to talk about four particular issues, and Richard and Carolyn will also add some comments. These are the Australian Seniors Gateway Agency, which is one of your recommendations; funding arrangements; regulations and the complaint system; and mergers and consolidation within the sector, which I see as an important issue. Your recommendations may have some relevance to that particular issue, but I couldn't see any direct recommendations that go to this important of: we have so many providers, is there a need for some degree of merger; would this be in the interest of consumers, would this be in the interests of the community?

MR WOODS: As I recall, that was one also that you had in your earlier submission to us. I was curious as to how that could be implemented by government, but maybe it can be facilities.

MR GROOM (SCC): I'll comment on that.

MR WOODS: Thank you.

MR GROOM (SCC): As I think is recognised by the draft report, there is a great deal of confusion in the minds of people about what aged care can provide, when someone is going into aged care, or their family looking into mum or dad going into

aged care, or aunty or uncle. It's a very complex situation, people just don't understand what is available, and there's really no place they can go to with all of the information that should be provided to our community when people are about to enter into aged care. We are very pleased that the commission has recommended in the draft report this Australian Seniors Gateway Agency, which would provide, as we understand it, essential information to individuals and families to help them make the appropriate decisions. I know it does other things as well and I think Carolyn may comment on this.

We think it would be very helpful if this agency, as you recommend, would have a presence in regional centres around the country. In the Tasmanian context, we think there should be a pool of skilled people available. We see a problem in having a sufficient body of expertise in, say, the north-west coast of our state, or in Launceston, or in Hobart. I'm not sure where this pool should be - it might be Launceston, it might be Hobart - but there should be, I think, a pool of expertise that could travel around and back-up the local people in such a centre. The centre should be very obvious so the people know where to go, it should have a good shop front of some sort so that people know where to go to seek advice. But we do believe there should be this pool of people to move around. We think, as you, I think, have accepted, that there should be a presence in all the key regional centres around the country.

MR WOODS: That presence need not be just the gateway itself, it should use all of the other opportunities to have a presence. Centrelink offices, there should be prominent displays of, "This is the number you contact," or, "This is somebody you can speak to." Medicare centres, local councils should all have information on how to access the gateways, so that we would envisage that we disseminate that information very broadly wherever people are likely to come across it, but that it channels them into the gateway so that they get to that.

MR GROOM (SCC): We think the gateway should have a very obvious presence.

MR WOODS: Yes, as well, in itself. Yes.

MR GROOM (SCC): As a one-stop shop almost, although other agencies should no all about it and direct people to this place.

MR WOODS: Exactly, yes.

MR GROOM (SCC): But there should be a form of one-stop shop, where people can go and get all the information and advice that's available. Just on funding arrangements, we had recommended in our initial submission to the commission that funding provided by the Commonwealth government should reflect the actual cost of

providing services and that there should be an indexation formula which accurately reflects annual increases in costs. Quite frankly, this doesn't occur at the present time. I know it's hard to work out exactly the percentage increase, the sort of COPO factors. 1.7, I think, for the current or the last financial year. There are some additional factors that bring it up a little bit, but it's probably still below the realistic assessment of what the increase in costs are that are being borne by aged care providers.

I said this in our initial submission, but we also think that providers be permitted to charge bonds for both low-care and high-care residents. That's been accepted in your recommendations. I know the bond issue is quite a sensitive issue for families and indeed for governments as well. It's not a simple issue, but we've found it, in our organisation, to be of great assistance to us; to talk to people who can afford to make a contribution by way of a bond, and it's all an agreement/understanding reached. We don't talk to everyone; indeed, a small percentage of our residents pay a bond, a very small percentage. But to talk to them about what they could afford, could they make a contribution. This helps us raise some capital to properly maintain our facilities, upgrade our facilities, indeed look to building new facilities. One of the great challenges in aged care is that obviously facilities age over time, and where do we get the capital from to make sure we maintain those facilities. The bond system has helped us considerably to achieve that important end.

We agree with the recommendation that the distinction between low and high care should be removed, and extra services are mentioned as well; we don't have extra services. We have considered it, but in a sense it's not in keeping with our philosophy to try to be fair to everyone, so we've not pursued that in any vigorous way. We think that this removal of the distinction between high and low care and the bond issue should be attractive to government because it doesn't impact directly upon the budget. Although it has its political issues in terms of the finances of the government, which are in a difficult position with the global financial crisis, the floods, the cyclones, and all the rest of it having affected the budget, we can imagine the government not being keen to greatly increase the amount of money being provided. That would not be a difficult decision to take for government to permit bonds to be raised from people who can afford to pay in both high and low care.

The idea of a periodic payment instead of a bond certainly is helpful to some degree, but that would involve us raising the capital. If we needed to have capital to build a new facility or to be involved in a significant upgrade of a facility, then we would use that regular periodic payment to raise some capital, so that has its own difficulties.

MR WOODS: Just like most of the economy does, but yes. You would have to go

to the bank with a bankable proposition.

MR GROOM (SCC): That's right, we would have to. There are prudential requirements for the bonds, and we certainly have very strict prudential requirements in our organisation and we meet those requirements. There is a suggestion that there should be further prudential requirements. We do not disagree with that, so long as they're not too onerous; I'll touch on this in a moment. The amount of regulation in the aged care sector is so great that if there's lots more paperwork to be involved in filling out and so on, it'll just add to the burden.

I mentioned regulations and complaints. This is a very serious issue, it's been mentioned, no doubt, by very many people, and I suppose every sector of our economy is regulated to some degree. I find, personally, that the amount of regulation in aged care is extraordinary. I know that governments respond to some problem that arises with a lack of care in a particular facility; let's have more regulation and have more policing. It's the easy response for government and, having been in public health for some years, I understand all of that, so I won't overly criticise that approach. But it has meant that we've had so many regulations developed over the years and our staff honestly spend so much time complying with regulations and filling out all the necessary forms, contacting the department, and all the rest of the authorities that are necessary, therefore there isn't the optimum amount of time available to care for people.

We exist to care for people. This is the reason we're created. We don't make a profit, no-one has any equity in our organisation, so we're there to care for people. When we spend so much time - and our senior staff can be in tears almost. This has literally happened on occasions, trying to comply with all of these requirements. So we think a concerted effort should be made to try to reduce the amount of regulation applying in aged care and I note that your draft report does address that in quite a significant way. We commend you for that.

A particular concern is the complaints investigation system. Again, you've addressed this, but we just want to highlight it. It has been an extraordinarily lengthy process. I have a file here. I won't go through it, I wouldn't talk about the details of it or the names, but just as an example of just the layers of problems that arise when someone makes a complaint. Sometimes they're genuine complaints and we can't say there shouldn't be a complaint system; there must be a complaint system. But sometimes there's a misunderstanding about what has happened, often the complaints are ultimately found to be unwarranted.

But you go through this process of, initially, complaints are made to the department and you address that with the department. Your senior staff are involved in this and it takes hours to fill in all the forms and address each of the complaints.

Then you go to the commissioner if there's an appeal and then, in this example, there were changes in the nature of the complaints. The issues raised were changed and more issues were raised. Virtually a whole year was taken up in one facility addressing the issues that were raised and all the various steps in the complaint system. I just think somehow we have to reduce this; still have it effective as a complaint system, but reduce the layers of appeals and reconsiderations and so on that are involved in it.

We note that the complaint handling is to be part of the role of the Australian Aged Care Regulation Commission. I'm not thrilled with the name. The gateway name I believe is good, but the regulation; just chop out the word regulation, but that may not satisfy you. Just the idea, when we're concerned about regulation, to have a commission that's titled "regulation".

MR WOODS: We're trying to put all of the regulatory functions. We picked up the Walton recommendations to separate complaints out to the department and tried to bundle them all into just one body that would actually talk to itself.

MR GROOM (SCC): Yes. We note there's an objective early resolution, which should be the case, and conciliation. Could I add the point that I prefer the term mediation to conciliation. I do some work in this area, but I just think good mediation can be most effective at an early stage from someone who has the right approach, brings the parties together, and talks it through effectively. I think mediation is a good way to go. Conciliation is more a directory-type of approach, mediation is, in a sense, a better way if it's properly conducted. Alternative dispute resolution generally is the way things are heading these days. A lot of cases don't go to court, finally. They are resolved through ADR, as we call it, and this is an almost vitally important part of the process of litigation in Australia at the present time and this can be reflected in what you do.

There's a recommendation of a right of appeal to the Administrative Appeals Tribunal, and I must say that I have slight conflict of interest: I'm a deputy president of the Administrative Appeals Tribunal. I think it might be important to consider drafting legislation in a very careful way to limit further appeals from the AAT - this can be done, but it has to be very carefully worded - so that it doesn't go on and on and on. Normally, from the AAT you can go to a single judge of the Federal Court, you then go to the full Federal Court, and then go to the High Court. Quite a few cases go through that process. So if you're going to reduce the cumbersome nature of the complaints process, then I think that is something that should be seriously addressed.

MR WOODS: Do you have any particular perspectives on that that you'd be willing to commit to paper and submit to us separately?

MR GROOM (SCC): I'd be happy to, yes.

MR WOODS: If you could put your mind to that, given your experience.

MR GROOM (SCC): Yes. I just touch briefly on the idea of mergers and consolidation. I did raise this at the ACSA national conference briefly, and I think you may - - -

MR WOODS: And you've raised it in your earlier submission.

MR GROOM (SCC): I've raised it, yes. We have about 60 providers in Tasmania. I'm not sure of the exact number, but it's something like 60 in a small state like ours. Many are battling. We have this feedback all the time; many are struggling with the financial burden and the need to provide the highest level of care. Each is burdened with this administrative structure: you have to have a CEO, you have to have financial expertise, you have to understand the complexities of aged care, you need good senior staff. The small operators often are unable to negotiate the best deals in contracts, for all the services needed, the food for example. As a larger organisation we can effectively negotiate for a good deal in that regard. We think there could be substantial savings, of hundreds of thousands of dollars in many cases, if people came together in some form.

I'll just give you an example: we've merged with a number of small organisations. They've approached us and we've effectively merged with them. One example is Ainslie in the north of the state. Ainslie have an aged care facility at Low Head, in the far north on the Tamar River. There's a village there of independent living units and there's a village in Launceston of independent living units, quite a substantial one. We merged with Ainslie; it has been very effective. Ainslie retains its identity, it still continues to operate the facilities at Low Head and at Launceston, but they have the back-up of our senior people, our financial people, our CEO and so on to support them. They were not viable before, but now they are viable and in fact they are making ends meet quite effectively with this back-up. It's just an example.

This is done voluntarily and ultimately it has to be a decision for the individual organisation if they wish to do that. The other way would be just for smaller organisations to come together in some way and pool their resources or to jointly have a senior management team to assist them and reduce their costs. You mentioned, what role does government have: I see education as potential role influencing this, if the local people want it, but perhaps also some sort of incentive system; that is, maybe a grant that could be provided to upgrade a facility in some way if there is to be some sort of merger flow from that or some consolidation of

some sort to flow from that. Then the local board would be happy with what's happening because their local facility would be upgraded, the people would be happy, and I think this could encourage such a result, possibly. There may be other ways to approach this.

Ultimately it has to be a decision for the local community. The key thing is we need to have aged care facilities in small towns, in regional centres, in the big cities, and we need a variety of aged care facilities, so it's vitally important they remain viable. We see this issue as quite an important issue. There've been some attempts to look at this issue in our state, but we see that as an important issue. That's all I wish to say, chairman. I just say that we appreciate the chance to meet with you today and we wish you well in your endeavours to finalise your report, and I'd invite, perhaps, Richard and Carolyn to comment as well.

MR WOODS: Yes, please.

MR SADEK (SCC): Commissioners, one of the issues that's very much of concern to our organisation is the workforce issue. As Ray Groom has mentioned, we employ 850 staff right across the state. Can I say that I'm very pleased to see a lot of comments made in the report relating to this issue, in particular can I draw to three significant matters on pages 367, 369, and also 359 and 360, where the commission says, "There is a trend towards employing less-skilled staff in residential aged care facilities." It's said there:

> A pressing issue for the formal aged care workforce is the imminent retirement of a large proportion of registered and enrolled nurses, and the projected increase in demand for high-level care services.

On page 360:

> The aged care workforce will need to increase by between two and three times as a direct result of Australia’s ageing population.

Lastly, which I was really pleased to see:

> A more detailed examination of the workforce implications of this proposal will be conducted before the release of the final report of this inquiry.

Our workforce is mainly comprised of care staff, as illustrated and mentioned in the report. Of particular significance, if you look at our workforce, 76 per cent are in the age group of 40 to 69 years. For instance, 40-49 year olds amount to 30 per cent of our work force; 50-59, 34 per cent; and 60-69, dare I say,

12.4 per cent. So 76 per cent of our workforce, predominantly, are in the care area and are of that age requirement fitting in with the priorities that you've identified.

MR WOODS: Sorry, also the average age of staff at which you recruit them is presumably also not at the early-entry-to-profession age?

MR SADEK (SCC): Correct.

MR WOODS: You tend to recruit them at a more experienced age, if I could describe it as such.

MR SADEK (SCC): Correct.

MR WOODS: There's a replenishing that happens within the older age groups as well, so it's not as if everyone is entering at the front end and they've all bunched up at the back end and are about to retire. You actually replenish to some extent in that more experienced range.

MS WALLACE (SCC): There're actually very few applications from the younger age bracket. A recent example: a large industry closed down in Hobart. In the last year or two the career advisers who are assisting people who were seeking re-employment, the career adviser contacted me and they were only advocating training in aged care for their workers over 40. It hadn't occurred to them that we actually would find their younger workers a more attractive prospect to train to aged care. So there is that perception that aged care isn't seeking younger people, but would prefer the experience, which perpetuates the problem we have.

MR WOODS: Yes.

MS WALLACE (SCC): Can I say, we saw this, in a visionary sense, back in 2002 as the major issue for our organisation. In fact we initiated an RTO in 2002, as you suggested in your opening comments.

MR WOODS: Yes, we saw that.

MR WOODS: We opened it up in 2003, after we went through the accreditation process to existing staff, so we provided some in-house education in 2003. In 2004 we opened it up for external courses as well, your care services, your lifestyle, leisure, et cetera. Carolyn has responsibility for the RTO. We were pleased to see in Prof Hogan's report a number of initiatives and recommendations made in relation to the Australian aged care workforce. They are documented as recommendation 8. I was also very pleased to see that the commission undertook some research in 2008 and identified four key challenges.

Can I go back to the RTO: we saw the RTO in 2004 and beyond as an concept of being able to provide not only recruitment ECAs, extended care assistants, for our organisation, but also provide a service to the industry at large. Unfortunately it fell over. It still exists, we've reverted back to using it as an in-house education service. We weren't able to recruit the calibre of applicant to make sure that there is some sort of longevity in terms of fulfilling a career in aged care services. The wastage rate was enormous and in fact we closed it to external courses in about 2008.

Very quickly, there seems to be a lot of initiatives and a lot of discussion around this area, but I'm not quite sure if there is a strong direction in relation to having a national workforce strategy developed; a very strong national strategy about where we are going into the future in terms of the three pages and comments that I've mentioned on those pages of your report. I think I would ask the commission to give some strong thought in terms of developing or initiating a national strategy that the industry's aware of, that we can commit to, in addressing this very crucial need in going forward into future.

MR WOODS: Thank you.

MS WALLACE (SCC): Can I just add a comment there, that Health Workforce Australia project is looking for medical officers, nurses, and midwives, to be self-sufficient by, I think, 2025 is the date on that. 70 per cent of the aged care workforce isn't in that category, so there's nothing looking at what about that other 70 per cent of people. There doesn't appear to be anything looking at ancillary staff, domestic-type staff. If in the future, as is hoped, that more elderly people will remain at home, those other sort of people and the workforce skills will be needed to help people stay at home, and there doesn't appear to be any project looking at how many of those types of workers and what training will they require to be able to support people to do that.

MR WOODS: Yes. We are talking to Health Workforce Australia to try to get all the various bits working together. We are, sadly, running out of time and there are a whole range of questions we'd like to pursue, but maybe we can find time to talk at least to your CEO, or however you wish it to happen, at a later date. But with the opening up of the supply constraints, so that you won't have to have, apply for, and get a number of packages, et cetera, you'd be in a position to look at your business plan and who you want to reach out to and offer services to, both community and in ILUs, in retirement villages, and in their own homes, wherever they me be, as well as your facilities as such. Do you have a view as to what opportunities these reforms would provide to the organisation and where you might head, what your strategy might look like?

MR GROOM (SCC): Do you wish to comment on that, Richard?

MR SADEK (SCC): I find it difficult to comment. I really don't quite understand the detail of how you can establish a supply price in a regional context.

MR WOODS: Let's separate care from accommodation. The care price will be transparently set, and one of your recommendations in your earlier submission was that it reflect actual costs, so that's our intention. On the care side there would be a set price for each of the type of care services, that care services would be flexibly drawn upon to meet the individual needs of people, they would come out with an entitlement and a price that would go to all providers; it would be an equal price for all providers. So you wouldn't compete on price, you would get a set price. Some of that would be a care co-contribution from the individual and the rest would be a government subsidy. But it would be a set price, so no provider can compete on price. You get the transparent price that reflects actual costs.

On the accommodation, if they're supported residents there would be a set charge, a subsidy that would be provided for them, again that would be transparently set. But for the rest of the accommodation, that would be a matter for you as long as you offer a periodic charge as well as offer a bond. But it would allow you to go out into the area of older people that you wish to cater for and provide services to and offer your services to them. So I was wondering if, maybe it's too early yet in the process, but maybe if you could reflect on it as to where you would go, what opportunities it provides for you, are there any concerns about the issues?

MR SADEK (SCC): It appears to be a more competitive arrangement, that there's no limit on how many beds we could have in facilities or packages that we could - - -

MR WOODS: The only limit is the number of people who think that you're the provider of choice to them.

MR SADEK (SCC): Yes. Just one of the basic points that I see in that is the danger, perhaps, that the smaller providers in local communities may struggle in that environment. That's just an impression. I know you probably have an answer for this, but having a little facility in a small town, so that people can actually remain in their town - - -

MR WOODS: But nobody is going to put in a competing facility if there isn't demand for it.

MR SADEK (SCC): No, but it could be a nearby town, now there's a choice issue.

MR WOODS: Then the consumer makes the choice.

MR SADEK (SCC): But there are other factors involved in that. You've handed down the recommendation, could I ask you how you would see that affecting us?

MR WOODS: We would see that in large part you would be servicing more people in the community, if that was the direction you wanted to go, and then, because you wouldn't be constrained by how many packages you're able to get, et cetera, you would be able to deliver services to people in a whole range of accommodation situations, whether it's in their long-term existing home or they've moved into an ILU or services apartment, that you'd be able to offer them services as well as for those who would be more frail, ultimately. Because your profile must be changing, presumably, over the last five to eight years; frailties increasing, duration of stay, except for the dementias, is shortening et cetera. So that trend is going to keep happening, but you'd be able to deliver services to people earlier on, in a more diverse manner, and target services directly to their actual needs, not be able to say, "We've got X packages. You either fit or don't fit that profile."

MR SADEK (SCC): I would basically see it as an advantage to our organisation. We believe we're efficient and we provide high quality of care, so in the market place, if it's freed up in that sense, I think it would provide more opportunities for us, given greater flexibility.

MR WOODS: I would've thought so.

MS WALLACE (SCC): The successful organisation into the future would be one that is able to be flexible and able to change to quickly depending on what the demands were. Some smaller providers with a heavier infrastructure may not be able to change quickly.

MR WOODS: That's why they may then be able to come to you for support, so that you would providing some of the community support, they're operating their little nursing home in that village.

MR GROOM (SCC): It might encourage that consolidation.

MR WOODS: You can feed into that.

MS WALLACE (SCC): Some of that administrative running and organisation business structure, that may need to be provided.

MR WOODS: Sure.

MR FITZGERALD: Just on the mergers and acquisitions or mergers and

consolidations, there's no doubt at all that some of that is taking place. We've seen a very substantial number of organisations sell out of the aged care and others have grown. The question is to the extent to which government should be facilitating that or not. In a sense, going forward, the one thing we're not doing is we're not going to have the aged care box. A residential aged care facility into the future will have, obviously, a very high number of people with severe dementia, frailty, but they will also have subacute, transitional care, restorative care, rehabilitative care, and palliative care. The day of a low-care, high-care boxes disappears. Going forward, the shape of aged care in relation to residential care will be up to what the market determines; what you as providers and consumers decide. Equally that will also be true in the community.

Again, the money will go with the consumer; the consumer determines where to go. It's becoming less and less likely that the government should try to actually design what the market looks like, rather the players within it will actually shape it. So the question in this area, and merged to that, is it appropriate for government to take a role, rather is it for the industry itself, both as individual providers, but as peak bodies and what have you, to try to work this out in a better way? So it's a question, but it's actually happening; we see the market is changing dramatically now. Some providers, as I say, will exit, new providers will come. But I'm just cautious about the notion that in this particular changing market, what is the government's actual role in this space?

MR GROOM (SCC): The reason I've raised it is that I see it as tremendously important that people have the chance to live in their own community in their latter years. I just feel that there's a need to pay particular attention to the problems faced by very small providers in small communities. We're a very decentralised state; there are villages around the state, if you like, and up the east coast, down the west coast, tiny little communities, and they love their local community. Are they able to stay in that community or do they have to go into Hobart or Launceston or somewhere for their - - -

MR FITZGERALD: That's why we think a much more community based care helps that.

MR GROOM (SCC): It's happening; the danger is that little places close down and the beds are moved to a nearby community perhaps or one quite removed from that local community. I see a need to pay particular attention in this whole question of aged care reform to small towns, regional centres around Australia, including in Tasmania.

MR FITZGERALD: But is that about the way we fund those services? There is an issue, you're absolutely right, that you gain greater efficiencies if there was a

merger of some of the organisations, because of back office costs in all those sorts of things; that's true. On the other hand, there is an absolute role for very small, boutique operators that have found a niche: they cater for a particular type of client or they offer a particular type of service. Just as in business, we get large and small.

MR GROOM (SCC): That's a big city idea, I think.

MR FITZGERALD: Even more generally. But the regional one, the small town one, is an issue for us, and the question is whether or not you need different funding models for those communities. So in our report you will have seen that we've talked about the maintenance of block funding for some regional based operations.

MR GROOM (SCC): Yes.

MR FITZGERALD: Because of the viability issues. We recommended on-going block funding, for example, for multipurpose indigenous services in remote locations, because that's a better model. So is the question about mergers and consolidations or is it about the way in which you fund services in small, regional, or remote communities. You don't have remote, but - - -

MR GROOM (SCC): If the government is able to provide additional money, because these people are struggling at the moment, there's no problem. This isn't a problem if additional funding can be provided to these small operators. I'm assuming the government won't have the capacity to provide large amounts of money to ensure that these small operators remain viable around the country, because there are probably thousands of them around Australia. It's a large amount of money. They are struggling. We're able to make ends meet; not hugely, but we can make ends meet. The impression I have, frankly, and knowing Tasmania well and the aged care sector in Tasmania well, a lot of these places are struggling. They're doing their best, but they're really struggling.

If there's enough money, yes, that's fine. We would totally support the people remaining independent and remaining viable. We're a larger organisation, we don't want to merge unless it's in their interest; in the local community's interests. We're talking about community interest here, not our own interest. If they can remain viable with some support from government, that is good.

MR WOODS: But you do need a balance, because you also don't want to just be feeding money into what is an inefficient system where more efficiencies could be gained. So there is a midway point there to discover. We are out of time and we do have other participants, unfortunately. There are many issues we could continue to discuss with you, but we may follow up on some of those issues.

MR GROOM (SCC): Thank you.

MR FITZGERALD: Thanks very much for that.

MR WOODS: Yes, excellent.

MR GROOM (SCC): Thank you very much.

MR WOODS: Can I call forward Royal Guide Dogs Tasmania, please.

MR FITZGERALD: If anyone is having difficult hearing, let us know, because we don't have an enhanced mic system in this room.

MR ENGLISH (RGDT): Gentlemen, good morning. Thank you very much for the opportunity to come along today.

MR WOODS: Thank you. Could you, for the record, please state your name, the organisation you're representing, and the position you hold.

MR ENGLISH (RGDT): I certainly will. My name is Dan English, CEO of Royal Guide Dogs Tasmania. It probably seems a little strange that an organisation like Royal Guide Dogs Tasmania might choose to present in front of a forum such as this.

MR WOODS: No.

MR ENGLISH (RGDT): By way of explanation I might actually give a little bit of background as to both our organisation and how our own organisation represents our partner organisations in other states. Royal Guide Dogs in some ways is a misnomer: whilst our organisation is very much responsible for the provision of guide dog services, that only represents about eight per cent of what we do. Roundabout 92 per cent, therefore, of our services are related to the provision of specific and specialist services for people who are blind and vision impaired, as a result of which, somewhere in the vicinity of 75 per cent of our population or our demographic is actually aged 65 or over, so we have a very strong interest in this particular topic.

There is also a strong crossover between this particular topic and one of the other major issues the Productivity Commission has been looking at, which is the National Disability Insurance Scheme, and we actually see that there's significant gaps in both the reports in relation to Caring for Older Australians and also for the National Disability Insurance Scheme as they relate to people who are vision impaired. We certainly see the reform of the aged care system as essential to meet the challenges created by an ageing Australian population, and I'm sure there are people throughout the rest of the presentations that will speak more eloquently and in a more informed fashion about that. But certainly from our perspective we do expect that there will be more people coming into aged care, that it will be accompanied funding restrictions from a reduced taxation base, skills drain from structural waves of retirements, and limited replacement workforce for those who have more opportunities due to low unemployment.

However, older people with disabilities are already being failed by the current system and particularly people with vision impairment. It is a low incidence

disability and by and large it is overlooked both within the disability sector and also within the aged care sector. Older people with vision impairment fall through many gaps that are created by poor integration of the health care, aged care, and disability systems. Their rights to dignity and inclusion are diminished by the continual erosion of available funding and a sustained lack of investment in infrastructure. There is a pervasive myth that blindness and vision impairment is a natural process associated with ageing and in fact there are figures to indicate to indicate that a large proportion of people who are aged do have a vision impairment. But having said that there is equally - the other component of that is there are large components of the aged population that don't have a vision impairment. The assumption that vision impairment is going to occur just as a natural part of ageing is very much misguided and unfounded.

So we actually do believe that that is the premise of many of the cracks that people fall through, particularly within the disability system and the aged care system, but it's just a natural process. People just lose their vision as they age. Something like 40 per cent of people aged over 90 still have very functional vision that may only require refractive correction or the wearing of glasses in order to function quite effectively. Unfortunately that does mean about 60 per cent have the converse problem where they are significantly affected.

One of the most significant causes of vision impairment in people of that age bracket is age-related macular degeneration. There is also a high incident of diabetic retinopathy which is a growing social issue in Australia. There are issues of preventable blindness and vision impairment that need to be addressed, but there are also those that are not preventable, and in an aged care system certainly need to be adequately and effectively addressed.

So as a brief summary of blindness and vision impairment, the term "blindness" actually refers to someone who is legally blind, and so a broad definition, somebody who cannot see at six metres what you and I can readily see at 60 metres, or somebody with fields of less than 10 degrees where we would traditionally see around the vicinity of 130 to 135 degrees. So you're talking about a very functionally limiting disability. However, although a vision impairment may be functionally disabling in many ways it doesn't necessarily mean that, say, a person who is aged and has a vision impairment is destined to move automatically into aged care.

However, there is a 70 per cent greater likelihood that a person with a vision impairment will go into an aged care or supportive care facility. That is actually contradicted in many ways by the fact that the services that are provided by organisations like our own are incredibly effective in allowing people to remain in their own homes. There's a range of issues that impact on this, particularly in the

assessment of people in the aged care system. The optical assessment is actually optional. It is not a requisite component of the aged care assessment in relation to how a GP would assess somebody for aged care. We actually believe that that should be an essential component of the assessment process, such that it is identified early.

There is also not a great emphasis on vision impairment and assessment identification and diagnosis and then rehabilitative care in aged care for people with vision impairment. Again it's a continuation of that myth that it's just a natural occurrence and that as a result people actually fall through a number of gaps and they are actually even more limited than they would be. For those that are identified we provide significant amounts of care to limited numbers of people within the aged care system that actually makes their engagement, even in aged care, much more meaningful and significantly improves quality of life. So from our perspective we would like to see that there is compulsory inclusion of that assessment in the process.

MR FITZGERALD: Certainly our intention is to enable people to stay at home, whatever home that might, for as long as possible in their circumstances. So to the extent you can provide support for them, including in terms of their vision, then that's excellent.

MR ENGLISH (RGDT): Absolutely. Certainly that's not funded under aged care in any way, shape or form at this point in time, that's purely done through the services of organisations like our own that are funded primarily through public donation.

MR FITZGERALD: Yes.

MR ENGLISH (RGDT): As noted, the prevalence of blindness and vision impairment increases with age. As I said, it's not necessarily an inevitable outcome of ageing. Based on current incidence rates by the time a person is aged 60 to 69 they have a one in 20 chance of a level of vision impairment which prevents them from holding a driver's licence. That increases proportionately over the ensuing decades but certainly the lack of mobility is one of the most defining features of a loss of vision.

One of the major outcomes of a lack of mobility that we find - and we also find that our services are very effective in countering - is that as people lose their vision they lose their mobility. Obviously they become much more tentative in moving around. They don't have necessarily access in a mobility form to all the other forms of both social, medical and the whole life sphere of engagement that they may have. When you bring that down even further as they move towards legal blindness, you're talking about people having difficulty with mobility around their own home. One of

the major outcomes of that is actually a higher incidence of falls. I'm sure you're very much aware of the increased mortality rates associated particularly with hip fractures.

Orientation mobility, which is one of the core premises of the services provided by organisations such as our own, is typified normally by what you'd see people with either a support cane or a long cane, white stick, has a significant impact in reducing those types of falls and therefore the associated medical costs with them as well. We have two major groups of concern to us: they are those who acquire their vision impairment prior to 65 years of age, and obviously there are some compounding issues with the process of ageing that cause significant concern to that group. So the fact that they already have a disability prior to moving into the aged care sector and their capacity to fund their aged care, their capacity to remain in their communities and age in a way that would be conducive to what they would consider to be a good quality of life, is limited.

I mean, there are those obviously that receive their vision impairment subsequent to the age of 65, and there are differences in the way those two groups need to be addressed, assessed, identified and funded. There are a range of impacts of blindness and vision impairment that we believe again aren't necessarily well identified. In particular, rehabilitation can deal with the functional impacts of blindness and vision impairment. Another major impact that is under-serviced and under-funded is the very high incidence of depression related to vision impairment. That's a factor that comes back to again a lack of social integration, distancing from social networks, an inability to function at a level that people might have considered appropriate prior to their loss of vision.

Certainly from our perspective it's an area that does need both identification to be addressed appropriately, mainly within the actual training. The group that spoke prior to me spoke about their workforce, workforce training and workforce education, and we actually believe this is a key component because there is a high correlation between ageing and vision impairment. We believe there needs to be significantly more education in that particular area to make sure that workforce is keenly aware of the impacts of vision impairment, but also keenly aware of the services available to actually overcome those impacts and allow people to still have a good quality of life. Mental health is obviously a very important component of it.

Assessment and early intervention. Loss of vision is easily and often overlooked in aged people, both by carers and treating health professionals. It can be hard to notice a gradual loss of vision and it is often, as I said, mistakenly perceived as the normal ageing process. Australian research indicates that a failure to identify and acknowledge vision loss inevitably leads communication breakdowns, leading people to withdraw from society and interactions with people around them, either

within aged care facilities or within their own communities. A senior health assessment conducted by GPs must include that vision assessment as mandatory rather than an optional requirement.

I have touched briefly on social isolation and it doesn't really take a lot to infer the significant impacts that that social isolation can occur with people. The costs of disability: typically many people with long-term blindness or vision impairment do experience those additional financial stresses, as I touched upon already, from the costs associated with their disability and this is where we have significant concerns in relation to the national disability insurance scheme and how it will crossover with the aged care reforms that we're looking at. The national disability insurance scheme, to be honest, scares the pants off us because by and large any disability acquired over the age of 65 will be considered part of the aged care sector, not part of the national disability insurance scheme. With 75 per cent of our client base aged over 65 and particularly the funding model they're looking at for the national disability insurance scheme we perceive that it is going to have a significant impact on the income available to us to actually continue to provide services, the services that we are providing, to that demographic at this point in time. We believe there will be a philanthropic malaise.

So basically we believe that it will significantly reduce the philanthropic gifts that are given to organisations like our own if people are already contributing to what they perceive as a national disability insurance scheme that funds all disabilities and we don't believe that there is anywhere near enough information being promulgated about the fact that there are significant disabilities, including vision impairment and hearing impairment, that will be included from the national disability insurance scheme in the way that it's funded, in the way that it has been touted to be funded. We will have significant loss of income, we believe, as a result and our capacity to then meet the needs of this very significant client base - and we're talking about 5.8 per cent of the Australian population are diagnosed as having a vision impairment of some sort which is obviously - - -

MR WOODS: Will you be addressing that inquiry or do you want us to feed those concerns through this to that?

MR ENGLISH (RGDT): I will be addressing that inquiry. As I said, we do believe that there needs to be some integration of those concepts.

MR WOODS: They're both within the commission, there are two teams and the commissioners are working together.

MR ENGLISH (RGDT): Most certainly. But as you can see the nexus between those two - - -

MR FITZGERALD: We're going to run out of time, so I just want to come to that. We had Blind Citizens Australia, is that right - - -

MR ENGLISH (RGDT): Correct.

MR FITZGERALD: - - - present to us in Melbourne the day before yesterday, I think it was, and they've raised the same issues and undoubtedly they are concerns. But can I just bring up, the group of people that acquire blindness or vision impairment after 65 at this stage would be within the aged care system, just assume that for the moment. There are two issues: one is about the services that that group need and so irrespective of whether it was a disability system or aged care system, one of the issues we want to look and say is, "What are the services that that particular group need to be able to access," both in terms of aids and anything else that might be necessary, and you've mentioned a number of them. The second is then who funds it? So there are two separate issues but they're both important.

Clearly you have some reservations in relation to our aged care report that we've not identified adequately the needs and services that should be provided to people with vision impairment over the age of 65, irrespective of funding. Is that right?

MR ENGLISH (RGDT): We believe there are limitations in it, yes. Certainly, the adaptive technology needs, the assisted daily living or independent living skills needs and the orientation and mobility needs, particularly the orientation needs we believe - - -

MR WOODS: And the assessment process?

MR ENGLISH (RGDT): - - - are significantly under represented and then the actual overall assessment to make sure that people are being passed through the process to come to us.

MR FITZGERALD: So if you can ensure that the assessment process picks up, both at an early stage and at a later stage, those needs and then that gets translated into an entitlement to services or a particular aid, that process itself should work if, of course, those services are available and properly funded to be provided.

MR ENGLISH (RGDT): Correct.

MR FITZGERALD: What is the best way for assistive technologies and for those aids to be provided? Is it through organisations like yourself, in other words, the actual service delivery, the provision of those services and the provision of that

equipment? Do we have a system that, if adequately funded, would work well so there is in fact that place where people can access those services?

MR ENGLISH (RGDT): There are certainly a number of organisations Australia-wide that have the capacity to provide those services. All of those services are, at this point in time, based on charitable organisations like our own. If we look at the guide dog services, as I said, guide dogs only represents 8 per cent of our work, but if we look at our funding, guide dogs represents about 90 to 95 per cent of our funding. So our capacity to actually raise funds for those, if you'll excuse the term, very non-sexy items is incredibly difficult.

So whilst we do provide those services, they are really funded on the back of what is, as I said, broadly a misnomer. If we look at probably our major competitor in this sphere which is Vision Australia, they have actually moved into the guide dog sector as well very much based on the very attractiveness of that funding because it is very, very difficult to attract funding from the general public for a low incidence disability; low incidence but has a high functional impact or a high impact on people's functional capacity. It is very, very difficult to attract funding and it is only charitably funded at this point in time for those major - - -

MR FITZGERALD: Can I ask a broader question: what is your view as to the role of government in funding those services? Historically they've come from a charitable base, that is true. But going forward is it the view of your organisation and/or your peak bodies that in fact governments should be in fact paying a greater percentage of the cost of the provision of those aids?

MR ENGLISH (RGDT): I don't think there is any charity that exists that is not going to say it would be nice to get more government funding. By and large I think the charitable sector within this particular area is actually doing a reasonably good job of providing those services. Our concern is if the National Disability Insurance Scheme is introduced and a Medicare-type levy is implemented to fund that, that - - -

MR WOODS: It's not their current proposition.

MR ENGLISH (RGDT): It's one of, it's certainly one of.

MR WOODS: An option.

MR ENGLISH (RGDT): Yes. We're not exactly sure how it will be funded at this point in time but if something like that in particular was to be introduced our concern would be that people would feel that they are already funding disability and their capacity or their will to continue to fund organisations like ours would be limited and, therefore, it would actually fall back on the government which is - - -

MR FITZGERALD: Can I ask another question which you have raised, but it's relevant for our inquiry. Assuming you get the assessment right and there is an entitlement in some way, shape or form or referral to the services, what is your organisation's positions in relation to co-contributions by clients? How does the person with the vision impairment, many of whom would have access to some wealth - some would not be obviously but others would - what's your approach to their contributions to those services

MR ENGLISH (RGDT): At this point in time all of the organisations within the guide dogs field by and large services are provided free of charge.

MR WOODS: Free, irrespective of the wealth of the client. Is that something that is sustainable into the future.

MR ENGLISH (RGDT): There are clients that will purchase equipment through organisations such as our own but by and large the training and the provision of the services is free of charge. So if we look at our orientation mobility services, if we look at our guide dog services, if we look at most of our training there is equipment sometimes that is purchase but by and large the training is provided free of charge.

MR WOODS: That is your significant cost, the training side?

MR ENGLISH (RGDT): Absolutely. Our most significant cost for all of our organisations would be the professional stuff. I suppose our other concern is significantly the availability of trained staff. There is a global shortage of the professionals we use and we're talking about people with postgraduate qualifications that are employed to provide the service in the same way that other organisations are struggling to get people and manpower and resources, we particularly do. There is only a handful - I could count on probably two hands the number of qualified guide dog instructors. We have one instructor here in this state, there are two in South Australia, two in Western Australia. So the profession is very difficult to continue to fund.

MR WOODS: Are there any particular points that we haven't addressed that you would like to bring to our attention?

MR ENGLISH (RGDT): As I said, I think that one of the primary things for us is the inclusion of the compulsory component of the assessment and the channelling through.

MR WOODS: Will you submit that or some variation of that as a final submission?

MR ENGLISH (RGDT): By and large the major components have been addressed in the submission by the Australian Blindness Forum which we are members of and they are the peak body that represent us.

MR WOODS: So we will take their submission as reflective of your views.

MR ENGLISH (RGDT): Most certainly.

MR WOODS: Excellent.

MR ENGLISH (RGDT): Gentlemen, thank you very much.

MR WOODS: Thank you very much.

MR FITZGERALD: Thank you very much.

MR WOODS: Can I call forward Advocacy Tasmania. Thank you, gentlemen. Could you please, for the record, each of you state your name, the organisation you represent and any position you hold.

MR HARDAKER (AT): Ken Hardaker, CEO of Advocacy Tasmania.

MR OWEN (AT): David Owen, policy officer, Advocacy Tasmania.

MR WOODS: Please, talk to us.

MR HARDAKER (AT): In the limited time we've got we'd like to say a little bit about our organisation and quickly recap our response to the general terms of reference for the inquiry; comment on some of the key transmissions in the Tasmanian population that are impacting on the aged care sector; outline what we see as the program logic for advocacy services within the current and emerging aged care sector, and point to some possible confusions arising from the draft report's approach to the role of advocacy services and to seek clarification on those issues.

We did not originally put in a separate submission to the commission. We were part of the NACAP - National Aged Care Advocacy Program submission - which involved the eight Commonwealth-funded aged care advocacy services, but we had a significant role in helping to put that submission together. We intend to focus on a relatively small range of issues that relate to our core expertise which is supporting consumers, both in the community and residential care sector, who are constrained in their capacity to negotiate complex service systems.

We would also add that we support the major strategic direction of the commission and of the recommendations to date, so we congratulate the commission on the work that you've done so far. Just by way of brief introduction about our organisation, we have been in existence now for just over 20 years and have worked in the aged care advocacy sector since our inception. We're an independent not-for-profit community based organisation. We provide advocacy services statewide across Tasmania, and our sole focus is the provision of advocacy in various guises.

As well as working in the residential and community aged care sector, we also work in the disability, mental health, and drug and alcohol sectors. So we think that gives us some insights that make us certainly unique amongst advocacy services in the country because we're apt to observe, I guess, the experiences of consumers across those different systems. Our board of directors is made up entirely of consumers and carers, or people who identify as consumers and carers.

Historically advocacy, certainly in the aged care sector, has been perceived as a very reactive function, so people come to us with complaints or problems in relation to the care and services they receive. An advocate assists them to resolve those complaints and concerns. However, increasingly over the last decade we have changed our views of - our conceptualisation of the advocacy we provide because increasingly we find ourselves being drawn into more proactive roles to support consumers. In practice this means supporting consumer decision-making processes at all points along their consumer journey.

For example, that includes supporting people at initial assessments and care planning, which is increasingly becoming part of our work, and we have a service that relates specifically to people living with dementia in the community and that is a big part of the role of the advocates in that service to provide support to people in making decisions about some key issues that happen in their lives when they're considering using services in the first place.

We also support people in negotiations around service delivery, particularly in the disability area where individualised funding has been a feature for some years. There are numerous examples of where advocates have supported people to make a decision about changing a service provider, or where they have been awarded a package in the first place to help them make a decision about which provider to choose from the outset.

MR WOODS: That would be more a feature in the future.

MR HARDAKER (AT): We think so. Another common proactive role is supporting people through transitions; a typical one, from community to residential care, but also people who have had acute health episodes from hospital back to home, or from hospital to residential care, and to help support them in that process of deciding which of those pathways they will take. Increasingly, the reactive and proactive roles are forming part of, I think, a much more holistic approach to advocacy which we think has relevance to both this inquiry and the other disability related inquiry. We would largely describe these under the banner of supported decision-making.

Just to recap a couple of points from the original NACAP submission that we think are important to emphasise. The NACAP submission advocated for one community care and services system, so eliminating the barriers between disability and aged care. We believe if that isn't possible, there needs to be two systems, then certainly they need to have as few discrepancies between them as possible because increasingly people who move between the two systems will get some of their care and services from the two different parts. Any differences between the systems will be obvious inequities which will be problematic. I think the previous submission

from the Guide Dogs Association probably highlighted one of their fears which was potentially around that sort of issue.

In the disability inquiry there is a lot of discussion around individualised funding, and in this inquiry a lot of discussion around consumer directed care. I think we have to be clear about, are we talking about the same thing or are there differences? I think that's an important issue. The second point we wanted to make around the original submission related to Australian government human rights obligations, particularly the United Nations Convention on the rights of people with disabilities. We think that has a particular relevance for this inquiry.

As we know, the largest group of people who experience a core function limitation are older people, and that's a growing proportion of people considered to have a disability. So the convention certainly has relevance to the aged care system. Some of the key rights that we would highlight are those around choice, decision-making, participation in community life, and seeing participation not just as having a presence in the community from time to time but being active citizens making a contribution to their community. Certainly the residential care sector historically has been a separate world apart from the community, and while there's been many valiant efforts by providers to try and break down some of those barriers, we've got a long way to go I think before residential aged care is really part of the community for people living there.

The commission's commitment to a significant shift towards individualised funding is something we strongly support, and in the original NACAPs submission we also asked for a recognition of the need for a concomitant emphasis on the support structures required for older people and their families to participate as assertive, informed consumers. We argued that this second shift to a comprehensive, coherent infrastructure of supported decision-making will be required, even if the current supply orientated system of aged care continues unchanged. It will be especially important as we move towards a greater diversity of service providers. The more choice, the more decisions people have to make, the more complexity in the system there is potentially, the more the need for independent support and advice to assist people to navigate through that complexity.

In this context we stress the roles played by individual and systemic advocacy in support of the effective flow of market information in two ways: advocacy assists the consumers of services to understand the choices available to them to optimally participate in decisions about those choices and to effectively communicate the decisions to service providers. It also assists service providers and system level decision-making, such as funders, to better understand the needs of consumers. Because of these roles we argue that advocacy, both individual and systemic, must therefore be understood as a core desired feature for any coherent services. I'll hand

over to David.

MR OWEN (AT): We wanted to very briefly just talk about four important transitions that are occurring in the Tasmanian community that we think impact on not just the demand for aged care services but for support through negotiating that particular system for advocacy support in particular. They're largely well known but we wanted to point to them anyway. The first is obviously the demographic transition in terms of the ageing of the Tasmanian community. We've now finally reached that point of having the highest median age, having overtaken South Australia, and I think we're proud of it, but we recognise that it brings some challenges.

One of the things that has arisen is I think a lulling into a sense of complacency in the community, that they have absorbed the notion that, yes, we're a rapidly ageing community, we're looking to 2040, 2050 and those rather worrying projections, and the focus has gone off what's happening year to year. We make the point - and here we're assisted significantly by Tasmania's own Demographic Change Advisory Council - that those projections year by year are also very, very worrying and that in just four years' time we can expect to have something like 11,000 additional over-65s in Tasmania. That's not being planned for at the moment in terms of the current approaches to aged care service delivery. Nobody, I don't think, has any sense over that time scale as how that additional number of people eligible for services are likely to be responded to in terms of service delivery.

The second transaction goes hand in hand with that; it's already been mentioned, the correlation between ageing and disability. We know the figures there in terms of a quarter of people over 65 having a profound or severe core activity limitation and a third of those over 75, significant numbers of those who have multiple disabilities being in the over-65 age group. In Tasmania, that's another major shift that's occurring and certainly confronting organisations like our own.

The third population transition is about household formation. This is a state where more people live alone than any other and even couple households are more likely in this state to be alienated from extended family supports than in other jurisdictions. That has a significant impact on the likelihood of those individuals or even couples that may require other kinds of professional support in order to negotiate any service system, including the aged care one.

The fourth transition is about educational attainment and about a sense of entitlement. We are finally in Tasmania starting to play a little bit of catch-up in terms of educational attainment, but we have two things happening. We have by and large a population that struggles in terms of its understanding and some issues because of that low level of educational attainment, but we have at the same time an

influx of people, retirees and sea changers, tree changers, coming to Tasmania who bring with them an assertiveness, a sense of entitlement, a requirement that they be seen as co-producers, co-designers of services. So we're seeing some significant changes, as I say, not just in demand for aged care services but in demand for advocacy support in order to obtain what they require in those services.

I wanted to talk a little bit about what we see are the impact of the proposals that are in the draft report. We see them as being quite profound. We believe the recommendations are bold and far reaching and that they are going to change almost all aspects of the system and we are very, very pleased about that. In summary though, what they add up to is change and choice and both contexts bring the notion of advocacy into clear focus. Whenever there's a system changing itself, in flux, we find that we are under pressure to provide advocacy services to assist people to deal with that. Whenever there is an increase in the choices made available to consumers, even though we would all welcome them, they bring about an increase in the demand for advocacy. Again, we're extremely happy about that but we're not sure yet that the commission has acknowledged what that will mean in terms of the way that it is positioning advocacy within the overall architecture of the proposed system.

We in Advocacy Tasmania believe that there's a kind of a program logic to advocacy and it goes beyond the notion of rights, though the rights basis of our work is fundamentally important to us. But increasingly we see advocacy as an important design feature of any services system, that it's one of the key lubricants of a coherent effective services system, whether it's aged care or any other, and we mean any other in that sense.

In every service system there will be consumers who fail to get access to the most appropriate kind of services or fail to obtain the quantum of the services they require, whose service outcomes are compromised because they have capacity limitations with respect to their ability to acquire and process information, to take decisions and to communicate those decisions and who are without family, friends or community supports to complement the capacities that they do have. What we're seeing is that the proportion of the population who appear to require some complementary support services to deal with those capacity limitations is large and growing. To understand a future aged care system that will be coherent and effective, it's important for us to not see a major role for advocacy on the basis of our experiences.

We think that advocacy services contribute to service system effectiveness and efficiency in three basic ways: they improve targeting in a fundamentally important way. We believe that without advocacy services, it's almost impossible for complex service systems to reach the people they most seek to reach because those most in need of services are often most in need of support. Without the support, there won't

be the connectors required. Secondly, by supporting consumers to engage in decision-making processes about their own treatment and care is fundamentally important in terms of achieving the outcomes of any service system; thirdly, by contributing to systemic advocacy feedback webs, information webs, that allow service organisations and system managers, including regulatory bodies, to have an understanding about the consumer experience and make adjustments accordingly. Again, these kinds of considerations are there at any time but they're there especially when a system is in flux, and the commission is about to send that system into even more flux than it's in at the moment. Again, we welcome that.

We wanted to point out that the draft report, while it has an appropriate major focus on the regulatory functions, in chapter 12 especially, a good deal of emphasis on the important complaint-handling mechanisms, for example, there's rather less emphasis on advocacy and we wanted to express a couple of concerns about the way the draft report currently talks about advocacy services and to seek clarification if we could or at least put on notice that we would like further clarification. In part, our concern is a confusion about where advocacy is seen in terms of the broader notion of entitlement based services and the broader notion of the user-pay approach to services and structurally where it fits in the overall architecture.

There are a number of references in the draft report that concern us a little bit. In appendix E, for example - and I hope we get brownie points for reading the appendices as well as your report.

MR WOODS: Well done, yes.

MR OWEN (AT): That particular appendix, you will recall, talks about the key characteristics of good governance. One that it talks about is clarity and jurisdictional responsibilities, making it clear which level of government regulates what. There were references in the draft report in terms of advocacy and I can quote, "supporting all governments to continue to fund independent personal advocacy services". We're not sure what the design is here, whether there is an encouragement for state governments to continue to provide funding, whether as with other kinds of elements of the system there will be an expectation of the Commonwealth through the various structures being proposed to take over all of that funding or just what, but we do feel that that jurisdictional clarity isn't yet evident in the report.

MR WOODS: Do you have a preference?

MR OWEN (AT): Can I talk about the second lack of clarity first.

MR WOODS: Okay. Put it all together. I'm going to have to apologise soon; I've got a meeting that got delayed because of the floods but Robert will continue on

when I do disappear.

MR OWEN (AT): Okay. At the moment, advocacy in terms of the schematic diagram that I'm sure you'll recall from page 407 from memory, positions advocacy down on the bottom left-hand corner as directly funded by the Department of Health and Ageing, whereas - - -

MR WOODS: Yes, deliberately. Care, coordination and case management is part of the gateway entitlement to service, yes.

MR OWEN (AT): Yes, whereas complaint management mechanisms are dealt with under the AACRC.

MR WOODS: Yes.

MR OWEN (AT): We had always seen ourselves as being important partners in terms of the quality assurance aspects of this system and many others.

MR WOODS: True.

MR OWEN (AT): In the proposals being put forward as part of the national disability insurance scheme, that's certainly the case. Advocacy is understood as being a poor component of the supports in the mainstream service component.

MR WOODS: We also see it important that you're separate from those services, that you support the consumer, that you're not tied into the delivery of those services, but let's have that discussion.

MR OWEN (AT): We're certainly keen to see that support but also to understand advocacy as an important entitlement, comparable in that sense to any other service module within the overall system. So we're keen to get feedback, if not now, then at some stage in the final report about just what is proposed.

MR FITZGERALD: I think the point you raise is very valid. It's very clear in the hearings and the discussions we've had since the draft that the area that we have not done well enough is this area of consumer support, in trying to identify those roles. There's a number of elements to those. One of those elements is about information; one of those elements is about what you've called supported decision-making, and there's a number of other elements. So it's very clear to me that we've not been as articulate as we need to be about those sorts of support services.

A second but related group is social inclusion services which are of a different order. Those - what I can call community support and social inclusion services -

appear to us, going forward, to be, firstly, block funded, direct funded, not entitlement funded; in other words, they don't seem to lend themselves to a person walking in with a cheque for an amount of money. Now, I'd be interested in your view. We would think advocacy services are the same, that a block funded approach would be a better approach.

MR OWEN (AT): We'd agree with that.

MR FITZGERALD: Secondly, we see those services as being supportive of the consumer as they try to navigate and enter the system, and also as they process through the system, including making complaints. I think we haven't done a good job of articulating that, so I think you're right to raise that issue. In the advocacy area we did say we believed there should be an increase in personal advocacy or consumer advocacy, absolutely. I think we're at one on that. The question is, what is the best way to achieve that. So I agree with your point. I don't think we've done a clear enough, good enough job of articulating where advocacy fits, together with a number of those other services.

The second thing is, what is the best way forward. When we had the Elder Rights Advocacy - a part of your network - in Victoria, we asked them the question, should the government simply fund the existing national aged care advocacy arrangements - which you're part of that network. I think you get about 2.5 million collectively between the aid agencies. Is that the right model? But can I just preface that. In addition to that we've got a lot of peak bodies, for example, Alzheimer's associations and so on, who also claim, and rightfully so, that they're also advocates. So just give me a way forward. If we can get it right as to where it fits within the system, what is the actual way by which government should increase its commitment to advocacy, both systemically and personal advocacy.

MR OWEN (AT): Okay. If we've clarified that we're not heading towards an entitlement based approach to advocacy - - -

MR FITZGERALD: If you think that's right.

MR OWEN (AT): - - - and we don't, there still needs to be significant flexibility in the face of that likely significant increase in demand, and block-funded approaches tend not to be all that responsive to those changes, especially through the funding year, so attention will need to be given to that.

MR FITZGERALD: Can I just clarify what is your position: do you think advocacy services should be block funded or should be entitlement based?

MR HARDAKER (AT): I think we would say in general block funded. I think

when we're talking about entitlement we're thinking more in terms of the fact that advocacy has never been tied to the system in terms of the way other sorts of decisions are made, such as the number of people over the age of 70, for example. So we did an exercise about a decade ago in calculating what amount per service user in the system advocacy was funded out of. It was equivalent to a slice of pizza for each person. I think over the last 10 years since then it has actually gone down. So you're probably only getting half a slice of pizza. I think to have some sort of linkage between the number of people in the system so that they can access and be entitled to access advocacy is what we're - - -

MR FITZGERALD: Okay. So you're talking about entitlement to access, and a funding formula that responds to growing demand.

MR HARDAKER (AT): Yes.

MR OWEN (AT): But there's a further wrinkle, if I might say, further confusion for us, that there are references elsewhere in chapter 12 to subsidise consumer advocacy services. I'm presuming the term "subsidise" has been used carefully - it comes up a couple of times - and seems to indicate that advocacy services are to be understood as some part of the user pays approach with subsidies applying, but we're not clear.

MR FITZGERALD: No, well, to be totally honest, neither am I. It may not be deliberate. It may just be a use of terminology by the author, but what is your view about co-contributions in relation to advocacy - this is by people who are able to afford that?

MR OWEN (AT): Well, again in terms of our current cohort of consumers that walk through our door for advocacy support, they are almost universally on very low incomes and already facing the challenges of negotiating a complex system. To add another layer of complexity and potential access barriers would seem to be counterproductive, so we would oppose that. In terms of the future of a kind of entitlement based advocacy service for a broader range of people in a broader range of income strata who are now going to be negotiating a wider range of choices in the future system, that will need some thought.

MR FITZGERALD: Yes, that's true. But can I just go back a little bit further. Just assume we are talking block funded and assuming that you have some sort of way by which that funding can be more responsive to demand - and advocacy services I realise are very unresponsive in their funding - what is the best way for that to be achieved? Is it to increase the current specific aged care advocacy network as the primary way by which that is achieved, or is there a better way of doing it? Now, all of the peak bodies rightfully will say, "Well, we also need increased

funding," but what's the right way?

At the moment, unlike the disability area where there is a very large number of disability advocacy arrangements - and hence I don't want to comment on those arrangements - advocacy in aged care is much less and it's much more constrained.

MR HARDAKER (AT): I think we'd say what has always been a fear for advocacy services is the notion that organisations with direct service providers were also providing individual advocacy to consumers. The notion of direct service providers and other peak bodies providing systemic advocacy is entirely appropriate, but I think there's some real problems when you come to individual advocacy. The fact that there are disability advocacy providers who could potentially also be providing aged care advocacy - and there are at least three services already out of the aged care advocacy network that do both - means that there is probably a wider possibility in terms of who can provide those services to the aged care sector then just the NACAP services.

But I guess the NACAP services would say that each organisation has 20-odd years' experience in this area and that's something that isn't easily found anywhere else. I think we'd like to see it built on, and it has been a sector that's been starved of funding. There's been one small increase in the bucket over the last decade, and it really has been a forgotten part of the system.

MR OWEN (AT): Just to complicate things further, we do anticipate that an increasing amount of our work under the proposed structures of the NDIS and VH Care system will be assisting people at the interface of those two systems. That's going to raise some interesting questions if somebody is looking to receive support in deciding which system to be part of or which parts of the system to access, which funding bucket is supposed to support the advocacy service. We can deal with that within organisations to some extent and always have been a multi-sector organisation. But in terms of the purity of funding arrangements that we're talking about and what's most appropriate, there will need to be some kind of an accommodation between the two sectors at a funder level, a broad architectural level.

MR FITZGERALD: Yes, well, some of that still has to be worked through as you would be aware. I think your opening point was it would have been preferential to have the disability and aged care to come together. I can just comment on that: we looked and looked at that and it is not possible to do it in the Australian context for a number of reasons. As desirable as it looked originally we've just not been able to achieve that. You're right, we're going to have two systems but we've got to be very careful that for the person going through those systems they are not constantly pushed between one or other. We'll have to change their providers.

One of the important issues we've already agreed on is if a person who is on the disability system at the pension age or any age thereafter they will be able to elect whether they stay in the disability system or moved to aged care. That is completely independent of the funding. Where that funding comes from is still to be resolved. But we absolutely don't want a situation where a person is in the disability system, receiving appropriate care and support, with a provider that they're comfortable with and suddenly gets forced across; that we don't want to have happen. Who funds that is an issue.

MR OWEN (AT): That's right. We do anticipate though that in some ways the disability inquiry or the outcomes of that have trumped the aged care one in terms of lifting the bar about self-determination a little further, with further options of cashed-out entitlements and so forth.

MR FITZGERALD: Again we looked at that. You're right, the disability system will look slightly different in terms of the entitlement arrangements. It's very interesting that in terms of the advocacy that we received from the two sectors - both the disability sector and the aged care - the advocacy was entirely different in relation to those issues. It became very clear to us that the ageing sector and the disability sector, whilst they absolutely cross over, have very different views of the world, and that is reflected in the two, of course. Within each of those groups there's a great variation of views as you would well know. We've run out of time, in fact we're over time, but thanks for that.

I absolutely take on board your comments. As I said, we acknowledge that that's part of the report that we need to be much clearer about. As to the subsidisation, my feeling isn't about co-contributions for advocacy services. I actually think what the author of that chapter was talking about was simply public subsidisation and funding. I want to be absolutely certain about that, but it's not our intent at this stage to require people accessing advocacy services to co-contribute.

MR WOODS: Which is why we have that separate stream, rather than tied in.

MR FITZGERALD: Thank you both. We might break for morning tea. Thank you very much.

MR WOODS: Thank you. Could I ask the people at the back of the room if they can either resume seats or move outside, please. Thank you for your cooperation. Could you please for the record state your name and any organisation you're representing.

PROF ROBINSON (UT): My name is Andrew Robinson. I'm the professor of aged care nursing in the School of Nursing and Midwifery at the University of Tasmania and I'm the co-director of the Wicking Dementia Research and Education Centre in the Menzies Research Institute, Tasmania.

MR WOODS: Thank you and thank you for the several papers we now have from you on this topic. That has actually been very informative and in your most recent paper there is some excellent data there that we're working our way through so we're very grateful to your contributions to this inquiry.

PROF ROBINSON (UT): My pleasure.

MR WOODS: Please, talk to us.

PROF ROBINSON (UT): I suppose that I am really going to refer my comments specifically to the residential aged care sector in terms of the wider aged care system. So I'm just really talking about that sector because that is where I have been working very intensively for probably the last decade and, as I've outlined, we have done projects in over 40 aged care facilities across all the states of Australia that involved hundreds of aged care staff and students. So we've got quite a big repertoire of research to draw on and make our conclusions and I included a list, a summary of all those publications from that research effort at the end.

MR WOODS: I noted that and you are well quoted.

PROF ROBINSON (UT): I would say I'm probably the driver of that program but it involves collaborations across Australia. So I think that in the Productivity Commission it was very affirming to see what you described as teaching aged care services and I would describe as teaching nursing homes was endorsed in the inquiry and we were very appreciative of that and thought that that was very positive development. I guess why I responded in this way with my submission to you was that that seemed to be linked primarily to workforce and addressing problems with workforce which are endemic and seemingly irresolvable. As I have said to you before I think one of the statistics which is really remarkable in this area is that the Richardson report highlighted that between 2003 and 2007 the number of nurses in aged care decreased by 20 per cent but in that time we worked out that the number of

new graduates available in the workforce increased by 40 per cent.

So I think that highlights that we have a really significant problem. When you add that to the fact, as your Productivity Commission said, that we're going to go from .7 of GDP to 1.9 per cent of GDP, so we're going to have a massive growth trajectory, then I think there is a real issue here. I think part of the issue relates to that it is really evident in all our work is a very rapidly changing demographic of the population of residents in aged care and that those residents are now older, frailer, sicker and I would have to say to you when I first started nursing a lot of them would have been in hospital, they would not have been in residential care. So we have a disjuncture now between the way the aged care organisations function which has really, we would argue, a domestic rehabilitative focus. That comes out of the Aged Care Reform Strategy from the Hawke government which was the home away from home, which was a domestic environment, which was somewhere where people lived for a long period of time and the sector, I believe our work suggests, is still functioning organisationally along that model.

At that same time the profile of residents has changed. It is not unusual to hear aged care providers say that 50 per cent of their residents will die every 12 months. This is not a domestic environment. It is not unusual for people to say that 80 per cent of their residents have some form of dementia. So we have really shifted out of this domestic rehabilitative focus into what we might say would be a subacute end-of-life dementia care as a really key component of the work that is going on. What we do when we're coming in and we're researching aged care is we come and we try to build - we have been working with clinicians and trying to build evidence based practice and the Commonwealth government has been excellent in funding those sort of initiatives.

But what we find is that we probably spend half our effort on trying to manage the lack of capacity of this sector to engage in this sort of activity because there is no history, there is no precedent, there is no capability in this area. It is very different to a teaching hospital where you have got a strong research culture, you've got professors, you've got students, you've got all manner of people. But in this sector there is really no real capacity to engage in research. So a lot of our work and a lot of our effort goes in building that capacity. That is what needs to happen if we are going to manage this change in resident profile.

So, for example research out of America shows that 40 per cent of people with dementia in residential care have an unnecessary medical intervention in the last three months of their life. That is an appalling statistic but it really highlights that we're not managing that population. It's not for lack of volition, it is not for lack of wanting to do that, it is really around capacity. So part of what my submission is really saying to you is it saying that it is much more than workforce that teaching

nursing homes deal with. Our model which I supplied in a previous submission really talks about a whole of organisation change. So if you are in a business, you're in a corporate business in finance or you're in insurance and your market changes, you will need to bring in external consultants to help your organisation adapt to that change.

That is exactly what needs to happen in residential aged care. The sector needs assistance to look at how it needs to change and adapt organisationally to support the new care needs because at the moment our work shows there is a disjuncture between the organisational imperatives and the care imperatives and because the organisations generally work in a hierarchical model, the organisational imperatives overwhelm the care imperatives and that really is the heart a lot of the problems in recruitment, retention, care provision because we lack a capacity to really adapt to this very rapidly changing circumstance.

I have listed there - I don't need to go through it - our analysis of the issues that have come out of there, a lack of synergy between organisational priorities and changing care priorities; long-standing problems with recruitment. So a declining skill base; the real concern here is we have a declining skill base in the context of escalating care needs.

MR WOODS: And you talk about the RTOs in that context as well?

PROF ROBINSON (UT): Yes. RTOs in themselves are - 70 per cent of the workforce are unregulated workers and how can that be; how can they be unregulated in that sort of context, given the people they're caring for?

MR WOODS: It depends what the supervisory structures and the like - - -

PROF ROBINSON (UT): The supervisory structures, by and large, our work shows - and there's lots of evidence to say - are often a concern, because there are not adequate people. As well as that, our work shows that the knowledge - the capability - of the workforce; their knowledge, for example, of dementia, their knowledge of palliation hasn't kept abreast of that change in resident profile. I said in there that it was, I think, 2009 when the Australian Institute of Health and Welfare first mentioned dementia in their residential aged care reports. That's extraordinary that it wasn't a key analytical category for their clients.

MR WOODS: Can we just explore the relationship though between having a skilled workforce, particular providing the personal care support, and being regulated? Why the nexus?

PROF ROBINSON (UT): I would argue that's important because we need to have

some standard for training.

MR WOODS: Yes, agree with that.

PROF ROBINSON (UT): That's really the nub of it, so that we can know what we're getting. Currently, I think, when I speak around the country, people say, "You'll get somebody with a cert III who'll be fantastic and somebody that's hopeless." That training then needs to meet certain standards, because currently it doesn't.

MR WOODS: Isn't that what the industry skill council is meant to be doing - - -

PROF ROBINSON (UT): I can't speak for the industry skill council.

MR WOODS: - - - and don't we need to correct that process first, rather than - - -

PROF ROBINSON (UT): I think that may well be the case, and I don't really want to get into that whole debate about the unregulated workforce. What we do know is that we need to put some effort into how that workforce is trained and supported.

MR WOODS: Completely agree.

PROF ROBINSON (UT): What we're talking about then is that if you have that current environment in residential aged care and you put new graduates into it, it's not capable of supporting their development, hence high levels of turnover. So the teaching nursing home is a critical development to provide an infrastructure to make that happen. That's where you really need to get a strong alignment between universities, which can bring enormous resources into the sector, and residential aged care providers. To do that we need, as you noted, proper funding. I see that the issue of teaching nursing homes is a far more important issue than just workforce, because workforce is critical to that, but it's really about how are we going to provide appropriate care to rapidly increasing numbers of increasingly frail people. At the moment we can't do that.

In many respects, I've got to say to you, what is interesting in our work is that aged care people think about aged care, but they don't think about palliation. I know that comes into the ACFI funding tool, but a lot of people, for example, do not associate dementia with palliation; they associate palliation with cancer and dementia with aged care, they do not bring the two together. In fact it's a lack of recognition that dementia is a terminal condition; people don't die with dementia, they die of dementia. So we've got to build this hold new discourse around dementia palliation in the sector, about how do we support people with dementia to have a good death, so that we don't have family members coming in, seeing a decline of their loved one

with dementia, not recognising that's part of the trajectory, and then indicating that they don't have faith in the capacity of the aged care provider to provide care, so they send them to hospital.

MR WOODS: Dislocate the person and the unnecessary stress.

PROF ROBINSON (UT): That's right. The other thing that's really evident is that when we're talking about new models of care in residential care, is that when you have - the work that we've done, with my colleagues Peter Orpin and Kim Boyer, who's here, has really highlighted that people with dementia and their carer are a dyad: so when they come into residential care, the carer doesn't want to give up responsibility; they want to sustain responsibility. We have to develop whole new models for how that can happen, because currently it doesn't. Currently they come into a very hierarchical environment. That's historical. There's never been any effort, any funding, or anything to try to change that. It's been the accepted way things go. I don't mean this as a criticism of the sector, I mean it as a reality. They struggle to have a say. For example, that's one of the areas, and then so you have a much more collaborative model of care.

But this is all this research, all of this effort, about how we're going to actually care for people, how we're going to provide new models of care, what sort of skill base do carers need; we haven't really got any evidence of this sort of work. If we don't have an infrastructure to support developing that evidence base, we're not going to get it and we're just going to keep blindly going on. So the infrastructure is really around setting up a teaching nursing home. Rather than facilities having to take the whole responsibility for how they might support capacity building among their staff, support engagement of family members so you reduce complaints, support evidence based palliative care practice, we need to bring in the university, which has all this expertise in these areas, and provide an infrastructure to support that engagement, much as we do in a teaching hospital.

In a teaching hospital, if you take the students out, that would die. A teaching hospital is the place where, if you're very sick, that's where you go. I've personally nursed proprietors of private hospitals in teaching hospitals, because that's where you go when you're sick, that's where the professors are, that's where the evidence based practice is, that's where the cutting-edge medicine happens. We need a similar model, only not based around a medical model of care but a social model of care, a social model of care but with far greater medical input, into residential care. For us, we're putting out proposals and we now have small providers who are wanting to come into this program, involving whole of organisation change, where they subject their organisation to a review and redesign.

MR WOODS: That's not necessarily synonymous with the teaching nursing home

though. There's a whole spectrum of assistance that can be provided to residential aged care facilities, some of which is organisational redesign, some of which is additional training and upgrading of staff, some of which is a change of orientation to be more consumer directed, but there is also a need for teaching nursing homes at the other end of the spectrum. You wouldn't turn every facility into a teaching nursing home.

PROF ROBINSON (UT): No, you wouldn't. Our work, this very big body of work in residential aged care, would suggest that, whatever the case, if you want to change a nursing home or aged care organisation, you'll need to do some sort of organisational change process.

MR WOODS: Yes.

PROF ROBINSON (UT): The second area is that we say the best way to engage residential aged care is with students, because that's very non-threatening. If I go to a residential aged care provider and say, "Why don't we come and work with you to develop evidence based palliative care," their first response is often, "Don't you think we're doing a good job?" If I come to them and say, "What about we have students and we put in a whole infrastructure to support you, to look after students, to give them a positive place for experience, potentially recruit them," they say, "Can you come tomorrow?" So it's a very non-threatening way.

So our program would then involve students, and we've currently got a trial we're starting which would involve nursing students, medical students for the first time, and paramedical students. We've also got corporates such as Richard Sadek, here, Southern Cross Care in Tasmania, Catholic Homes in Victoria, and Rowethorpe, who are lining up to do this, to establish teaching nursing homes. In our model, that's how you would get them engaged. But what you would do then is set up an infrastructure, once you've established that engagement, and I outlined that process in my submission to you.

MR FITZGERALD: Sorry, just explain to me, the infrastructure is funded by the Commonwealth government?

PROF ROBINSON (UT): What we would say is that to fund this transition, where there needs to be external funding to fund, firstly, the engagement piece, where we engage, and then also to set up learning centres in these residential care facilities, and then to really provide support to establish conjoint positions.

MR FITZGERALD: In your submission you've indicated a cost of about $1 million to establish each such facility for the first five-year period.

PROF ROBINSON (UT): Yes.

MR FITZGERALD: That million dollars covers all of those elements?

PROF ROBINSON (UT): Yes, that would cover all of those elements. What we would see is that you would have a teaching nursing home that would provide a network for other aged care facilities, for general practices, for community care providers.

MR WOODS: So a hub and spoke type model.

PROF ROBINSON (UT): Yes. You would not want every aged care facility to be a teaching nursing home, but that would provide a local network in that vicinity.

MR FITZGERALD: Within the state of Tasmania, for example, if the government said, "Yes, we think this is a great idea," how many teaching nursing homes do you think, over the next decade, you would want to establish? I'm not asking you to be precise, but are we talking one per state? Are we talking several? What's your estimate?

PROF ROBINSON (UT): I would say, in a place like Hobart, we could easily have three or four teaching nursing homes, and you'd probably try to link them in to major organisations. Then in Launceston you might have a couple too, and then you'd have one or two on the north-west coast. So you might look at the state of Tasmania and you might say we would set up ten teaching nursing homes, and then we would review how that went. I think that in the first instance I would argue that we should roll this out to at least 100 facilities in Australia. Our work shows that we need to do it in a very strong and utilise a very strong and robust evaluation framework, so we can demonstrate outcomes.

My colleagues and I have developed a costing model for turnover. So we can cost the turnover prior to implementing it and then after implementing it; we can put dollar value on the changes in turnover. We can put dollar values in the changes in resident complaints, the changes in falls, transfers to hospitals, you name it. The idea would be that we know that people want to work in this sector, they want to work with elderly people. Our work shows, unequivocally, that if students are in a supported environment that a large percentage of them will want to work in aged care. They love the engagement with the elderly residents.

MR WOODS: Have you been able to do some piloting through scratching resources together?

PROF ROBINSON (UT): We've done piloting where we demonstrated through

the clinical model that we could go from 40 to 50 per cent of students saying they'd consider aged care to 90 per cent saying they'd consider it, and from 20 per cent saying they would definitely not consider it and zero per cent saying they would, to 20 per cent saying they would definitely consider it and zero. We modelled it and said that if, of that 20 per cent of students who said they'd definitely go into aged care, if half that went in, in two years we'd have 2500 extra aged care nurses. We are in the process of beginning a prototype of two teaching nursing homes in Tasmania and now we've got our corporate partners with Southern Cross in Tasmania, Catholic Homes in Rowethorpe, Curtin University and ACU. Where I'm not linking with Catholic Homes in Victoria, ACU are linking with them, so I facilitate that process. So it's a partnership between a university and an organisation to establish this, and they are lining up; we are simply waiting for funding for this to come on.

My concern is, if we do it and we provide inadequate funding so we don't have a learning centre for students, we don't have somewhere where they can go and have a university-level infrastructure in that site, that will greatly diminish their experience. That's also then something that would be available and accessible to the residential care providers, and for Health Workforce Australia, for these prototypes, we've costed that down to the chairs. We have a training room with 15 or 20 people, video conferencing, a student common room, we have four computers, we have photocopying and printing and an office for four people, so we can establish conjoint positions between the university and the residential care providers. So when we come in and we do projects in residential care, it's a bit like the tide; we'd have footprints until the tide comes in, we go and there's not a capacity, despite the best will and the strong volition to sustain that, unless it's in the centre of someone's desk.

MR FITZGERALD: Can I just go back to a question Michael raised about the personal care workers; as you say, the unregulated although not completely unregulated. Unregistered, certainly. We have heard, universally, concerns about the quality of training of that workforce, and we've mentioned it in the draft and we intend to ramp that up in the final. Putting aside the teaching nursing home for just one moment, what are the absolute essential changes that you think are necessary to get a better consistency and a better quality outcome in relation to certificate III level of training?

PROF ROBINSON (UT): My view is, and it's just my view, that there are some structural and conceptual problems. For one, we locate it in the VET sector, so that it's really difficult to have a research-informed education in that sector, because it doesn't engage with research. Our work and our research informs all the teaching that we do, and so you really need to (1) build a much strong evidence base so that we can have students being taught what they need to be taught. For example, I did a talk and somebody from an RTO got up and talked about their fantastic program. They didn't mention palliation, and this is an area where 50 per cent of residents will

die every 12 months in a lot of places; how couldn't palliation be a core construct. But it wasn't actually considered.

So our view in the Wicking Dementia Research and Education Centre is we are really, in terms of the university, thinking that we are looking at ways that we can provide education to unregulated workers. For a start, one of the things that we think that they need is they need to understand, for example, if the biggest problem is managing people with dementia, they need to have some idea of the pathology of dementia. They don't need to be neuroscientists, but they need to understand why it's inappropriate to go up and tell someone with dementia, "I told you, you shouldn't do this, you're very naughty." That's what we hear all the time. They need to understand something about that. So all of our work now involves some effort around talking about neuroscience and pathology, then they need to know the link between dementia and palliation; they need to understand that. Conceptually that is not a link that people make in the public and, I say, in health people don't make.

MR FITZGERALD: Why do you think the course itself - because what you're going to is you are actually saying the cert III course, and we've heard very big differences in the way it's actually delivered, but the actual course itself is no longer appropriate or relevant to the complexities around aged care?

PROF ROBINSON (UT): I wouldn't say to you I could make a judgment on that, because I'm really dealing with the products of the education. We've done some analysis of the courses and, I have got to say, from our perspective - we haven't done them all, obviously - there are problems, not only in the content, but I would argue in the way they're being taught.

MR WOODS: Sure.

PROF ROBINSON (UT): So we need a much, much more sophisticated approach because the people that they are working with - and I've got to tell you, if I talk about residential care it's even more notable in the community where unregulated workers go into people's homes, and who would know what's going on, and their capacity to actually look after those people.

MR WOODS: We keep focusing on people without sufficient skills.

PROF ROBINSON: Yes. So this is a really critical element here. So what needs to happen - you see what I'm arguing is that we need to bring residential care into mainstream health. That doesn't mean it's going to become medically dominated but it's got to become mainstream. We need to bring unregulated workers into the mainstream educational environment. But regardless - I've got to say - our work shows that if we do not have some fundamental change in the infrastructure that's

available to sector and how it functions, we can put all the people we like in there, we can give them all the training, we can do whatever we like but it will not make a big difference because the organisation, the sector itself, has to adapt to this new reality.

MR FITZGERALD: Excellent. Thank you very much.

MR WOODS: Thank you for your time. It's very helpful, a lot of the stats and that.

MR FITZGERALD: That's true, thanks.

PROF ROBINSON: Thank you.

MR WOODS: Aged and Community Services Tasmania, please. Good morning. Could you please individually for the record state your name, the organisation you are representing and the position you hold.

MS SAVELL (ACST): I'm Jill Savell, I'm the president of Aged and Community Services Tasmania.

MR MATHEWSON (ACST): Darren Mathewson, the chief executive officer of Aged and Community Services Tasmania.

MR HUNT (ACST): Rod Hunt, vice-president of Aged and Community Services Tasmania.

MR WOODS: Thank you for coming today, and thank you for your contributions so far in this inquiry. We've had discussions, meetings, visits and it has all been exceedingly helpful. We've also got some notes of matters that you want to raise today. Please proceed.

MR MATHEWSON (ACST): Thank you, commissioner. What we thought we'd do this morning is make an opening statement and then take questions. What I will indicate is that we've got a copy of the statement here, and any references to documents we've got copies of those if you would like those at the end of the hearing as well.

MR WOODS: Thank you.

MR MATHEWSON (ACST): Firstly, we'd like to focus our comments on Tasmania and identify the relevant issues or recommendations or areas of the draft report. The Aged and Community Services Australia submission which we've contributed to, will reflect the broader sector views on the draft report, particularly the broader systemic issues. Our feedback has been derived from experienced conduct of a one-day statewide forum of members, meetings with other Tasmania stakeholders and a series of surveys of our member organisations.

Firstly, ACST would like to indicate its support for the aims and principles outlined in the draft report and for the overall focus and thrust of the more detailed sections of the report. We believe this report provides a vision with detail on overdue reform of care and services provided to older Australians. We will mention a word of caution. Any new system will not be perfect and should have the ability to adapt to a constantly changing environment and respond to community and local issues, situations and demands within a fiscally responsible and accountable policy framework.

A clear lesson from the current system is that a rigid centralised system that places tight controls at all levels, results in a whole system failure and local disempowerment for all stakeholders. In terms of Tasmania, what we see as a regional island state, when you consider the size of our state and our population it should be of no surprise we fit a regional profile. In addition we have the most dispersed population of any state; the fastest ageing population; average income well below the national average; a limited and small state income base, and one-third of the population dependent on a government benefit or allowance.

Considering how these factors intersect with and influence the provision of aged care facilities and services, it can be argued that we, like other regional, rural and remote areas of Australia, will face major changes in tackling future reform. However, in light of our struggles with the current system, our providers will take on this challenge. We'd like to highlight some of these challenges and how we believe the final report should respond to these.

Firstly, the debate of collaboration versus competition in a regional area like Tasmania. Recommendation 1.3 which focuses on removing regulatory restrictions on the number of packages and licences is supported, as are other recommendations that deal with the loosening of controls over pricing and cost. However, in the context of a regional area and a small market like Tasmania, it is arguable whether competition will produce the best outcome for consumers and communities. This is reflected in the dominance of not-for-profits in the Tasmanian sector, upwards of 90 per cent, and small to medium organisations.

It may be that some metropolitan areas in our capital city would be able to support a level of competition but we believe that an approach to regional, rural and remote areas involves the following: block funding to ensure services can respond to community needs, as per recommendation 8.4; integration of health and aged services into community hub models similar to MPS, would also include a social inclusion wellbeing and community building focus in addition to that; incentives for diversification, collaborations, integrations that produce efficiencies, improved productivity and enhanced services to consumers and community; and state government to lead projects in regions around the use of remote technology et cetera, including sharing equipment with a broader industry.

Such issues we believe would simplify and localise access and maintain services and employment in local communities. These should also have connections with teaching aged care facilities and build well-resourced and supported local governance. Health reform needs to work with aged care reform in a state like Tasmania to drive the destruction of silos and build a collaborative culture with integration and access underpinning a community and person-centred approach.

Page 262 to 265 talks about the critical interface between the two sectors and in-reach pilot projects.

The hospital aged care liaison team and outreach team that works in the Launceston General Hospital has produced real results. Such programs need to be ongoing in nature and be established practice. Also where transitional care units have been established in our aged care facilities, these have been instrumental in reducing hospitalisations and providing appropriate care. Tasmania is also lucky enough to have the Wicking Dementia Research and Education Centre, which is part of the Menzies Centre and University of Tasmania. We believe this provides an opportunity for a productive partnership with the sector in terms of research and evaluation. Draft recommendation 13.1 should encourage such partnerships to ensure research evaluation evidence based best practice is embedded and part of the sector, not separate.

In surveying members there was definite support for a collaborative approach, consistent with the recent projects we have coordinated and the regional nature of Tasmania. Our members continue to explore options for creating sustainability, ensuring local services and maintaining the local identity and ownership of community organisations. These may include sharing the cost and operation of back of house services; management of small community based organisations whilst maintaining their local identity and assets, and group purchasing arrangements.

It may be worth considering a regional viability incentive for the sector in Tasmania which recognises the locational disadvantage but seeks a solutions innovations based response from the sector, underpinned by collaboration and potentially integration of broader services in specific communities. This may also be a useful encouragement tool in the HACC transition as these organisations enter a broader system, less characterised by jurisdictional demarcations.

In terms of local costs and challenges, firstly utilities: we support the costing of care to reflect regional differences. Our costs of electricity, sewerage and other associated items reflect a small market with inadequate competition, plus a commitment to localised goods and services where possible. The move to retail contestability for electricity is a clear example where most of our residential care members report increases from between 15 to 25 per cent over a 12-month period with a smaller number reporting stable or decreasing prices. The key factor for a latter result is more than one supplier competing for the contract. The volatility of the energy spot market has resulted in a wide variance of results, even within a region, so measuring such an input into the cost of care, services, or accommodation will have its difficulties. The other significant challenge, particularly for our smaller providers, was understanding and engaging with the new contestable environment. Most of the education and support was provided by their peak body with little

government intervention or assistance.

In terms of labour, recommendation 11.1 raises an issue about what is a competitive wage in Tasmania. With the state government involved in the provision of aged and community services it is not unusual that they have provided a benchmark for payment of nurses, carers, and non-nursing staff above what can be paid by the not-for-profit and private sector. For example, a small not-for-profit, community based provider in a small town can only afford to pay ECAs $17 per hour, whilst next door a state-run facility can pay $21 per hour.

Recent changes around the administration of medications and the introduction of the new modern awards have proved difficult to implement because the relevant unions that are more active in the public sector see conditions and practices in this sector as the benchmark, which we understand and agree with but at the end of the day we have limited capacity to fulfil. When you add this to the challenge of actually recruiting new staff in the whole aged care and health sectors, it would seem that there is unequal competition for a scarce resource, where ultimately the consumer and the community suffers. It is most frustrating when this competition occurs in the same communities and our view is that collaboration and integration of services has to be a workforce strategy in such regional areas.

Recommendation 11.4 refers to teaching aged care services, and in Tasmania we are not only supportive, but our partnership approach with the University of Tasmania sees us starting down this path. This is despite the bureaucratic, cumbersome lack of support from government. We think this is the way to create a professional recognised career and pathways in aged care. We have also, driven with our sector and engagement with the RTO sector, focused on quality, responsiveness, relevance, and partnerships. Again these strategies have been driven and resourced by the sector peak.

Working environment is key to retaining and attracting aged care workers and quality educational infrastructure that is embedded in the sector and serviced by constructive partnerships, we think, is the key. Pages 12 to 19 of the National Aged Care Nursing Round Table Final Report, which I have copy of for you, clearly promotes the importance of partnerships, hub models, the need to support rural and remote, building evidence based best practice, and then map some steps forward. What we believe is we need to walk quicker, and in fact we need to break into a jog.

Capital and infrastructure: Tasmania will be faced with a high number of supportive residents relative to the other states and therefore it will be less able to set its own accommodation charges and potentially invest beyond current residential care capacity. Our members see capital grants as important to regional areas like ours. Recommendation 10.3 should be more overt about the need to ensure that

current housing stock for older Australians does not drop out of the market due to an inability to invest in rehabilitation and renovation. The experience in Tasmania is that older stock has been lost as affordable housing, and smaller providers in rural areas are struggling to maintain current infrastructure and/or access or navigate programs that could potentially offer funding.

Community care in the most geographically dispersed state: adequate funding must be provided to meet travel costs to deliver community care in rural areas. Some of our members are paying $1.05 per kilometre to staff to travel between clients in rural areas. In rural areas a "three times a day" visit for each client may be essential. It is common for a 40 kilometre roundtrip in rural areas, as indeed it may well be in the city, three visits a day in travel alone is $126, which leaves $6.99 per day for direct care from the subsidy of $132.89 per day. Client contribution in rural areas is often zero due to financial hardship. Brokerage of extended carer assistant care costs are about $35 an hour.

With reference to recommendation 8.1, if the proposed gateways are to be truly regional in Tasmania, they would need to be north, south, north-west, and also be mobile due to the geographical dispersal of our population and, subsequently, our client base. So we would also need to service the east coast and the west coast. Most importantly they would need to be adequately resourced; for example, recently in the north-west of the state there were 150 people in the community awaiting assessment due to inadequate staffing of our ACA teams and our members had vacant packages and residential beds unable to be filled.

Implementing reform and achieving local involvement: we believe that the approaches and partnership mentioned above have had to been driven by the sector through its peak, as the reality in Tasmania is that we face the following distinctive challenges around coordination of initiatives, reform, and championing change. We have a large number of small councils, local government with resources, who do not engage around aged care generally. We have a lack of physical offices or on-ground support from national coordinating bodies; for example, the Community Services Industry Training body. We have a lack of critical expertise available at the earliest opportunity; for example, around the Aged Care Funding Instrument. We have to wait and then we have to purchase that at a high cost.

Our accreditation agency operates out of Victoria and, more often than not, we are not included in critical sector consultations or projects, reflected in the recent round of Health Workforce Australia projects where Tasmania didn't get a project. To achieve true health and aged care reform in Tasmania there needs to be a process that includes aged care service providers, state government, acute health, primary care sector, consumers, and communities, and encourages them to examine the needs of communities and build integrated service models around this, ensuring services

and employment remain local, but, most importantly, older Tasmanians can age where they live.

The final point I will make is that a classic example of the role the industry has had to play in driving particular projects or changes is very current in terms of some of the flooding that's occurring around the state at the moment. There are clear obligations in the accreditation standards and there are significant pages of obligations communicated to us regularly by the Department of Health and Ageing, in terms of having policies and practical responses to external threats of flood and fire and other. It is only through the work of the peak and other agencies that we've been able to get a project up, which is partly funded by our members through their peak body, to put in place appropriate procedures, policies, and practical assistance to our members to start down the track of ensuring that we have appropriate procedures in place for emergency management in aged care, and when I talk about aged care, I talk about residential and community care. We've had no assistance from government, other than through the state government, and when dealing with the federal government we have been continually referred to different agencies and really not provided with the level of assistance that we should have. Thank you.

MR WOODS: Thank you. Would either of you like to add anything?

MR HUNT (ACST): No, we don't have any further submissions.

MR WOODS: If I could start at a specific level, rather than a general level, because one of the features of the Tasmanian scene as the operation of your MPSs, which, from my observations and our analysis, have actually quite a good model of collaboration. Do you see that as something that should be rolled out further, or are they occupying the right niche at the moment; and what is it about that structure that seems to work so well here?

MR MATHEWSON (ACST): I might kick off. We recently visited the Tasman multi-purpose service and that's a service that has had its challenges in the past, but we think has now come out the other side and is a proven case where it can work effectively within a community. It is now part of Hobart District Nursing, which is a metropolitan based district nursing service that provides broader services than just nursing. They are managing and they have undertaken a range of changes to improve that facility and, I think, have done quite well. In terms of what they provide, they cross all areas: primary care services, they provide aged care services, they provide community outreach; there's a broad array of services. We believe the model is relevant not just in that area - there's probably more a rural and remote area - but is relevant right across Tasmania, even when you look at the north-west coast, where recently a project we conducted up there indicated that an integrated health model, which we think is very similar to an MPS, would be relevant in that

circumstance as well.

MR HUNT (ACST): What struck me about that visit was the feeling of the integration of the service with the community, whereas I think it can be sometimes seen that an aged care facility is a bit remote from a community with the integration of a childcare service on site, the fact that the kitchen provides meals for both the children and the residents of the aged care facility and that they interact at various times during the day, the residents and the children, and also the fact that staff in the aged care facility also worked in the childcare service. It was very impressive and emphasised to me how important those sort of services were to actually giving the community a focus and retaining that sense of community and building that sense of community in those smaller areas.

MS SAVELL (ACST): The other thing was the great rationalisation of the medical services that they were able to achieve. They had gone from a system where most people visited the local GP after hours at the end of their day to a different system where they called the ambulance and they had doctors visiting regularly. It was really good.

MR FITZGERALD: Just in relation to that model, there are huge variations in the multi-purpose models around Australia. Most submissions prior to the draft were supportive of multi-purpose centres in rural communities. Some aged care providers felt that they excluded aged care providers from actually being in those centres because they're largely government run and others had a view that they take on a highly medicalised model or approach. It depends on the model, so I can't comment on the one you have. But taking my next point even further, is one of the ways to address the issue of very small regional communities where there are needs for health and aged services, is it to roll those sorts of models out across those smaller communities. Is that the right approach? In other words, trying to look at the Tasmanian issues specifically, what is the right approach to providing both community and residential aged care services to fairly small communities? What do you think is the way forward? We don't have to be prescriptive about that, but I'm unsure as to what you as a sector believe is the right way forward for those smaller communities.

MR WOODS: And pick up your concepts of collaboration in thinking through that.

MR MATHEWSON (ACST): We in Tasmania have been focused on creating relationships across both primary and acute and so that reflects our view that we think the multi-purpose services model has real merit. My colleagues in New South Wales often say that they have multi-purposes but they're not as good as Tasmania, in fact nowhere near it. So we must be getting something right if New South Wales say we're good at something.

MR WOODS: We have visited both models and we like what you do.

MR MATHEWSON (ACST): Yes, that's right.

MS SAVELL (ACST): It seems to work for the whole community.

MR MATHEWSON (ACST): Yes. I think one of the lessons from the Tasman experience is that firstly another provider that is larger and has critical expertise in terms of managing that facility and those services has come in and made a whole bunch of changes that I think initially made the community uncomfortable, but they engaged with the community, they talked to the community about the importance of running an accountable and efficient operation - - -

MR FITZGERALD: Sorry, could I just understand that. The organisation came in and does it run the multi-purpose centre?

MR MATHEWSON (ACST): Yes.

MR FITZGERALD: It's funded by the state government.

MR MATHEWSON (ACST): Yes, and the state government own the buildings and they manage the facility.

MR FITZGERALD: But an NGO actually operates it?

MR MATHEWSON (ACST): That's right, and that's been a success story in terms of it was a difficult road with the community but I think at the end of the day, the community has understood there's a balance between getting what they want, but also the viability of these sorts of organisations. The other interesting thing about Tasmania is we have multi-purpose services and then multi-purpose centres and I believe that one of your comments is right, that there is a bit more of a clinical focus in some of those areas because they are state government run, they have more resources generally than our facilities, they can attract more nurses, although they still have their difficulties, and so - - -

MR FITZGERALD: They pay public sector nursing wages.

MS SAVELL (ACST): The other thing is that they are self-regulated as far as quality is concerned. They don't have the accreditation process.

MR FITZGERALD: Is that a good thing or a bad thing?

MS SAVELL (ACST): It's working. The quality is there. From a practical experience, it would be more attractive to staff to not have to work under the cumbersome constraints of - - -

MR FITZGERALD: But just taking that point, you say there's no accreditation, including no health accreditation.

MS SAVELL (ACST): They have their own accreditation and I think they have ISO.

MR FITZGERALD: Because they're under the state system.

MR HUNT (ACST): Just in terms of the question of how you achieve efficiencies, I think there are two ways that you can ensure that there are services provided and that you achieve economies of scale, and that's either through consolidation of facilities and smaller organisations being taken over by larger organisations or you can have collaboration between smaller organisations. I think the risk with consolidation, although I recognise that's inevitable, is that decisions are made that a particular facility may no longer be viable and therefore it's closed down, so you haven't actually achieved an efficiency by that route, but what we're exploring - and there are examples of this, and I think the Tasman MPS one is a good one, but that's not the only one that is likely to happen in the near future - is that smaller organisations can combine to share back of house operations like payroll, like HR, like a quality section. Those things can be done and with that model where service agreements are made and services are paid for by the smaller organisation, you can actually retain that local identity but still have a service but have an economy of scale and have a service that still is open.

MR WOODS: So given that there seems to be logic to that and that it helps ensure the ongoing existence of those small facilities, what are the barriers, other than those facilities themselves fearing losing identity or losing control or not being aware of the efficiencies that could be generated? Where are the barriers and is there any role for government? I take a sceptical view to start with, but beyond that is there evidence that there is some role for government in this process, other than central planning, which I think we'll try and avoid.

MR MATHEWSON (ACST): Absolutely we think there's a role of government, particularly a facilitative role in terms of change. I mean, what we're talking about - and we've run a series of workshops with our members about change and about increasing collaboration. We've conducted the north-west project. But I think one of the obstacles which you referred to is that we can sit in a workshop or conduct a project that leads to a certain model. It's then, having our local volunteer boards, giving them the capacity and the support to see the bigger picture and then delegate

the power of the authority of the CEO to move to that and it's also I think critical for a player like the state government to play a leadership role in terms of facilitating that change as well. I think essentially that has been one of the gaps.

We get to the point where people can see essentially where we need to move to. It's then being able to include the broader group in the picture of where we're going to move and giving them the understanding and the support to do that. That's a challenge in Tassie where we have a large number of small organisations all with their own boards with passionate, committed community members and often we feel like we can't engage them around that debate where, in essence, my view is that we should engage them around that discussion, we should say to them, "Look, you don't have to carry the can on all this. It's about us working as a sector and a community to build what is the best for that community." One of my great frustrations is when you get in a room with various stakeholders, players, whether they be state government or our own providers, people automatically revert to who owns what and who does what. Our view is you start with, "Well, what are the needs of the community? How do we build something around that?" Forget about who owns what or who runs what and then build so-called around that and it may well be that not-for-profits do take over some state-run facilities or it may well be that the state keeps the building and we manage it. It's what may best fit that community at that point. But I think it is actually getting people to take the first step.

MR WOODS: We are running out of time but just one last one from me and then perhaps Robert. The debate in Tasmania - and I don't know why - but quite often quickly reverts to facilities, residential aged care facilities whereas the whole trend is for care to be delivered in the community and as you look out into the future that is where the vast majority of care will be delivered. So what are the issues and aspects of our report that you either want to make some suggestions or changes to or are supportive of on the community based care because that is where the action will be in the future and even in your small rural communities allowing people to live there longer rather than having to move to a facility in the town next door but providing services and the like.

Now, you made some mention, and quite correctly, about the cost of transport and the 40-kilometre distance and the three visits a day but are there more issues that you would want to draw to our attention in that?

MR MATHEWSON (ACST): I think one of the critical ones, particularly in the smaller areas, is the competition around for staff and the difficulties in getting staff. I think one of the things that we have talked about for some time - and we believe would be important for Tasmania as the HACC moves into, I suppose, the Commonwealth arena - is that part of that transition is again building those relationships with other aged care organisations. We have a lot of small HACC

organisations in Tasmania. We believed that at various times we've become siloed so that there are service gaps around Tasmania.

MR WOODS: Which we're trying to overcome by making it more seamless.

MR MATHEWSON (ACST): That's right. Part of that also though is an encouragement or incentive for organisations, whether they be residential or community care, to diversify and build relationship so they can plug those service gaps.

MR WOODS: Absolutely.

MS SAVELL (ACST): I'm really excited about the fresh approach that you have taken - because community care is my area - to eliminate the silos as they are now. I was really excited about that. The other thing that I think is wonderful is the fee determination to be done by an independent agency. I know that has been discussed by ACSA at a national level but I really see that that adds very much to the viability to organisations because it's a very difficult thing and if it's totally independent, away from the service provider, I think that that is just great. One thing I am not really sure about is what weight is being given to the new aged care model options which was an appendix to the draft report.

MR WOODS: It's an input into our process. We commissioned that at arm's length. We said, "Richard, we don't want to tell you what to write but we do value your views on these matters. You write a piece that looks at that issue. We will publish it. We will get people's responses to it and we will then reflect on that in our final." But it is not created in our mould for us, it is Richard's own thoughts.

MS SAVELL (ACST): Thank you for that.

MR FITZGERALD: The most central issue is whether or not in all of the care areas you move to a building-block approach or the alternative is a levels approach where you've got level 1, 2, 3, 4, 5, 6, 7. So in a sense Richard wrote that on the basis that there would be a move away from levels to a building block approach and we have moved. We looked at levels, we thought that was the way to go; we've moved to a building block approach. But we are very, very, very keen to get the sector's view as to whether that is appropriate and if it is, the detail of it. But that is a central issue and Richard's report does reflect a changed position that we had.

MS SAVELL (ACST): Yes. I think that because we weren't quite sure where it sat that there needs to be more discussion and debate but we would be really anxious to have some input.

MR WOODS: You give us your feedback.

MS SAVELL (ACST): We'd be delighted.

MR WOODS: Please tell us what you think.

MR FITZGERALD: Please tell us, yes. It is a very important issue.

MR MATHEWSON (ACST): I just wanted to make the point about the trend towards community that there are a number of organisations that, I think, would like to provide more community care packages. Of course what you need to do is actually win the right to provide the community care packages at the moment and that has been an incredible frustration in Tasmania in particular where we have expended enormous resources on writing submissions and then received minimal feedback telling us that, "It was very good but you didn't actually give us enough detail about point 6.4."

MR WOODS: All that goes away.

MR MATHEWSON (ACST): That's good because I think that you will find more flexibility and more responsiveness from current providers when that system is pulled away.

MS SAVELL (ACST): The organisation that I work for in Hobart has 40 community aged care packages. We currently have 150 on the official waiting list from the aged care assessment team.

MR WOODS: I'm sure you eke out and stretch the definition of - - -

MS SAVELL (ACST): We won't put that on record.

MR FITZGERALD: Going back to Darren's point, it will, much more than the residential side, it will really shake the sector because residential frankly there is a clear way forward under our proposals. In the community sector a lot of people will put their hand up to be providers that are not providers.

MR MATHEWSON (ACST): Yes.

MR FITZGERALD: In that area I think industry associations like your own are going to be very important because that part of the market will change quite radically over time, more so frankly than residential where everyone keeps talking about. It's the community side that's going to change, we think for the better, but there will be some major transitional issues going forward on that area.

MR WOODS: Any final comments? Thank you. That has been very helpful and we appreciate your ongoing contributions to the inquiry.

MR MATHEWSON (ACST): Thank you.

MR WOODS: If I can call Kim Boyer. Could you please, for the record, state your name and any organisation you are representing.

MS BOYER (UT): Hi, I'm Kim Boyer. I'm senior research fellow in rural health policy and service planning at the University of Tasmania.

MR WOODS: Please speak to us.

MS BOYER (UT): I guess I'm talking from the other end of the market than the previous speakers and Andrew. Our research - can I speak on behalf of a team of people which I will tell you more about later - is working at the end of the market of the representatives of the 70 per cent of Australians who actually don't receive any designated aged care services, either residential or community based, albeit that they probably are intrinsic parts of their community and obviously share in both provision and reception of the range of services that communities provide across all age ranges.

MR WOODS: Provide a lot of informal care.

MS BOYER (UT): Absolutely, both ways. I certainly don't want to in any way belittle the importance of the residential and the high-level care community packages for older people but I think it's really important that as part of the commission's report that you've actually focused on a wellness model but yet the framework for that is pretty frail, I think. If I can just tell you a bit about our research. Is that okay?

MR WOODS: Yes, absolutely.

MS BOYER (UT): We've provided you with a set of overheads and we have also provided, if you like, an off-the-record draft of a publication prepared by one of my colleagues. It's simply confidential at this stage and not for publication only because it's awaiting that dreadful academic stuff about presentation for journals and so we have to leave it like that but it's pretty valid. So essentially our team in Tasmania was formed for a range of reasons. We are seriously committed to the whole prospect of ageing well or healthy ageing in this state. Our work has been predominantly in rural communities and you have talked a bit about that before with the MPSs and with Aged Care Tasmania, so that's terrific and you've clearly got a really good understanding of our issues.

But I think it's fair to say that our regional basis is pretty common across regional Australia, particularly the eastern seaboard, and we have partners in a number of areas that we work with, say, in Gippsland and so on. So essentially our research team is headed by Prof Judy Walker who was a professor of rural health here and is now professor of rural health at Monash based in Gippsland; a senior

geographer called Elaine Stratford; Andrew Robinson, who has spoken earlier; Dr Peter Orpin; myself - and I'm called the partnership maintenance manager, that's because I used to be a former senior bureaucrat and dep sec here, so I actually try and get people across the university talking with people in the bureaucracy, and it's great. It actually does take a bit of work sometimes. Then Hazel Baynes is our post-doctorate research fellow and then we've got partners from the home and community area in Janet Carty; Carol Patterson, who is also here from the Tasmanian Council of Social Services; and Nadia Mahjouri, who was actually placed in our project. We've got a reference group to that group that includes two older and well-respected Tasmanians who played major roles in their communities; includes the state manager of the Department of Health and Ageing plus senior people in the state Department of Health. That group actually helps guide some of our research approaches.

So basically we were united in wanting to see change in policies and services to support successful ageing. We knew that that couldn't be done just by health providers alone. Health providers have important insights but they don't necessarily have all the insights. We wanted to obviously try and embed whatever we found into some sort of outcome. So I guess from our perspective we hear a lot about the ageing demographic and we hear about the problems it's going to cause, the extra costs it's going to cause us and everything, but we actually don't hear any of the positives about how much older people are contributing to the community and how valuable their insights and their roles have been.

Our research was really attempting to show what those older people wanted, but we were also keen to look at what might make the difference early. I mean you would know really well that if people have to get services they need to be assessed, and their care is high level, low level, medium level, they're okay for HACC but not for nursing home, that sort of stuff. Our view was there were large numbers of people who weren't anywhere near that but one or two particular events might cause them to tip over into that area. If we could actually put in place a system that could intervene at that stage to help them from tipping over, well, that might actually stop them from being on the long and rocky road.

It was pretty clear from the research that we've read that there were a number of those sorts of tipping areas. They would include - particularly in rural areas where I notice in your wellness model you actually tied it up with other social policy like transport and housing. In rural areas - transport, transport, transport. It's a major issue. If someone who has had a licence all their life loses their licence - - -

MR WOODS: That's right, the isolation.

MS BOYER (UT): It's absolutely critical. That's an area that we want to do more

research on how people manage with that. So that was one particular issue. Then you find in that transport area that the rules are such that you can only use transport to go to medical appointments - that's government subsidised transport - when naughty old transport people actually did things like take the old guys to the football or - - -

MR WOODS: Or the bowling club.

MS BOYER (UT): Actually took some people to the casino once, which was terrible. That they were roundly scolded that this was inappropriate and yet for those people's social wellbeing, having lost their licence, that was actually more important than going to the jolly doctor. So there was those sorts of things. Obviously death of a spouse or death of a close family member in that community is one of the things that ties people's social interaction and social engagement in that community, and that was important too.

So what we were trying to do is to look at what sort of intervention models might happen. We talked to - and we wanted to hear it from older people themselves. So we talked to about 70 older people in three rural areas in Tasmania. We tried to choose really different areas, so we chose - and our reference group was very important, with that. We actually chose the north-west coast close to Circular Head, so we had Smithton and Stanley: Smithton, which is a strong agricultural, forestry - or was, at the time - agricultural and business centre; Stanley, that was much more a tourism and fishing area. We chose the west coast which had mining in Queenstown and then at Strahan far more of the high tourism and, if you like, retirement area now. Then in the central highlands we chose Ouse and Hamilton, which are major agricultural areas but also we chose that area because it had just lost its aged care facility. It moved from having an inpatient facility to a community health centre at the time of the research. I guess the research was warped a tiny bit in that area because it actually reflected very much the loss of that facility and how people saw that.

The important thing about the people that we spoke to though was that only 6 per cent of them, so that was actually quite a small number, actually saw their own health as poor. They all otherwise saw their health as excellent, good or fair, even though they were all demonstrating a pretty significant level of chronic disease in some cases or other minor disabilities. So they all had challenges but they were overcoming those challenges. For them, the experience of ageing was that it was not a pathology but it was actually just one more step on the road of life, and in some cases, a positive step. It couldn't be cured but there were times when they had jolly good times and there was a need to address the issue for them that you didn't just put them in one basket and say they're old, they need help, they need care.

I wish we could get away from care when we don't mean care. I wish we could actually talk about support or involvement or some other word. I'm going to suggest afterwards that what we're actually probably trying to talk about is we actually need a pre-HACC HACC model.

MR WOODS: I'm sorry, a what?

MR FITZGERALD: A pre-HACC HACC.

MS BOYER (UT): A pre-HACC HACC model. In other words, that you actually don't have to be formally assessed in a medical or - - -

MR WOODS: Sure, yes.

MS BOYER (UT): But there's a way of actually picking up that you might need some help. So basically everyone ages differently. Our ageing is often a product of our youth, our history, or community, where we've come from, the sorts of experiences we've had in our lives. We don't just change because we've turned 65. I'm nearly and I'm certainly not intending to change, except I might have a - - -

MR WOODS: I don't think you could change either.

MS BOYER (UT): Basically what our older people are telling us is that there was some loss of things like mobility, energy, but the significant, if you like, vulnerabilities, were those areas that we talked about before: loss of licence, loss of spouse. I don't to actually say it in that order but those sorts of major losses were ones where potential intervention and support at that time could make a difference.

As well as that, their communities were changing around them. Like other people, younger people, older people coped differently with that change. Some welcomed the change, some found the change really confronting and disappointing. Much of that related to how much their own social networks and their own continued social engagement was able to continue at the level that they wanted. Most of them were actually engaging less than they had when they were younger but they were - if you like, the intensity of the engagement was just as strong.

So I guess from all of our findings and in bringing together that issue about the importance of social engagement and what sorts of issues might actually interrupt or affect that social engagement, another area was a major health event. If someone had a major health event that took them out of circulation and out of their normal social context for a period of time, sometimes for older people getting back into the social world, if you like, wasn't all that easy, and some assistance in that sort of area could be really useful.

MR WOODS: Including falls?

MS BOYER (UT): Including falls, particularly. We had one lovely example of an older woman who told us about having - she was an avid bridge player. She had to have major back surgery and her grandson worked out that she could play bridge on the Internet while she was sedentary. It made the difference. She could continue to play with her friends and meet her friends virtually, so it meant she fitted back in right around the bridge table when she actually was able to return six months or seven months later. A fairly small intervention but a really very positive one.

So I guess we looked at models in the community and we were lucky to find one that didn't deal with older people particularly, it dealt with men at risk of suicide in rural areas. It's called Rural Alive and Well and it's part of the national suicide prevention program. What those people did was actually keep an eye on - they lived in the community, they were part of the community and they just kept an eye on people, but they had very strong privacy protocols and all of that sort of stuff to do it properly.

So what we want to do, and we're working with our state colleagues, is try and develop a model which looks at testing that sort of support within communities for older people model. It doesn't replace existing services but it puts people in touch with existing services and it makes sure that those services deal with those people, so it has almost an advocacy role as well. It actually deals with older people as real people. It deals with them as part of their community, because our older people didn't want help.

They didn't see themselves - like, "What's the government got to do with us?" they would say. They loved HACC programs but they didn't ever see those HACC programs as being government provided. They saw HACC programs as being community provided. I think that's great. The government is not so keen on that but I think, thought it was great. So day centres and those sorts of things they could do as a group were really important. Individual services were also useful if they could have things done like lawns mowed or heavy things done, but in many cases, those of them who were getting HACC services and they had been assessed for HACC services, they didn't want what they were getting. If they had someone coming round to do the cleaning twice a month, they said they would much rather have someone taken them to the shop to do the groceries, but they weren't allowed to do that. So there's an issue about flexibility here. I know the new lot of packages are actually trying to do that.

I think what we'd probably be saying from our research is your wellness model is great but it needs to actually ensure that services aren't tied to being inflexible and

being required to do that. The other thing that we actually find is that the medical and nursing model of occasions of service and how that's measured and how services are evaluated in terms of occasions of service often doesn't work for the sort of support services that we're talking about. Perhaps I should answer questions now.

MR WOODS: Yes. One of the features we note of HACC is when people do get on it, they're reluctant, if they have a change of circumstance, to go off it for a while because they fear that they will never back on.

MS BOYER (UT): Never get it again, absolutely.

MR WOODS: They actually hang on to it, whereas hopefully with our model, when you assess for a need, you may be re-evaluated in three months and if you don't need it then for a while - your carer has come back and you'd much prefer that the two of you carry on - but with the certainty that should your circumstances change yet again that you would come back in and be able to access the services. So if we can change that approach, then people will use them when they're required but not just hang on to the package so that they can stay on.

MS BOYER (UT): It's important from the perspective of the social engagement issue that that, quite properly, in terms of personal interventions, doesn't then pass on to the community interventions which people hold really dear. So just say you're the HACC person you talk about, that shouldn't preclude you from going to the HACC day centres and all of those - - -

MR WOODS: Absolutely, no.

MS BOYER (UT): I think that's really important because that's got to be appropriately interpreted. One of the big dilemmas we found is that numbers of service providers were breaking the rules all over the place for the benefit of their client group and they shouldn't need to feel that they're doing inappropriate things. That issue about flexibility of service provision is really important in this sector, particularly if you're serious about looking at older people and wellness.

MR FITZGERALD: It's very clear - and I made this comment previously - that the draft report inadequately dealt with what you've talked about and what others have called social and wellbeing supports or social inclusion or social engagement, all of those areas, and it's very clear that the final report needs to, so we take that on board absolutely.

MS BOYER (UT): But at least you mentioned it; that's great.

MR FITZGERALD: Yes, but it's inadequate. But one of the things about it is

what fits within that and I don't want to create an artificial division but we do need to. To some extent, the gateway is to provide entitlements to aged care services and referrals to other services.

MS BOYER (UT): Yes.

MR FITZGERALD: But as you've rightly said, there's a number of services which should be provided where you can just simply access it; you don't need to go through a gateway or an assessment. Let's just call those "social and wellbeing supports" for a moment. From your research, what fits in that category? You don't need an assessment, you don't need the entitlement. It's a block-funded service either by state and/or Commonwealth. So what is it, this set of social or wellbeing supports, that we need to especially acknowledge?

We understand, just to qualify that, there are a whole lot of preventative health strategies that are important, there's a whole lot of other things that have been provided both by the health and disability support services, but have you got a snapshot - if we created this box called Social and Wellbeing Supports - which you can directly access or be referred to by the gateway? What would fit within that as an essential suite?

MS BOYER (UT): It's a really difficult question because it really depends on the dynamism and the infrastructure of community supports in a particular community. If you've got a vibrant, exciting community that's got strong service clubs, strong sporting clubs where people who, pre-ageing, have been part of and can continue to be part of, then I think that works really well. I spend most of my time living in a small community on the east coast and I see how that bowls club, for example, has within its own structure a means of social support of the older members of the community in terms of transport and a range of other things.

MR WOODS: People can take the wheelchair down to the bowling green and they can roll a ball and they feel absolutely part of it.

MS BOYER (UT): Exactly.

MR FITZGERALD: So you've got those informal things.

MS BOYER (UT): But there are some communities that don't have that capacity and that infrastructure, so I guess I would look at that sort of model as rather than being an individual funding model, a brokerage model where organisations could actually access it on behalf of individuals and some form of community development model as well.

MR FITZGERALD: But in some senses, the brokerage model, the community options program, was that, wasn't it? It was a relatively flexible brokerage based localised model, wasn't it?

MS BOYER (UT): Yes. But in many cases, smaller rural communities didn't have the capacity or the infrastructure to operate community options. So I guess our research, while I think there's probably some truisms for urban areas in our research, those particular issues that relate, for example, to transport and transport options are really critical and that's more than one person operating a transport system. That's actually about having the capacity for community transport which may actually work very well for other people as well.

MR FITZGERALD: Can I ask another question, but you may not have the answer to that. Are those type of services that you're referring to best delivered through the state governments? I don't want to get into a jurisdictional war but it does strike me that so long as we have state and territorial governments, they have a vital role in understanding their local communities and responding according, whereas the Commonwealth is much better at funding very substantial service delivery type arrangements which is the bulk of aged care, formal aged care. So are these sorts of arrangements best left to a more locally devolved sort of policy and funding mechanism?

MS BOYER (UT): If we had robust local government in Tasmania, particularly robust rural local government, I'd be saying local government would be the place to do it and - - -

MR WOODS: More like the Victorian model.

MS BOYER (UT): Yes, more like the Victorian model - but we don't. I think with the Victorian model, that would suit very well at local government level. I have to say as a former state bureaucratic, I agree that it should be the state, but I think that most of my state colleagues would - you know, it really depends on what frameworks are there and each community is different, but really we're talking in terms of the resourcing here. We're talking about very small buckets of money compared to the other end of the aged care structure.

MR FITZGERALD: Sure.

MS BOYER (UT): And small amounts of money could make a huge amount of difference.

MR FITZGERALD: But the Commonwealth in my view is not very good at small amounts of money - - -

MS BOYER (UT): No.

MR FITZGERALD: - - - and is absolutely not very good at flexibility.

MS BOYER (UT): No, although they funded the Rural Alive and Well suicide prevention and have done it superbly.

MR WOODS: Is there also a danger though that what constitutes the social capital and heart of those communities, ie, the service clubs, and they do their raffles, have a trash and treasure and charge a coin entry, the sporting clubs who treat their senior members as respected elders of the club et cetera and value the services they provide, partly because they go to some sweat and pain and do the sausage sizzles and collect the money, is there a danger that all that sort of gets commoditised and taken over? That to me would be a huge pity. Having been in volunteer organisations all my life, that binds you together. That creates a sense of identity and purpose.

MS BOYER (UT): I quite agree. I think what our research would be saying is that there are sort of levels. So where the infrastructure is strong like that it may be that very small amounts of money, like grants to the bowls club to assist with transport because petrol costs are higher, those sorts of things that actually support that existing infrastructure you're talking about would be terrific.

But there are other communities that are less well off or where crucial champions within that community who have been the core of that community leave or die and leave a major hiatus. Then having a capacity to move in - and this is what this other organisation has been able to do - to try and make sure that gaps are filled are those support are there. It's a bit like trying to find research about what makes a vibrant, effective, functioning community and where a community is dysfunctional. If we knew the answer to that, we would be right, wouldn't be?

I don't have a simple answer but I do think we're looking at flexible buckets of money and that's why I talked about the potential of perhaps we need a pre-HACC that's particularly community focused and pre the need for care.

MR FITZGERALD: I think we agree. How you get there is an issue and I think you acknowledge that. For us it's also about what's in that bucket compared to this bucket. I know that annoys people immensely but as a former public servant, you would understand, that is just life.

MS BOYER (UT): Yes, it is.

MR FITZGERALD: You actually have to be able to work out what is in the aged

care system, what's in the community support system, so trying to work that through. Can I just ask this: in your research and your ongoing activity in this, are there particular things that have a very high level of impact on the wellbeing of ageing people, in your mind? Given that you can do 100 things, has the research shown that there are a couple of things - you've mentioned transport. We're well aware for the last 30 years every single survey that has been done with older Australians, transport is number 1.

MR WOODS: Mobility and access.

MR FITZGERALD: And that's the one that we deal with poorly. But are there are other things that have come up that have either struck you or that we should be struck by that really requires a particular focus?

MS BOYER (UT): Some of the other research that we have been doing is about nutrition in older people.

MR WOODS: Hydration especially.

MS BOYER (UT): We find it really frustrating that much of the funding for nutrition through delivered meals programs of various sorts through HACC actually neglect the social aspect of eating where the old meals on wheels model was of the carer going and sitting down with the person. So in fact our research is showing very clearly that the social aspect of eating is far more important than the actual nutritional aspect of the food.

MR WOODS: Five frozen meals at the beginning of the week is no substitute for somebody coming in every day and seeing how they are and having a chat.

MS BOYER (UT): Absolutely. So I would have to say our second biggest thing apart from transport would be about social aspects of eating and how you can combine nutrition with that. I think that's absolutely major. Where there is a social setting for food, people are far more likely to be well than when they're alone and dependent on delivered meals.

MR FITZGERALD: You're going to give us a copy of those slides.

MS BOYER (UT): You've got them, I hope. You've also got a copy of a more detailed paper and, if you like, I can send you the ones for the food ones.

MR FITZGERALD: If you think it's relevant. You know the sorts of things we're trying to look at as we're going through the files.

MS BOYER (UT): I really like that idea of the approach. I don't envy your capacity for pulling a program around it but - - -

MR FITZGERALD: I think the post-draft discussions and the post-draft public hearings, even though in their early days, have already elicited a number of very helpful suggestions, including your own. So I think we are able to do a slightly better job or different job in the final in relation to that. Having said that, that is an area where both Commonwealth, state and local governments are players whereas in the other formal aged care it's going to be largely Commonwealth.

MS BOYER (UT): Absolutely.

MR FITZGERALD: Secondly, you're absolutely right, it's easy to talk about it in principle, it's actually hard to define it and we don't want to be too prescriptive about that. So that is always tricky but I think we're advancing.

MS BOYER (UT): Albeit that the reform with the Commonwealth taking over HACC does actually provide in some ways a positive.

MR FITZGERALD: Absolutely. Thank you very much.

MR WOODS: Can we call the Health and Community Services Union. Could you please, for the record, state your name, organisation you're representing and the position you hold.

MR EDDINGTON (HCSU): Yes. James Eddington, representing the Health and Community Services Union in Tasmania and I am the industrial officer or an industrial officer.

MR WOODS: Thank you and thank you for your submission to us. You no doubt have a statement you wish to make.

MR EDDINGTON (HCSU): Yes. I've got quite a long statement but I understand I don't have much time.

MR WOODS: If you focus on the key points, that would be helpful but we do have written material from you as well and we're happy to also accept your full statement to put on the record.

MR EDDINGTON (HCSU): Yes, all right. I will just be basing my comments on our full statement, just providing a summary of some of the major points those being most importantly we feel wages - it was identified in the draft report, we considered that the issue of low wages and also excessive workload are the most important issues in relation to workforce issues in the aged care industry. In reality we will never overcome workforce shortages unless we can adequately address low wages and excessive workload. We would add that appropriate care of the aged flows from having adequate numbers of well-trained and a well-paid workforce.

In relation to the current recommendations in the draft report we would recommend that they be broadened in the following ways: it's mentioned the concept of competitive wages. We ask that wages not only be competitive but they be fair. The competitive level of wages and a fair level of wages could be established by the proposed regulation commission using comparators with other certificate III workers in other industries. We ask the question as to why should qualifications in female-dominated aged care industry result in different wages to qualification holders in male-dominated - for example, manufacturing or metal trades, just for instance - industries. We're aware that certificate III in, say, for example, the metal trades industry as a result of enterprise bargaining commonly earn between 25 to 35 dollars an hour. Secondly, we note - - -

MR WOODS: Sorry, the predominant wage rate for your members here is 17 or higher or moving up to 21?

MR EDDINGTON (HCSU): In around that mark, yes.

MR WOODS: Some providers up to about 21 or so?

MR EDDINGTON (HCSU): Absolute maximum, yes, and that's only as a result of enterprise bargaining and that would be the highest level of supervisors but generally not that high, no. The other issue, and I'll probably expand on this a little bit later as we go on as well in terms of wage rises that derive from increased funding, we are concerned that there probably wasn't enough attention given to the importance of wage - if a funding increase happens, that that money goes to increasing wages. We consider that's absolutely important. We understand that in the past funding increases haven't filtered their way down to wage increases and we feel that it is absolutely crucial that funding finds its way to the people that need it the most and that is the workers.

MR FITZGERALD: I don't want to interrupt but it is such an important point. Do you have a mechanism by which that can be assured? We're aware of the issue, what is the mechanism by which you ensure that additional funding finds it way into, as you say, additional wages, if that's its purpose. We would like to see some exploration of doing that by tying it to the enterprise bargaining process so that whereby this would work so that employers and employees would both be eager and keen to go into the enterprise bargaining process because employers would understand that their funding relies on an appropriate outcome achieved through that process. It might be too simplistic to try and tie it directly to a percentage of wage increase, but if you had, say, a 4 per cent wage increase or a 5 per cent wage increase, that the level of funding is tied to that wage increase that is reflected in the enterprise bargaining agreement. So that may be a mechanism of - - -

MR WOODS: So an iterative approach. So funding goes up by this, wages should go up by - - -

MR EDDINGTON (HCSU): That's right.

MR FITZGERALD: Have you any examples of agreements that do that? I don't specifically want the name, but have you been engaged in enterprise agreements that have a link between wages and government funding or government financing?

MR EDDINGTON (HCSU): No, we're not aware of that. In fact the absolute opposite takes place. Enterprise bargaining agreements usually start with an employer saying, "Well, at the moment our funding increases 1.7 per cent, so that is where we will start with wages."

MR FITZGERALD (PC): Thanks for that.

MR EDDINGTON (HCSU): I'll move on to a part of our submission that was just in terms of, I guess, the general aims of where we sit with the aged care industry. A fundamental principle of HCSU is that people who reside in aged care facilities reside effectively in their own home and we believe that the aged care workforce structures need to reflect that fact. We don't believe that aged care facilities should over-medicalise or over-institutionalise residents. Aged care residents are not patients in hospitals and an over-medicalised or over-institutionalised environment leads to unnecessary dependence and passivity and a sort of learned helplessness. We believe that sort of environment would also lead to a more rigid workforce and add to the overall cost of providing care. So we advocate a development of a workforce that steers away from medical or clinical interventions where they're not absolutely necessary and treats residents as though they are in their own home with the dignity and respect they deserve.

MR WOODS: Do you cover members in both the facility and community sector? I assume you do.

MR EDDINGTON (HCSU): Yes, we do. In relation to wages, again on our point, comparing wages as currently existing in male-dominated manufacturing and other industries, as opposed to female-dominated age care industry, obviously we're dealing with residents and the people who are the most vulnerable people of our society, but they're also our mothers and our fathers and our grandmothers and our grandfathers and we would argue that it's a matter of decency and logic that these people should be closer to being among the highest paid and most respected occupations in the country and yet we find the opposite is true.

In summary in relation to our recommendation in relation to wages, we would argue that the most immediate and urgent attention needs to be given to those who are the lowest paid and that the government and employers need to address that as an issue of priority, that comparative level of wages for aged care employers is based on market comparisons in most enterprise bargaining outcomes should be specifically established by the regulation commission as a general target or aspirational level for expected enterprise bargaining outcomes in aged care and that funding for aged care providers should be predicated on the wages level established by the regulation commission and also be conditional on such outcomes being delivered by aged care providers concluding enterprise agreements.

In relation to the workforce structure and analysis, we made some points in relation to our submission in relation to a workforce analysis. We believe that the commission should provide workforce analysis and comment on workforce structure, our workforce structure, being identifying pathways from the most junior to senior positions, which we believe are currently lacking in the industry. A detailed analysis

and breakdown of the industry could include a range of occupations and positions, looking at the type of work done by each category, the percentage of workers by each category, average income level earned at each level, gender by category, average age of workers by occupations and workers that are from community and linguistically diverse backgrounds.

We noted that there was more of a tenor in the draft report in relation to moves specially regarding nurses and increasing nurses' wages and skills development and we feel that this probably was slightly neglectful of the majority of the aged care workforce, which 50 per cent of the workforce in this state is relating to those personal carers or ECA carers and you've got 23 per cent who provide indirect care. So that's three-quarters of the workforce in the aged care in this state at least, and I believe it would probably be similar nationally, don't have an identifiable workforce structure and to focus it just particularly on nurses, while that is absolutely important and we don't resile from that fact, but we would like the attention also paid to the carers and also indirect carers as well.

In this respect, we would urge the commission advocate a holistic approach to looking at aged care. So we would look at a workforce analysis, the result of that. We would look at it having the effect of being able to redesign jobs to more effectively use existing people, make recommendations on training and investment on training in the industry, provide a robust career structure for workers from the lowest levels through to management and nurse levels and form the basis for negotiations.

MR WOODS: Just on that, we would certainly be very grateful for your further views - and maybe you can provide them as a supplement after this hearing - on the quality of training that is provided, why there appear to be inadequacies in both the content and the delivery of the cert III. The content is a generic issue and the delivery is a variable issue, depending on the quality of the various RTOs, but where would you constructively focus attention in ensuring that the content does reflect the actual demands on your members and on the personal care workforce generally and why are some RTOs at the poor end and why are they allowed to continue to operate and what should be done to improve that? We do fully agree with you that we do need to look to management structures, broadening scopes of practice and encouraging that third level of worker to accept and be skilled in having more responsibility. In those areas, if they're not covered in your presentation, could you give some further thought to that.

MR EDDINGTON (HCSU): Yes, we will. I think that's part of the problem at the moment, is that there is no identifiable structure of rising from the bottom to the top and that's where we advocate, and I'll speak later about - we believe the importance of having a certificate III as a compulsory requirement.

MR WOODS: But a good quality cert III.

MR EDDINGTON (HCSU): That's right. But at the moment where were trying to stick it in it's just sort of floating there. It has got to be part of a structured program from the bottom to the top.

MR WOODS: But we've been to good operators in Tasmania who have well-trained cert IIIs who then go on and take their cert IV and see that progression.

MR EDDINGTON (HCSU): That's right, yes. That's what we need to work on. The next point I'd just like to make is in relation to staff to resident ratios. I guess with a wage increase excessive workload is the big-ticket item in terms of what we feel is a problem in the workforce at the moment. We believe that the commission should investigate and recommend introducing minimum staff to resident ratios. Quality of care is highly dependent upon adequate direct care staffing levels. Our organisers will tell us aged care workers experience understaffing daily. It causes excessive workloads, it leads to physical and mental stress. Of course this will naturally lead to a diminished quality of care for residents. So we fundamentally believe it's really important.

We were discussing recently that what has been happening whilst the number of aged care workers is increasing the amount of residents and the people that they're being asked to care for is increasing by a far greater rate. Obviously a lot has been said about Australia's ageing population. We feel that unless something is done to correct that then that is just going to keep happening.

MR WOODS: We would encourage you to explore the proposal that we have that when setting a price or recommending transparently a price for care of course you would need to form a judgment on how many hours of care by what level of skilled person would be necessary to deliver an adequate level of care and whether that's a better reflection of the needs of care delivery than a ratio, which can be a very blunt instrument.

MR EDDINGTON (HCSU): Yes, well, we can obviously consider that. I mean our view is that a ratio is - - -

MR WOODS: Start with ratios and work backwards, yes, I understand.

MR EDDINGTON (HCSU): Look, we understand that it's a - the aged care sector is a large and disparate sector with a lot of residential care. So obviously when we've provided our submissions is that we're not - we're expecting a staff-resident ratio to have a lot of flexibility in it. We're not trying to use it as a blunt instrument, so to

speak. As mentioned earlier - I'll move on to qualifications, training, skill development.

MR WOODS: Yes.

MR EDDINGTON (HCSU): At the moment a lot of aged care workers do have a certificate III already or are already training towards a certificate III. We believe that this would be a good requirement to establish a certificate III level for aged care workers. We would like the commission to emphasise the importance of the vocational education or training system as an excellent way to increase skills. Again, we would reiterate the importance of focusing on probably the 75 per cent of care workers other than nurses that - - -

MR FITZGERALD: Could I ask this question? It's a more fundamental question. In recent days we've had a large number of representation from registered nurses and the ANF, and this afternoon we'll have the ANF from Tasmania. There's a very strong push by some to see personal care workers or extended care workers as really another level of the nursing stream.

MR WOODS: And regulated.

MR FITZGERALD: And so the push for registration, seeing the actual course as having a much more medicalised model and being a career path from personal care worker to enrolled nurse, you know, up the chain. Is it your view here in Tasmania, your union - that that is an appropriate way or do you see the personal care worker - the training and the recognition of that worker as being of a different nature; because it seems to me there is a fundamental issue here as to what is the role of a PCW going forward and which stream or where - or put more simply, where they should fit within the health workforce.

MR EDDINGTON (HCSU): Yes. I mean this - it gets back to our client-centred enabling approach that we mentioned in our submission. It effectively gets back to simply residents in nursing homes in the aged care sector are living in their own homes, effectively. That's the principle that we think should determine the type of care that they should be getting. It is not a hospital. It is not a situation where - as I mentioned before, where we want residents in their own home to be - I feel that they are being over-institutionalised or over-medicated.

So the type of care that we're advocating is a care that is reminiscent of somebody being cared for in their home, in terms of programs being established, the gardening or for sports or things like that. That's our point in relation to that. We don't feel - we feel that there is already a large workforce - 50 per cent of the workforce already are ECAs or personal care workers. It would be improper just to

simply replace them with another workforce and call them a different name.

MR WOODS: Of course in the community setting it's even higher proportion - - -

MR EDDINGTON (HCSU): Of course, yes.

MR WOODS: - - - are PCW or related entities, rather than the nurses.

MR EDDINGTON (HCSU): Yes.

MR WOODS: Yes, I assumed your earlier comments were a shot across the bows of others.

MR EDDINGTON (HCSU): You could interpret it that way.

MR FITZGERALD: Yes, well, I mean it is an important issue. Apart from union coverage and all those sorts of things it's actually, taking your point, a broader view of the workforce; trying to understand both now and into the future what this workforce looks like, what does it have in terms of both training, its scopes of practice - all those sorts of issues. So trying to understand where the PCW, both in the community and residential setting, should be placed is quite - and you recognise that.

MR EDDINGTON (HCSU): Yes.

MR FITZGERALD: But at the moment it seems that there's differing views about that.

MR EDDINGTON (HCSU): That's right. I mean I can understand the position of the other party in terms of trying to advocate, as I say, a more medical approach and we trying to steer away from that.

MR WOODS: Yes.

MR FITZGERALD: Okay, that's good. I think we've only got time for a couple more points.

MR EDDINGTON (HCSU): Right, okay. Other issues we had were in relation to just attracting other people to the sector through an increased marketing campaign, community and linguistically diverse workers. It was mentioned in the draft report the possibility of increasing migration. We would probably argue that we should be looking at Australia's current unemployed, 600,000 of them, and also considering an important point is that there is a lot of underemployment currently in the industry. A

lot of our members expressed to us that if they had the opportunity to have more hours then they would certainly like to do so, but that, obviously with the funding, is not possible at the moment. There was a point in relation to licensing as well, where we're against licensing. We believe it adds an additional administrative burden.

MR WOODS: So you and the LHMU are sort of - locked step in relation to that?

MR EDDINGTON (HCSU): In relation to that point we would agree with the LHMU.

MR WOODS: Or they with you, one or the other.

MR EDDINGTON (HCSU): Yes. So look, in summary, if there's anything that we can perhaps emphasise more than anything is obviously the importance of a wage increase but also having some mechanism that that wage increase filters down to the people that actually matter.

MR FITZGERALD: Can I ask just what is your view at the moment, if you have one, on the Fair Work case in relation to gender equity wages? I mean one doesn't know obviously what the decision is going to be but that mechanism is designed, obviously, to increase the wage parity of female-dominated workforces. Is that case, if it were successful, going to make a significant difference to what you call a fair and competitive wage, or over and above that will action need to be take in the aged care are specifically?

MR EDDINGTON (HCSU): Well, I think it possibly will. But obviously your funding needs to come on board with that as well.

MR FITZGERALD: If it arises that there's a significant pay increase?

MR EDDINGTON (HCSU): If there is a significant pay increase.

MR FITZGERALD: Yes.

MR EDDINGTON (HCSU): Or otherwise if the pay increase - if there's a pay increase but there's not the funding we're in the same situation as what we find at the moment.

MR FITZGERALD: Yes, okay.

MR WOODS: Are you intending to table that as a response to our draft or are you going to amend it or elaborate on it? How do you want to deal with it?

MR EDDINGTON (HCSU): Our submissions?

MR WOODS: Yes, well, your presentation today, is that a document you intend to table as well?

MR EDDINGTON (HCSU): Not really, no. I think we were just going to rely on - I mean I'm - - -

MR WOODS: But you have got a formal submission to our draft?

MR EDDINGTON (HCSU): We have, yes.

MR WOODS: Okay.

MR EDDINGTON (HCSU): And we would rely on that.

MR WOODS: If there are any further thoughts where you may not have dealt with it adequately on the quality of the cert III and why it is and how to adjust it, as well as the delivery of the cert III - - -

MR EDDINGTON (HCSU): Yes.

MR WOODS: - - - that would be great. We will adjourn until 1 o'clock.

MR FITZGERALD: Good, thank you. Thanks very much.

(Luncheon adjournment)

MR WOODS: Thank you very much for coming, and could you please, for the record, state your name and any organisation that you are representing.

MR JAMES (AIR): My name is Dick or Richard James, and I represent the Association of Independent Retirees. In that capacity I'm the state president of the Independent Retirees.

MR WOODS: Excellent, thank you very much. Thank you for providing us with a document with some comment, and you focused on three particular issues in that. Either take us through that or supplement it with additional points; the floor is yours.

MR JAMES (AIR): If I could I would like to preface my comments with a general congratulations to the Productivity Commission on the report that it has produced. I think it's tackling an area that's been somewhat ignored in more recent times and it seems to me that it's come up with a considerable number of proposals in its draft recommendations that will be for the benefit of my age group, because I'm of that age now. I would like to make just two or three points, but the first one is that it's the strong desire of old people to continue to live in their old homes.

MR WOODS: Absolutely.

MR JAMES (AIR): Above all else, that is their desire. I believe it behoves governments to do all they can to ensure that happens and it's the cheapest option; to support somebody in their own home is far cheaper than having them fully reside in an aged care situation. If people are going to remain in their own homes for as long as they possibly can, even when they've lost some of their competencies, then it's important that they get some level of support, I believe: to have community nurses that visit at least once weekly; to have some situation to ensure that they still maintain a reasonable diet, maybe it's Meals on Wheels or some similar provision; that there's some help with housework; some help with ground maintenance. Not a great deal, because obviously the extended family of that person has got a lot of obligations as well.

MR WOODS: A role to play.

MR JAMES (AIR): We don't wish to replace what the family would do voluntarily for paid help.

MR WOODS: That's a very interesting balance to try to achieve.

MR JAMES (AIR): Yes, a bit of a tenuous line that's got to be trodden through there. But one of the things that should happen is that homes where aged people

continue to reside should be made so that they're supportive of that. It probably means such things as those deep armchairs, that you sink back into but then provide one hell of a business to manage to sit up and get out of them, need to be lifted at the back so that you're more upright in your seating positions; in the toilet, in the shower, bath, there should be rails and other provisions such as that; and somewhere an emergency button.

So the first point I want to make is that, let's keep old people in their homes as long as we possibly can. I understand that about 92 per cent of the population presently manage to survive in their own homes till death, so it's just that smaller group that are moving into aged care facilities, and it's not a popular choice with aged people. One of the problems is that you move them out of the environment that they're familiar with, you move them out of the situation where the next-door neighbour with whom they have a chinwag over the fence, they know the people around them, maybe members of their family are not very far away, and so on. So they're moving out of there into an alien situation that is far more regimented than what they've been used to, where they're in the midst of a bunch of strangers.

Quite often you are going to find people don't adjust to the changed situation. How don't they adjust: they adjust by being as difficult as they damn-well can be. I'm one of them. I know that old people are quite often crabby people; they wish to get their own way and they'll be rebellious if they don't. I sympathise with an aged care facility where limited staff are trying to cope with a number of people that don't wish to be there in the first place.

MR WOODS: Sorry, just on that point then, in terms of our proposed reforms, where we get rid of the supply restrictions on community aged care packages and HACC programming and the like, that seems to be supportive of your view then that we open up the supply of services into the community, so that people can choose to stay there and that you have a more flexible range of services to help people?

MR JAMES (AIR): Very much so. I strongly support that.

MR WOODS: Excellent, thank you.

MR JAMES (AIR): As I say, it's a cheaper option, even though much more than what is presently directed towards those people who are maintaining their own homes is desirable. Many people that move into aged care situations have got mental problems, because they move in there with anti-feelings and, as well, when you get old, somehow or other, your health is not ever quite as robust as it might have been, so you're going to have other problems to do with your ageing. They might be levels of dementia through to Alzheimer's, but it might be that there are particular needs that you manifest that are going to make it very difficult for the providers to meet

your needs. So one of the few criticisms I'd have of the draft report would be that you didn't really address the matter of salaries and staffing in aged care facilities. You made the point that this needs to be inquired into and much more needs to be done.

MR WOODS: I noticed you had some press around that issue earlier. I've been following your media statements. Without taking up too much time on it, but we did deliberately use the phrase "the need to pay competitive wages" and you've acknowledged that in our recommendation 11.2, but we did so in part because that was the actual wording that the ANF and others signed up to, that they agreed as part of the National Aged Care Alliance that that was the right description of what they wanted to achieve for their wages. So I was a little surprised at your earlier media that then said that we hadn't fully addressed it, because we actually used the ANF's choice of words in that respect. But nonetheless - - -

MR JAMES (AIR): The ANF itself is agitating, isn't it? I went to a meeting last Friday where I signed a document that said, "These are the things that we need," and it all related to staffing in aged care facilities. They don't wish to continue as the poor relation of nurses in - - -

MR WOODS: We agree. If we don't get the workforce, then you can't deliver the care.

MR JAMES (AIR): But that's only part of it. The other side of the penny is that because aged care facilities are quite often hard-pressed for funds, they will move down the scale in the type of staff that they hire, so instead of qualified nurses, they'll have aides and this sort of thing. So we become aware of some fairly horrendous situations. There might be just one nurse on duty and there you've got 60 inhabitants of this particular facility, which is a pretty impossible situation. So we're supportive of the matter of staffing being addressed, but basically it's a matter of the budgets generally being addressed so that the money is available and these groups are not trying to do it on a shoestring.

Could I make another point here, and that is that I am fervently of the belief that the best facilities for aged people that need to move into high care is in their local community, so that a facility at St Helens or Swansea or at Ulverstone or wherever is far better for the locals there, rather than shipping them off to the big towns, where you can certainly guarantee that they know not a single person, more often than not. So leave them in their communities if you possibly can. That is support the facilities, the homes that have been established in local communities. Usually the history of these homes is that they've been established by well-meaning persons, maybe a church group or an offshoot of a local council or whatever and they get a lot of community support, but they still have difficulties in maintaining their

budget. I'm aware of two homes that have closed in Tasmania in more recent times because of this.

MR WOODS: Certainly it's been one of the features of our multiple visits to Tasmania is the dispersed nature of the population and the small village environment and the facilities. So we're very conscious of that and we're asking people, including yourselves, for your views on what is the best way to maintain a local presence so that people can continue to live the rest of their lives in their local community.

MR JAMES (AIR): The issue of funding is a very vexed one and I don't claim to have any answers. I did suggest that maybe, like many things in life, it's a user pay situation as far as possible, but if that's going to be the case, then planning has got to be long term. It's a bit like superannuation. If you introduce superannuation, you haven't solved any problem until about 20 years have elapsed and people have accrued then a reasonable income that they can retire on. At the moment we've got a situation in this nature where superannuation has been extended and the level of it has been increased and is going to increase further, but there's always this period before the funds build up to the point where they can support a person. I believe ultimately that there ought to be another 1 or 2 per cent in there somewhere that goes towards making provision for that person in their old age.

MR WOODS: We noticed in your presentation that you had elaborated on that and we're certainly looking still at the various funding options and so we'll take your views into account on that.

MR JAMES (AIR): I think I've probably covered the areas that I wish to cover.

MR WOODS: Can I ask you in terms of enabling people to remain at home for as long as possible, what do you see as sort of the key services that will help them stay in their homes, whether it's their long-term home or whether they've moved into a retirement village or an independent living arrangement, wherever they choose to live, but what particular services do you think we should be focusing on to make sure that they get that support that's necessary?

MR JAMES (AIR): I'd say the broad principal is let's ensure that they don't become prisoners in their own home. Let's ensure that they still are part of our society, because I believe that the more old people participate, then the more purpose they see in their life and the longer they will live. That's not necessarily a good thing for governments. It would be nice if it were 1984 and - - -

MR FITZGERALD: Only economists think like that, I have to tell you. Most of us think it's a good thing.

MR JAMES (AIR): So your support must ensure that they are comfortable and they are leading a reasonable life, that is they've got a diet that's sensible et cetera, but there's scope for them to get out and about. So it seems to me that a lot can be done in that regard and some is being done by some organisations so that they have community buses that might do the rounds and pick up some of these folk and take them off for a social day. Being social is a critical aspect of still living a happy, well-adjusted old age. So let's ensure that they don't become hermits in their own particular environment. Apart from community buses, visits by others, outsiders and the encouragement, maybe they've got some scheme where they can get taxis with subsidised fares to a hairdressers, to supermarkets and so on.

MR WOODS: I remember in the days with Meals on Wheels when somebody would come in each day and so they would just see how they are and if there were any issues arising, they would be able to contact the relevant authorities, but five frozen meals delivered once a week is just not a substitute.

MR JAMES (AIR): My direct experience in the area would be that I had parents who were in an aged care facility, low care in southern Tasmania. They welcomed Meals on Wheels and old people don't eat that much, so they found generally that the meals that arrived managed to provide lunch and tea as well. But they valued the interactions that went on with other people there. So, yes, the essential is that old people still feel part of our society and are still able to contribute. One of the other beefs I've got, and this is outside your - - -

MR WOODS: Please.

MR JAMES (AIR): Is that we don't value old people here in this country. I've been in Vietnam and there was a seat for myself and my wife right up the front of the bus, the best seats in the bus. Nobody else could sit on them. We were the grey-haired ones, we got to sit on those seats, and there was a difference there that you don't ever find here. You're just a bloody nuisance when you're old and bundling along. There's no respect. I don't know how we change that, but that's my own personal beef.

MR WOODS: We as a commission strongly take your point that you can have services delivered to you and care provided but if it doesn't empower you and it doesn't work with you and give you that social contact, then your phrase "being prisoners in your own home" is not a big improvement on in fact being in congregate care in a facility where at least, you know, you are wheeled out to a social activity and there is movement and life around. So I think that is important to ensure that what is being does provide that social engagement and the relevance of you as a person in your community.

MR JAMES (AIR): We have a fairly simple philosophy, I guess, in old age, I suppose it is all based around "use it or lose it" and we believe that people ought to still be physically active and ought to be assisted in subsidised gym membership or swimming pool membership or whatever. We believe that people have to maintain their mind, so schools for seniors and libraries, but getting out and talking and discussing and so on - - -

MR WOODS: University of the Third Age, all of those things.

MR JAMES (AIR): - - - and the social aspects of it all.

MR WOODS: We agree that they're very important. Thank you for your presentation today but also your notes to us which elaborate on some of those points further and no doubt you will be continuing to watch our inquiry and provide commentary on our performance as the inquiry goes along. Thank you very much.

MR JAMES (AIR): I thank you for the opportunity to present. I do apologise for that 10 minutes.

MR FITZGERALD: No, that's all right.

MR WOODS: No, that's fine. Not a problem.

MR JAMES (AIR): I was actually sitting downstairs waiting for a light meal to come on.

MR FITZGERALD: We had a similar experience, so it's all right.

MR WOODS: Join the club.

MR JAMES (AIR): Thank you very much.

MR WOODS: If we can invite Carers Association of Tasmania. Good afternoon. If you could give your name and the organisation and the position you have in that organisation, for the record.

MS McKENNA (CAT): Yes, my name is Janis McKenna and I'm chief executive officer of the Carers Association of Tasmania Inc.

MR FITZGERALD: Thank you very much. I must say we have had lots of association with your sister organisations throughout Australia so we're very familiar with many of the carers' issues but if you could make an opening statement and then we have some questions.

MS McKENNA (CAT): I would actually like to place the focus on the uniqueness of Tasmania and just before we start I would just like to present some relevant Tasmanian evidence to the commission - - -

MR FITZGERALD: Yes, that's fine.

MS McKENNA (CAT): - - - which was a report commissioned by Carers Tasmania in 2009 and led by the well-known economist, Dr Bruce Felmingham, and the demographer Associate Professor Natalie Jackson from the University of Tasmania.

MR FITZGERALD: We will grab that in a sec. That's fine.

MS McKENNA (CAT): I think how I would actually present is address our recommendations and then work backwards.

MR FITZGERALD: If we can have about 10 minutes of comments from yourself and then we can have a discussion, if that's enough. So just the key points, that would be great.

MS McKENNA (CAT): Okay. I suppose the key points are number 1, Tasmania itself and those key differences in Tasmania versus the rest of Australia and just a couple of brief facts. There are 69,500 carers in Tasmania and 2.6 million nationally. 15 per cent of the Tasmanian population are informal carers and that's versus the 13 per cent nationally. 48.3 per cent of Tasmanian informal carers are not in the paid workforce, versus 33 per cent nationally and the most important statistic here, 36 per cent of informal carers live in outer regions or rural areas against a figure of 12 per cent nationally.

I think just for the benefit of the commission here I do want to stress the term

"carer". When I refer to "carer" I actually refer to an unpaid family carer, an unpaid friend who may be delivering support to the carer or the term "informal carer", not to be confused with a paid carer which I use the term "support worker".

MR FITZGERALD: Right.

MS McKENNA (CAT): So I think the key areas that Carers Tasmania is interested in is how the new system will look on the ground. We support most of the recommendations within the commission's draft. One area that we'd like a closer alignment with is, of course, the Carer Recognition Act 2010 and the 10 principles of the Carer Recognition Act can be very closely aligned to some key issues that I'm sure you've heard and I will duplicate that have been presented to you from my peak organisation and my other colleagues in the national network.

I will now address the work that I wanted to present. One of the main recommendations, and it's the first recommendation that I put to the commission, is that to identify Tasmania as a priority state for the new rollout of the aged care system due to the existing older population and the high level of disability need. We do know that Tasmania has the highest ageing population in Tasmania. The second recommendation is that the commission recommends additional investment in basic aged care infrastructure to bring Tasmanian services to a parity level with other states and territories.

Geographically Tasmania is different. While on the mainland the population is highly concentrated on metropolitan and inner regional areas, Tasmania has a much greater proportion of its population in regional and rural areas. As expressed previously, 36 per cent of informal carers are living in those areas, compared to 12 per cent nationally. These elderly people in these areas already are restricted in access to basic infrastructure. There is limited health care facilities and fewer residential beds. As Tasmania's population geography has the highest concentration of people in Australia living in regional and outer areas, we see this as providing a great opportunity for testing the proposed building block approach as part of this new design.

Sample sizes of older people living could be easily obtained from smaller geographical areas. There would be different levels of infrastructure there so there could be a good comparison to how the service can roll out there versus in some of the larger urban areas. Social Services actually faced higher costs delivering services to some of these areas in Tasmania and the current funding models, of course, don't actually allow cover for those extra costs. The lack of social support infrastructure is already a critical issue, particularly in the north-west of Tasmania where people usually live in small coastal areas from farming, mining communities and the terrain, that whole geographical environment can be quite challenging when having to

commute from one area to another.

The harsh Tasmanian winters and the fact that a lot of people living in those areas still use log fires can actually cause a great strain with aged people, whether they be carers or aged people. That can often mean that ill people may have to move into residential care for winter, and that care can actually be not close to where they live and their social infrastructure.

One of the main concerns that we have is that the rollout of what we see as the seniors gateway - we see that this - we are presuming that this would be a national call centre. That's a presumption, we don't know. There is a presumption that that will be located in a large state.

MR FITZGERALD: No. It will have a regional outreach. So the gateway is a Commonwealth agency and either directly or through subcontract arrangements would operate at a regional level.

MS McKENNA (CAT): At a regional level?

MR FITZGERALD: Absolutely. Now, the issue that we're seeking feedback from is what should that region look like.

MS McKENNA (CAT): Yes.

MR FITZGERALD: So that's an issue, but no it will absolutely operate at a regional level, even though it will be a Commonwealth agency.

MS McKENNA (CAT): Yes, because I think that that regional knowledge - it's essential that you don't have someone thinking, "Oh, well, the informal carer will bring the care recipient to medical treatment, only has to travel 30 kilometres," but that 30 kilometres actually may not have public transport and may take them a very long time. So, you know, what occurred to us that it would be a good contrast to actually trial the model in yes, your typical urban area, but that Tasmania would also be a very good example state to actually trial the other side of it, and that being that - with that strong rural, remote focus, where there's good comparison. Evidence then can be gathered and you get a good idea as to what the whole picture should look like.

I think one of the things that - and I refer to the evidence that I have given to you - are the facts of informal carers in Tasmania and the current work that they actually deliver in that caring role. It's indicated that they actually work for an average of 103 hours per week, whereas nationally that's around 36 hours per week. Again, it's because of the lack of service and infrastructure, and that that figure is

probably highly weighted around the rural and outer regional areas.

The projections also - when we commissioned the report we wanted to project out to 2028. We have actually - demographic evidence has shown that if the constant rates of disability are assumed for the age groups, it will increase by 42 to 57 per cent by 2028, leading to a total of 34 to 37 thousand extra people requiring informal care needs in Tasmania. So we actually are awaiting the figures which are Tasmania specific, and the report naturally will take a change.

But I will now move to care and support. I think one of our major concerns is the - a lot of the care and support is very care recipient focused. That causes an organisational cultural issue in the organisation delivering service. Naturally when a carer becomes a carer - that could be through a catastrophic event or we're talking ageing here, when someone is aged and frail and needs intensive and formal care, or may have Alzheimer's, dementia or another chronic illness, the informal carer naturally will be concerned, and their number one focus would be on that care recipient. They would have to absorb what's happening, learn about the problems with their care recipient, connect with service and start on that caring journey.

We believe that at that point it is very important that an early intervention strategy is in place for the carer. They may not want to access service for themselves for some years but it is very important that that is really made very clear to them early on in the piece. The evidence is based on when carers come into service. At Carers Tasmania we service approximately 5000 carers per year. Those carers are on their hands and knees when they come to us because they have been too busy looking after the care recipient, and as human nature is, they don't look after themselves.

We appreciate that those people delivering services to care recipients, whether it be district nurses, whether it be people in the Commonwealth respite and caring centres, are very busy and under pressure, but there is not that culture to put equal percentage of focus on the carer. I am relatively new to working in this sector and I actually thought respite was for the carer. Evidence tells us that respite - what the carer does during those respite hours is play catch-up. They actually go to the shops, go to the bank, do the cleaning. They do the things that they should be able to do in a normal day. So they don't actually get to do the things that they might really want to do: play golf, go to the pub, go to the cinema.

So we really need to - the model needs to give the information very early and instil in the carer the importance that there's a trigger personally within them that they recognise. I do believe that the model will have triggers with then, you know, the interface to recognise carers. But carers need to be recognised by the system, because we know that the majority of carers are hidden carers. They are mums, they're dads, they're partners, they don't see themselves as carers. So I think the new

service must actively be able to identify carers rather than simply require the carer to self-identify.

The information that's supplied should be appropriate to the carer's circumstances and needs. We really do welcome the idea of the carer service centres. I think the challenge with that - and based on the information that we have - is that the accumulation of the services, the respite service, which has a very carer recipient focus, and then the services which are care focused: your counselling, education and training, advocacy et cetera. We welcome more information on what the carer service centre will look like. We do realise it could be run by some service organisation. Branding is something that is a concern.

To use the example, the Carers Tasmania brand means to carers a confidential, expert service. Many of our carers who access counselling reveal it to our counsellors in confidence some very intimate and very, very confidential information which they may not feel very comfortable delivering that information or seeking that service to an organisation, with all due respect, that has a government logo on it. We are funded by both state and federal government and recognise that on our brochures and in our publications. But I think the branding of the service centres must conjure in the carer's mind confidence in them that they know they're going to be safe to be able to discuss those very, very intimate and confidential matters.

MR FITZGERALD: I was just about to comment, the carer support centres that we're proposing build on the National Carer Respite Program, but, as you rightfully say, would be very different, in the sense that they would offer a number of other services: training, counselling, peer support, and so on. They are a much broader range of services. The second thing is, a number of your associations run the carer respite services.

MS McKENNA (CAT): Correct.

MR FITZGERALD: Our expectation would be that most of the current providers, plus some new ones, would in fact by the providers of those centres, but again that may vary over time.

MS McKENNA (CAT): I suppose that's where our concern may be. I am aware that some of my interstate colleagues run both a carers association and the respite services, and I have to say I think they all do it very well; I think the evidence is there. This is not my opinion, I think it is departmental evidence. But we are aware that there are lots of centres that are not run that well, and that's where I come to that organisational culture issue, whereas if you have a centre that has not run the carers services, in those services that are auspiced by the carers associations, those services of counselling, education, training, peer support, et cetera, are a separate business

unit, you could say, to the services run from the Commonwealth Respite and Carelink Centre. It would be very interesting from an HR perspective and an organisational culture perspective to see the marrying of the two; will it be just one business or will it be two specific business units. That's where I see a problem, because people working delivering respite services have a very care recipient focus.

MR FITZGERALD: Sure. But one of the aims of an integrated carer support centre which would facilitate emergency respite, but also do the other things that Carers Australia has been asking for some considerable time, it would in fact make sure that that is very carer focused, as well as recipient focused, obviously. But that, we think, gives it exactly what we thought - and think - Carers Australia have been basically asking for; which is a centre that provides an integrated set of services. The second thing I would say, just to be very clear, is we would see the carer support centres, they serve as carers of people with disabilities of aging, of mental health, and of frail partners and family members, so again it won't be a specific aged care service; it would be a broader one. Again we think that is consistent with what most carers organisations have been saying.

MS McKENNA (CAT): Yes, it is. As I say, we do really welcome that. But the small point is around those things. I suppose one of the key drivers of the difference between those respite centres run by carers associations is that carers associations are membership based organisations and the members are the owners, so that makes a big difference.

The next point that I'd like to make is around workforce issues. Again Tasmania has some unique features: because of our small population and low salaries, we face challenges. I know this grows across the nation in the aged care, whether community services - through these sectors. But in Tasmania I think that challenge is higher. Many of our young people who train as social workers, clinicians, et cetera, do want to go to the bright lights and move interstate. That is a major challenge. The other problem I felt with the report was - and I think this will be reiterated by my interstate colleagues - that the carers were actually included in the workforce section.

MR WOODS: We will have a separate chapter called Dealing With Carers.

MS McKENNA (CAT): Yes, I'm aware of that.

MR WOODS: It doesn't change our policy focus on carers, but if for some reason, presentationally, having it with a separate chapter heading does something for you, then we have no problem with that.

MS McKENNA (CAT): Just on that one, I think, it is again aligning to the

principles from the Recognition Act. The valuable social and economic contribution that carers make to society should be recognised and supported. In my Tasmanian report, Tasmanian carers save our economy $1.26 billion a year; that is just in Tasmania. I think there's differences between our informal carers, that I represent, versus support workers/paid carers. I refer to the previous gentleman who spoke and I agree, and there was a strong emphasis, in what I caught at the end of his presentation, about elderly - and I'm close approaching; I'm a late baby boomer - that we will want to stay in our own homes. I think there needs to be a stronger emphasis on the differentiation between informal carers, saving Tasmania $1.26 billion a year, and paid support workers who, number 1, get renumerated for their job. Their remuneration is a lot more, although it's not great remuneration, than what the carers' payments are.

They would also get support from the point of view of professional development, they have a safe working environment, they would be trained, they would be protected by occupation health and safety. Carers doing work in their own home do not have that protection and they are carrying out a lot of duties that could cause them damage, and we know that heavy lifting, et cetera. Rest and recreation: a paid support worker works specific hours; some carers, as we know, work 24-7, 365 days a year. Retirement: our informal carers, there is no provision for retirement. They don't have any superannuation, and many, who through a catastrophic event have been catapulted into the informal caring role, have had to dig into their super to survive, so they are in a very, very difficult position. I do recommend that there needs to be that very clear differentiation, because in the wider community, nationally, although we all work very hard, there is still a huge confusion around paid carers and identifying informal carers.

MR FITZGERALD: I'm just conscious of time. Are there any other particular points you want to raise before Michael and I just ask some questions?

MS McKENNA (CAT): No, I think I've probably covered most key points.

MR FITZGERALD: Could I just ask one. You've concentrated on the unique nature of Tasmania and thank you very much for that report. It is different, there's no question about that, so we acknowledge that. One of the issues that we've spoken about a few times during the day is about the way we respond to the needs of older people and their carers in smaller communities within Tasmania, almost the villages that exist right throughout this island state. What's your approach to the provision of support for carers; what should be the approach for this provision of support for carers, given that geography and demography?

MS McKENNA (CAT): One of the things that I've actually promoted in local policy submissions is the use of a hub system, bearing in mind we have to be cost

effective. One of the models that we work from our office in the north-west coast. It's only manned by an advisory person and a counsellor. What they do is they work with other service providers, number one being the Commonwealth Respite and Carelink Centre, and other relevant service providers, but also maybe it could be Centrelink and someone else delivering a very different service.

So let's say they decide they're going to travel to the far west coast of Tasmania. Rather than everybody going separately, they go together. They car pool so that cuts costs, but they advertise this in advance. It may be held at a local hall if the town is so small that it doesn't have a community centre. So therefore it may be three cars with four people in each car will head to this area. It also makes it a social function, so we're looking at the inclusion of carers and the care recipients, so there will be a light morning tea. They will set up their stations and the village or the township, the community, come in and speak to numerous people, so there will be numerous services. They will get information, be given referrals if appropriate but then have a social interaction. It's not going to be possible for every town in Tasmania to have a centre.

This is actually, I think, a very good model. The model already exists in Western Australia. It's just something that's been developed by service providers working collaboratively. So to me, something like that, with the added social add-on - because I know when they go it becomes - they do their work, but then there's that nice social thing. So I think you need to look at that for these outer areas because you can't have a carer service centre in every town.

MR FITZGERALD: Sure. Michael?

MR WOODS: No, that's fine by me, although we do have a helpful list of suggestions as to what to do to expand our draft report.

MS McKENNA (CAT): I think one thing, just to support that - and maybe if it looks differently - across the board in services who are funded to support any service, whether it be younger or older Australians, there should be clear KPIs that service providers collaborate. We are well aware that because of competitive tendering - and we know that this is probably going to get even more competitive - that there is a lack of collaboration because, you know, "They're my carers. Don't let service provider B get hold of them," because you know when you're filling in forms you have to tick the box, so I think that needs to be clear KPI in reporting requirements for any organisation, whether they're block funded or whatever stream of funding they receive.

MR WOODS: Thank you very much. Appreciate that.

MR FITZGERALD: Thanks very much for that.

MS McKENNA (CAT): Thank you.

MR WOODS: Faith Layton. Thank you for coming. If you'd like, for the record, to give your name and also if you are representing any organisations.

MS LAYTON: Faith Layton and I represent the residents committee and residents of the Glenara Lakes Retirement Village.

MR FITZGERALD: Thank you very much. Please speak to us.

MS LAYTON: I am an 85-year-old resident of that village where I have resided since 2002 from the time the village was established. I speak on behalf, as I have said, the residents committee and the residents, and this submission has been made because we feel that although we cannot claim to present a professional viewpoint, we do present the ideas and opinions of those who are likely to be recipients of nursing home care.

Some of our residents have already required care packages and some have made the transition from our villas to the apartments which is the strange name we accord to our nursing home. Glenara Lakes is a caring village and many of our residents serve at the nursing home in various categories, reading to patients and so on. We use the apartments' swimming pool and we retain communication with the facility manager who has jurisdiction over the whole site. Therefore, we have a good overall view of the functioning of a retirement facility.

Observations have been based on the reading of the recommendations, the draft recommendations, and the overview on the summary of the draft report. There is understandable concern by residents about what monetary commitments will be required of them. I know that government publications cover daily living costs for accommodation, living expenses and daily care, but costs of bonds remain unknown. The draft recommendations make clear the differentiation between pensioners and non-pensioners, and whilst the user pays principle is acceptable it should be acknowledged that not all non-pensioners are multi-millionaires, and the differentiation between the two groups should be fair and just.

When buying big items during one's earlier lifetime, costings are always available, for example buying a residence. It would be useful if amounts payable for bonds according to one's capital and assets were available to prospective residents before any negotiations begin.

We wholeheartedly agree with the need to pay salaries for aged care staff, especially nurses, on a par with salaries in other areas. It can be dangerous to be understaffed, particularly in the overnight shifts. The difficulty is that more money is required, and we viewed with interest the commission's suggestion that a compulsory

insurance scheme be discussed. Would the government run the scheme or would the scheme be given to a private insurance company to run? Would there be a levy which would be placed into the insurance scheme. Currently we do not know as individuals how individual taxes are used.

I doubt if the younger generation - apologies to the younger generation - would greet with open arms a levy for the older Australians because youth never see themselves in aged care facilities or losing their youth. We've all gone through that stage. Running aged care facilities is a daunting task. Society and government should be grateful to the not-for-profit organisations that undertake this arduous task. It is a matter of concern to us that so many profit-making groups are entering the field of aged care. Profits are difficult to achieve in this realm, and once making profits for owners or shareholders becomes more important than assisting the elderly, services will inevitably suffer, and it is a bleak prospect. Profits more important than people? I hope not. Some extra incentive to non-profit-making organisations could possibly be considered by governments - cash-strapped though they may be.

For many years, Glenara Lakes has sought in vain for their own care packages, and we concur with the committee's recommendation to remove restrictions on care packages. In our case, we feel it is far preferable to be dealing with staff who have known us over the years and understand our needs, than to deal with those unknown to us. Likewise, in disposing of differences between high and low care is absolutely commonsense, especially as the high-care residents need extra care yet often do not pay bonds as the low care folk do. With the tendency to stay in our homes longer the revenue of nursing homes most be affected.

We could not agree with the proposition to base average costing on a two-bed standard room. As we age we appreciate the dignity of privacy which a one bed per room gets. It also disadvantages those nursing homes - as with Glenara - who provide all single rooms. Their government payment would be reduced and such organisations are penalised for providing better service and privacy. Concerning complaint handling, we asked the question if the current aged care commissioner has the authority to implement his or her findings. I must confess I gained this idea some time ago from a Four Corners program. I assume this program is careful about its statements in view of libel laws and I trust my perception was correct and not distorted by the passing of time. I would be interested in the answer. Of course the main point regarding complaints handling is that impartiality is guaranteed, implementation of findings is rapid and that no vexatious or trivial complaints get into the system. I understand that happens quite easily at the moment.

To the outsider, staff time is best used to care for patients and there is a feeling that too much staff time is spent complying with government demands for more and more reports. No-one denies the need for adequate protection for staff and residents

through appropriate reporting, but duplication and irrelevant demands can get out of hand. Therefore any attempt by this committee to bring aged care under one authority is applauded. Accreditation is another area where staff is required to spend excessive time away from nursing duties. Reduction in this time could be considered.

Naturally the government must supervise how standards are being kept, but the record of particular providers is known to them and surely the purpose is to find out about those who do not reach the required standard. More visits to those suspected of not complying and fewer to those with good records may be helpful. Finally we congratulate the productivity committee on their comprehensive draft report and sincerely hope that the reforms are implemented and this report does not moulder in a cupboard gathering dust, as many former reports have done.

MR WOODS: So do we. But of course that will in large part depend on whether the various stakeholders, once our report has been submitted, putting sufficient pressure on government to adopt the recommendations that they support.

MS LAYTON: So our task is not finished here today.

MR WOODS: No, your task is definitely not finished here.

MR FITZGERALD: Could I ask a practical question about Glenara. At the moment, if you're in the retirement village and you need to move into the apartments or the nursing home, I assume there is low care and high care on that site at the moment.

MS LAYTON: There is, and also a separate dementia area.

MR FITZGERALD: Just take low care at the moment. What happens in relation to accommodation charges for an existing residence? So would you be required to pay an accommodation bond.

MS LAYTON: We would.

MR FITZGERALD: You would. Has that posed a problem, in your knowledge, for residents?

MS LAYTON: There has been concern that they don't have enough information before they start and we do feel that we are rather at the mercy of those who are negotiators and they are negotiating from a much stronger position than the person who is wanting a vacant bed.

MR WOODS: So do you sell your retirement unit and then part of the proceeds of that be applied for a bond for - - -

MS LAYTON: No, there is no link between the two.

MR WOODS: So they're independent transactions.

MS LAYTON: When we move out of the, as we call them, villas, it goes back to Southern Cross Care, who has the duty to sell it. If there is a gain, we share the gain; if there's a loss in value, we share that loss too, and that completes the matter.

MR FITZGERALD: So by removing the difference between low and high care - and you agree with that and we're pleased to hear that - obviously we're saying to the providers that the resident would have the right to either pay periodic charges, daily or weekly charges, a rent in effect, or they would have the choice of paying an accommodation bond, so that becomes a choice. Your concern is that obviously there are some people who have modest means. So the pensioner with very limited means is taken care of by the government subsidy. Your concern is for that next group that have very modest means and what would happen to them.

MS LAYTON: Yes.

MR FITZGERALD: We appreciate that.

MR WOODS: One other point that you did raise about knowing what the price was: in our reforms, we're recommending that it be mandatory to publish both the daily or weekly rental and the bond so that you know at the front end what is the charge that they're proposing for the accommodation. That is separate from the care, but for the accommodation, for residential facilities, that they are required to offer a daily or weekly rental as well as a bond option and that they must publish what that rate is so that you understand at the front end.

MS LAYTON: I think people would be much more comfortable with that.

MR WOODS: Yes, and it just seems sensible, but rather than approaching the facility and them first asking you, "How much money have you got," you get to ask them first, "What is the price of your accommodation?"

MS LAYTON: As you do in most of the major transactions during your life.

MR FITZGERALD: Absolutely.

MR WOODS: Absolutely.

MR FITZGERALD: I think one of the things that probably hasn't been clear to people is that you have a mix and match. You could have a bit of rent and a bit of accommodation bond, rather than the current arrangements. Just a second point if I can. You've mentioned the desirability - and certainly our proposal would allow this - of the retirement village owner, in this case, Southern Cross, to be able to provide community support. Currently they're packages, but into the future that will be different. Some people have cautioned against that only on the basis that they fear that the owner or operator of the retirement village would in fact have too much control, too much influence in a sense on residents and that it might be better for residents to access some services from external providers. But you seem very comfortable with the notion that the provider, in this case Southern Cross, could also be the provider not only of the retirement villa, but also the community care at your choice.

MS LAYTON: At the moment, you see, those packages have to be bought from outside.

MR FITZGERALD: That's correct.

MR WOODS: What we're preposing is in fact that you would still have that choice. If you have a previous provider who you are very comfortable with and you are entitled to a bundle of community based care or home based case, you could continue with that provider or you could change. You could say, "Thank you. That was terrific. We've looked at what this provider" - and in this case it might be the provider who also operates the residential aged care facility - and go to them for your community home based care. So the choice is with you. At the moment, we know of many operators, particularly of current low care facilities who don't have community packages and so exactly the situation that you're talking about, that they've got staff, they know the people, they come in and in fact use the community facilities, quite often they'll take meals in, but they can't provide the services back to those people and this is - - -

MS LAYTON: That is the situation with us.

MR WOODS: This would dispense with all of that. If Southern Cross Care chose to offer services to you, then you would, as the holder of the entitlement, be able to go to them and say, "Thank you. We would like you to deliver those services." So hopefully that gets rid of that problem as well.

MS LAYTON: Yes.

MR WOODS: Complaints was another one you raised. The current aged care

commissioner, although an independent entity, relies on the staff of the department for the complaints processing and analysis and can only make recommendations to the secretary of the department, if my memory serves me correctly. So although it's an independent position, it reports - - -

MS LAYTON: Too convoluted.

MR WOODS: Yes. There was a report called the Walton report which went through all of the complaints activities and recommended that they be taken out of the department and made independent of it, and we're accepting that as a very sensible approach, so that the independence is complete and so you don't get this confusion of responsibilities that currently applies.

MR FITZGERALD: It is a difficult area. Your question was, can the aged care commissioner force a provider to do something and I think the answer to that is no. One of the difficulties with ombudsman-type schemes and complaint commissioners is that often they can investigate the complaint, they can make a finding, but does the provider actually have to respond, and that's an issue I think we need to look at, because you can quite often have a finding but actually no action is taken, or the only action that can be taken is that the provider loses their licence to operate, which often is too extreme.

MS LAYTON: Yes, I think so.

MR FITZGERALD: We are grateful for that comment, because we are looking at that at the moment, but it's a difficult area.

MS LAYTON: What would your opinion be on, as I've put, vexatious and irrelevant - - -

MR FITZGERALD: I used to be an ombudsman. I know all about vexatious complaints. The vast majority of complaints are not vexatious; they are well-intended, even if they're not correct. Having said that, there is always a level of vexatious complaints and in human services, like children's welfare, or disability, or aged care, people's emotions often cause that, but good complaint handling processes deal with that. That's just part of business, but it's not the majority of business. I would be confident that, whatever proposal we've put forward, they would be able to handle that. Are there vexatious complaints, always, but not the majority.

MS LAYTON: Can I just speak about something a little different. I make a habit of visiting this wonderful 91-year-old person and she has carers coming morning and night; they arrive about 6 o'clock seeing that she has her tea and is ready for bed. But she made a very pertinent comment and as a person who lives alone myself I can

agree with her and I know what she means. She said, "After my carer goes at night I feel very much alone and insecure." I think that's a point we have to remember. I think it's wonderful to stay in your homes, we all want to stay in our homes, but there are little other not so well known aspects of it.

MR WOODS: My mother, who is 94, says that once she shuts the curtain at night it's a very long night until the next morning.

MS LAYTON: You're very well aware of the situation.

MR WOODS: Yes, it is a reality. She fills in her time doing a whole range of crafts and other things, but still makes the point that when you shut your curtains at night it is a long time till morning.

MR FITZGERALD: One of the points I think we have made in the report, and it's a difficult one, is that not everybody can stay in their own home. We acknowledge, as has been said by previous speakers today and in every forum, the vast majority of us want to stay in our own home. There are points, hopefully very late, where that is not appropriate because of safety and other areas. What we have got to do is design a system that allows people to stay in their home as long as is absolutely possible and desirable, but then there is a point at which other forms of care are probably more appropriate, and that is a very difficult decision.

MS LAYTON: It is.

MR FITZGERALD: But even in going forward there'll still be a very large number of people living in aged residential facilities, and most of those facilities are very good.

MS LAYTON: Of course, as I understand it, we of the village are helping to prop up and pay for the nursing home section.

MR FITZGERALD: You could be. If our proposals are accepted you won't have to do that.

MR WOODS: That won't be the case, no, but they will be funded at a level that is commensurate with the care they are delivering and the accommodation that they are offering.

MR FITZGERALD: That's our aim.

MR WOODS: So that we don't get that crossover. Of course, what could develop over time are a broader range of accommodation options. You could have, for

instance, more supported apartments and serviced units that have got common areas and the like, so that they are not nursing homes in that high-care sense, because people don't need that intensity of care service, but who choose to move from either the independent living unit or their long-standing home into a form of accommodation that does have common rooms and things; so at night time they feel safe to be within the building, at the coffee shop downstairs, the common room that's putting on a show on the first level, and they get higher intensity services but they operate within a safe environment. That takes away some of that stress and pressure. That won't suit everybody; I can't imagine my mother going into one of those just yet. She's 94 and says, "Thank you, I'll keep driving and I'll live by myself," but there are others who are more amenable to those sorts of environments.

We would hope that by separating out the care from the accommodation that people explore a whole range of accommodation options that suit people and by trying to neutralise impact on pensions, that people don't feel that, "Oh dear, what will I do if I release some equity, I'll lose part of my pension." We would hope that there is a flourishing of a whole range of options for people, and that may overcome some of those issues.

MR FITZGERALD: Thank you for that, that has been very, very good.

MR WOODS: Yes, we appreciate your time.

MS LAYTON: Thank you for hearing me.

MR FITZGERALD: Thanks very much, Faith.

MR WOODS: We are awaiting for the Tasmanian ANF, who we understand are due to be here at 3.30 but not yet.

MR FITZGERALD: 3.00.

MR WOODS: Sorry, at 3.00, yes.

MR FITZGERALD: We're ahead of ourselves.

MR WOODS: We are. Why is that?

MR FITZGERALD: There was an accidental half-hour gap.

MR WOODS: There was, that's why. They probably won't appear. Do we want to have Community Options come and give some evidence for the record, please. No?

MR FITZGERALD: Does anyone else want to make a comment on the record?

MR WOODS: Do you wish to come and talk to us on your services and functions?

MR FITZGERALD: You don't have to.

MR WOODS: We're not scary, we don't bite.

MR FITZGERALD: Just five to 10 minutes will be fine and, when they arrive, we'll proceed.

MR WOODS: Please, for the record, if you could give your name and your organisation.

MR TOWNS (CA): Sure. Joe Towns, CEO of Care Assess, trading as Care Assess, care assessment consultants.

MR WOODS: Could you describe your services, please?

MR TOWNS (CA): We are a community care organisation. We're a private health care organisation, for profit. We provide a number of programs, predominantly funded by the state and federal government, although we do provide other private services to GP surgeries and to private members of the public as well. As I said, most of our programs are funded from the government and relate to HACC eligible clients. Three examples of those programs would be: our post-acute program; we take referrals from the hospitals after a post-acute episode; we go into the hospital,

do a comprehensive health assessment; people come into a six-week program where they receive, essentially, rehabilitation services in their homes to regain independence in the home.

Another similar HACC program is our home independence program. It is similar, however originally it was dealing with chronic conditions; that was the origin of it. We did a pilot with the government about 10 years ago and they wanted to move it into the chronic direction. However, more and more, over time we also have people coming into that program that may have had an acute episode or be a disability client, and they just simply need to regain independence back in their home. We have interdisciplinary teams, exercise physiologists, OTs, registered nurses as coordinators, delivering services in the home so that person either regains independence in the home or maintains the independence to prevent going into residential care.

The other major program in that category is our home care program. We have a lot more ongoing clients on long-term home care, receiving the maintenance services and the personal care services that mean that they can just continue in their homes for a lot longer period. Those are examples of community sector programs. On the other side of things we also just deliver assessment services for GPs and hospitals that are essentially just doing a comprehensive health assessment for the GP to take the burden off the surgery. It might be actually putting one of our staff, who is a nurse, into the surgery for one day a week, again to be providing clinical services to take the pressure off the GP and we do that a little bit with the hospital as well. So that just gives you an idea of the organisation.

I very firmly believe that there is a role in this transition for the place of for-profits as organisations. I believe our organisation is a very, very good organisation with very, very good outcomes in terms of the quality of care we provide and I believe part of that is because of the efficiencies that we need to create and the effectiveness of our services because we have a board that is motivated by running a business with proper corporate governance. When I say "proper corporate governance" of course I'm not meaning that a not-for-profit organisation doesn't have it, I'm just meaning that it is compatible with a profit organisation that is able. I certainly know over the 10 years of history of our company we have, year after year, been assessed against the quality frameworks and so forth and received very, very good outcomes, 19 out of 20, 20 out of 20 and so forth.

I think part of that is our ability, because of the profits that we make, to then sow back into the organisation in terms of strategies of recruitment and improving the nature of our organisation over those 10 years because of the slightly different model. That is a very spontaneous comment that I'm making but it was just flipping off a comment of an earlier person.

MR WOODS: You actually then broker out to HACC providers for delivery of services.

MR TOWNS (CA): We do.

MR WOODS: But apart from the accreditation they go through, presumably you have preferred providers or a second layer of quality assurance or something to ensure that what they're delivering is what you want them delivering on behalf of the client.

MR TOWNS (CA): Absolutely, that's right. They have a memorandum of understanding with us. We do that every year. But on an ongoing basis we're maintaining, if you like, their KPIs in terms of what we have asked them to do, the time frames in which they have delivered it so we have good performance information internally to monitor our service providers. We're an organisation that is statewide, Devonport in the north-west, Launceston in the north and Hobart for the south. We have only 29 employees but we have about 50 service providers and we brokerage out.

MR WOODS: So do they pay you upon them receiving some services that you've brokered out to them. Is that the model? Where is your revenue stream?

MR TOWNS (CA): We charge the government and the government commits to funding in terms of the service agreement with us for a particular program. We charge the government a portion for what the service costs and a portion for our organisation. So that has built within it how much it costs us to get out the service providers, for the hours that they delivered but also the vehicles that were used, some of the other infrastructure that is used and also our time and, as I say, referring back to my comment about efficiency, we then have to run a very, very tight ship from an efficiency perspective because otherwise we don't make a profit. The profit we make is not, by any means, exorbitant, it is completely transparent to the government. They know all of our - our books are completely open in that sense so they know what the break-up is. So that actually drives our efficiency so we have some pretty good runs on the board there.

MR WOODS: What proportion of HACC undertaken in Tasmania would be brokered through your activity? Do you have a rough sense of what market share you direct?

MR TOWNS (CA): No, because they don't let us know.

MR WOODS: No, but there would be public records on how much HACC is - - -

MR TOWNS (CA): Yes, that's right.

MR WOODS: So you would have a rough sense of where you fit in the market.

MR TOWNS (CA): We have grown substantially over the last 10 years so that we started with a small pilot and now we're probably one of the - I don't want to go on record as getting this wrong but we are a significant provider of these services.

MR WOODS: Yes, I'm just trying to get - - -

MR TOWNS (CA): In the state probably one of the top four in our particular niche to do these types of HACC homes based services.

MR WOODS: Do you specialise in particular forms of service delivery out of the total bundle of things that constitute HACC?

MR TOWNS (CA): We do. Yes, we have some unique models. For example, our home independence program, that is a unique program nationally, in fact probably the world, in terms of the particular way we deliver that, the paradigm, the philosophy. We adopt the wellness approach. We work with clients, not for them. So in terms of the model of doing a care plan, developing goals with the clients that are based on needs in terms of our comprehensive assessment, setting goals that are measurable over time and then doing reviews and actually looking at the achievement of those outcomes and the way we're bringing into disciplinary teams in terms of the flexibility to meet those needs; as I say, like, OT, exercise physiologists, nurses, mental health nurses and other specialists. That is a little bit unique and that has become our niche.

MR WOODS: So presumably you have some documentation around that because that would be one of your selling points.

MR TOWNS (CA): That's right.

MR WOODS: When you have finished, if you could talk to Mark at the back and we could work out how to access an understanding of that wellness and independence approach, that would be very helpful.

MR TOWNS (CA): Absolutely. I would be more than happy to and I apologise for my lack of organisation in getting a submission in in the first place, but it's just one of those time things.

MR WOODS: That's all right.

MR TOWNS (CA): I had the flu when I was reading the report.

MR FITZGERALD: Given that you may have had a chance to look at the recommendations in particular the freeing up of the services, the community based services in your case in particular, what do you think will be the impact on your business? I don't mean precisely about the business model but what do you think will be the issues you will have to confront as a provider in that opening up? So instead of seeking those HACC - and effectively we believe that the HACC program will disappear, the services won't but the program will disappear.

MR TOWNS (CA): I'm very unsure as to what the real impacts are going to look like. As I mentioned candidly previously we have tried many times from the Department of Health and Ageing to seek approval for provider status and been unsuccessful. So at the moment I can only see positive impacts in terms of, if you like, the deregulation of those packages whereby we would then be able to be a little bit more free to be able to provide care in some of those upper echelons in terms of the mid to high-need clients where we at the moment are a little bit excluded from providing that care. So it would open up more opportunities for us as an organisation and I believe a lot more opportunity.

So I am looking at the Productivity Commission's recommendations extremely positively at the moment from our organisation and I see that they do facilitate the prospect of community organisations such as ours being able to flourish more readily.

MR FITZGERALD: Thank you very much.

MR WOODS: Thank you. We appreciate you coming and giving an impromptu presentation. Can we call the ANF, please.

MS ELLIS (ANF): I have a couple of packs of documents, if I can pass those forward for your reference.

MR FITZGERALD: Thank you.

MR WOODS: We've got the fax, so that's excellent. Thank you. For the record could each of you separately give your name, the organisation you represent, and any position you hold in that organisation?

MS ELLIS (ANF): Yes, my name is Neroli Ellis and I'm the Australian Nursing Federation Tasmanian branch secretary.

MS PHILLIPS (ANF): Louise Phillips, senior organiser with the ANF Tasmanian branch.

MR ELLISTON (ANF): I'm working in aged care facility.

MR WOODS: But here on behalf of ANF?

MR ELLISTON (ANF): I'm with ANF, yes.

MR WOODS: Okay. Thank you very much. You will appreciate we haven't had the chance to read this in detail yet, but I did flip through the fax that came earlier and we're grateful for that. But please, if you could make - - -

MS ELLIS (ANF): We will take you through the - - -

MR WOODS: Yes, that would be good, thank you.

MS ELLIS (ANF): Thank you very much for this opportunity to provide a verbal submission. We're going to outline the Tasmanian context, in the understanding that ANF have provided a federal position.

MR WOODS: Lee and others have talked to us in some detail.

MS ELLIS (ANF): Yes, I'm sure, but we thought it was important that we actually brought our two reps who have been recently out - Louise has been recently working in aged care and Bob is still currently a registered nurse in aged care; so particularly around questions et cetera and to paint the picture in Tasmania about the aged care.

In Tasmania, ageing in the community sector has improved, and the ability for people to stay in the community has really resulted in now those being transferred into residential aged care facilities as being much more complex needs, as you're well aware. 85 per cent of the residents in Tasmania are high care, in facilities, and around 80 per cent have dementia and palliative care needs. So they do have complex care needs. It is probably higher than maybe some of the other states.

During my time as - I'm a registered nurse, but during my time in my role as the branch secretary of the Australian Nursing Federal I've had a lot to do with aged care throughout Tasmania. We have seen a lot of disputation around the reduction of hours due to funding. But the concern for us is the loss of direct care hours and also the lack of transparency around funding as well. That has been an ongoing sort of concern for us. We work very well with the providers. We have a lot of joint positions and we have all identified there's clearly inadequate and unsustainable lack of funding in aged care for the future needs of our ageing society.

So as part of our submission I'd like to sort of break it down to about five areas, one being skill mix and staffing levels in the Tasmanian staffing tool; the second being clinical governance and changing the culture back from that business model back into that clinical model that we need to be working towards, and the learning environment comes into that; training and the learning environment; medication management and finally wage disparity, which you knew that we'd be touching on, I'm sure.

MR WOODS: Surprise.

MS ELLIS (ANF): If I could maybe start then with skill mix and staffing in aged care. I will be referring to one of the documents in the pack when I do speak to the current staffing structures in the industrial agreements of Tasmania. We have got an industrial tool called the nursing hours per patient day in our public sector agreement. In our private hospital agreements we've also got a reflective industrial tool around nursing hours per patient day with similar principles et cetera. If I can just take you then to that first document in that pack, which is titled, Nurses (Tasmanian Public Sector) Enterprise Agreement 2007, it's about three pages in.

MR WOODS: Yes.

MS ELLIS (ANF): The tab, a purple tab, actually takes you - - -

MR WOODS: You are organised. Yes, thank you. Yes.

MS ELLIS (ANF): You will see very clearly - this is the benchmarking.

MR WOODS: Yes.

MS ELLIS (ANF): The purple tab will take you to the benchmarking page.

MR WOODS: Yes.

MS ELLIS (ANF): You will see very clearly there that in the public sector we have got a measurement for aged care. It's down the bottom under F, saying "Care Awaiting Placement/Age Care" four nursing hours per patient day. We have got that throughout the public sector in the transitional care units, the evaluation units, the areas where aged care residents of similar complexity that are in aged care facilities are admitted. We obviously feel that's the appropriate level. We don't have any skill mix or staffing issues where we have got four nursing hours per patient day and I will refer to the Bentley report and I have had some discussions - - -

MR WOODS: Sorry, not having read the document, but is this for RNs or RNs and ENs?

MS ELLIS (ANF): RNs and ENs and then HCAs - all these types - - -

MR WOODS: The AIN equivalent.

MS ELLIS (ANF): AIN, HCA, ECA is actually in addition to this. This is for RNs and ENs.

MR WOODS: Yes, that's what I was assuming. It's the div 1 and 2 in the old days.

MS ELLIS (ANF): Correct. As I did mention the Bentley report, I had some discussions with ACST, they are disputing that report. However, it is a report that is available from 2008, Bentley National Residential Aged Care Survey does actually indicate that Victoria and Tasmania currently has two hours and 20 minutes of total care per resident which is well below, we believe, the benchmark that our aged residents care receive in the public setting in the community rural hospitals et cetera throughout Tasmania. So we believe aged care residents do deserve the same level of care wherever they are living and that should be determined by a safe tool. This nursing hours per patient day tool is right throughout Australia. We have it in WA, Northern Territory and now Tasmania. You may note that New South Wales have just concluded a new enterprise agreement based on nursing hours per patient day.

MR WOODS: Interesting timing but, yes.

MS ELLIS (ANF): Yes. So we do believe a transparent funded nursing hours per

patient day that can be clearly identified as a funded tool would alleviate a lot of those skill mix and staffing level issue which I know that Louise and Bob are very keen to elaborate on. We believe that the accreditation system is failing to deliver the highest quality of care. We don't believe the accreditation system is accurately delivering the quality of care that residents deserve. So on that note I think I would like to pass over to Louise Ellis who has been an acting director of care of one of our facilities.

MR WOODS: In fact one of our earlier participants, if I'm not wrong, was a resident and a member of the resident committee at Glenara Lakes. She speaks very highly of the care that is being delivered.

MS PHILLIPS (ANF): A lot of caring nurses work at Glenara. As Neroli has just said, I have recently worked at this aged care facility where I was employed in a management position for a period of about 14 months. During this time I became increasingly aware of the strain of the unrealistic workload on the staff, particularly the nursing staff. This burdensome workload saw nurses who had a genuine love of aged care struggle to meet daily workloads, struggle with not having time to do the work to the standard they would have liked or to indeed spend quality time with individual residents. In my time there I saw quite a few leave and seek employment elsewhere because of no job satisfaction.

I have to wonder as to the effectiveness of the aged care funding instrument and the accreditation standards to ascertain correct funding requirements for individual residences and facilities and if a more accurate tool could be devised to enable an accurate reflection of workload per resident. Historically the aged care sector has been seen as an easy option for an RN or an EN with more complex patients being in acute care sectors. But I feel that that is no longer so because the reality is that the residents coming to a facility now have high levels of acuity. They stay in the community longer, as Neroli said, with supports so therefore these sicker residents that come in need more time, more care, more assessment skills from registered nurses and these care needs need to be reassessed quite often on an ongoing basis, even on a daily or shift basis.

An RN may have the overall responsibility of up to 90 residents across an area and that can be spread over high care, the hostel care and dementia so there is quite often a different section, so they're spread about, they're not just in the one area. Care for these residents is often complex and time consuming requiring advanced assessment skills for residents with multiple comorbidities and usually with a lot of medications on board as well. An early assessment and consequent intervention is vital for these residents when something shows that they're not quite well. Usually it's nurses' intuition to start with and then following assessments to prevent hospital admissions, thus allowing the resident minimum disruption and distress and freeing up a possible

acute care admission.

Although residents assessed as having complex needs such as palliative care attract more funding, often the paperwork required for this funding is not submitted prior to the resident's death because of a number of factors. They may die reasonably soon or the fact that their workload doesn't permit. So no extra nursing hours are made available to assist the staff during this time, with the intensive nursing required to maintain adequate time and symptom control. This is often using things such as syringes drivers, S8 medication, breakthroughs and other symptom control.

When a death occurs, it's the norm for the RN or the EN to stay back to complete the day's work, as they have been taken away to care for the dying resident, and to deal with the family's needs also during the time, which is very time-consuming to do properly. A nurse rarely can spend one-on-one time with a resident and when not administering medications or carrying out other direct care, an EN or RN's time management will often be driven by GP unannounced visits. Not very often do they announce when they're coming in and you need to catch them because there's quite often a lot of things you need to see because you don't see them that often.

They have ECA and student supervision, family member requests and resident-acute incidents, such as falls, and in a facility of approximately 90 residents, it would be a rare day where at least one resident doesn't fall. These falls require the RN to leave her clinical area to assess and deliver care, taking up to an hour or so of her time, depending on if there is an injury, which there often is, and the severity of the injury, which may require neurological observations over a period of hours for a head injury, wound care for skin tears and lacerations or sometimes a trip to DEM for x-rays if a fracture is suspected, and that all takes time in the transferring of a resident and the paperwork and the phone calls.

Indirect care such as documentation of progress notes, undertaking and writing up ongoing assessments for new residents or residents with a changed health status often get re-prioritised to the end of the shift when another nurse then takes over for the next shift. Therefore the RN or EN carries out documentation in their own time, rather than leave work unfinished, and that's the norm. It just happens.

There tends to be a shift also towards employing, from my perspective, from what I've seen across other care facilities as well, a clinical care coordinator to oversee clinical practice for an entire facility, instead of the old system of a nurse unit manager on different areas, and then there's a facility manager as the overall manager of all really; staff, buildings and what goes on. This, I believe, although a cost saving measure for a facility, is a step backward because a clinical care coordinator cannot be on top of what is going on in all areas. You just can't do it in

an average 80 to 90-bed facility. No-one therefore has ownership of any one area and often the areas can be staffed with casual or agency staff. So really I feel sometimes the care is less than adequate because casual staff, agency staff don't know the residents, don't know what the routine is, so they struggle.

A clinical care coordinator and facility manager can often work 10 to 12-hour days just to keep up with the everyday running of the facility and prior to accreditation, can often spend weeks to months with extra staff hours, bringing the facility into line to ensure compliance. I know that's not only at one facility. It does happen across the board in a lot of facilities. Business and facility managers become adept at talking the talk on unannounced support visits from accreditors so the follow-ups I don't think are a true reflection of usual practice, because quite often you're just running to keep up and a lot of things get missed along the way and then brought up to scratch at the end. To me it isn't a true reflection for funding. Thank you.

MR ELLISTON (ANF): Thanks for the opportunity to speak. I'd like to endorse what my colleagues have said. I've worked in community nursing and acute hospitals and now I'm working in an aged care facility. I have to say that, in my opinion - and it's not only my opinion - most nurses recognise that there's either poor or inadequate care being delivered to our high-care residents. Our low-care residents are doing a bit better because, to whatever extent, they can look after themselves. But there is a chronic shortage of staffing and difficulties getting appropriately trained staff into residential aged care facilities. I've written out a whole bunch of things here and I would like to - - -

MR WOODS: We're conscious of the time, so if you could push through, that would be good.

MR ELLISTON (ANF): For sure. I'd like to submit this because it is too long.

MR WOODS: No, that's fine. We'll put that on the record.

MS ELLIS (ANF): We might actually come back to that, if that's okay. We'll just keep going through these issues and Bob can probably expand through questions, et cetera, on those.

MS ELLIS (ANF): Yes, sure. The major point I wanted to communicate is that the federal funding for residential aged care is inadequate and it's causing a great number of problems within residential aged care facilities, including but not exclusive to inadequate care for our residents.

MS ELLIS (ANF): Thank you. If I can go to clinical governance and leadership

then in aged care.

MR WOODS: Yes.

MS ELLIS (ANF): From our perspective, we think it's very disappointing that aged care now has gone very much from a nursing and a care model into very much a business model, and I think the draft recommendations to date have actually focused very heavily on the business model and the funding mechanisms, et cetera. We now see that the majority of facilities are run by non-clinical staff, by health bureaucrats or however so titled, CEOs, CFOs, et cetera. They are answerable to the board and the board quite commonly doesn't have clinical staff on it either. So we've actually got a situation that the business model is driving aged care, as opposed to the clinical model.

We have heard from directors of nursing, directors of care, that they actually don't report directly to the board, so we are concerned that the quality and safety issues and the clinical issues are not potentially being accurately reported to the boards and we have got a concern about that. You'll note that the presentations today have been mostly from non-clinical aged care staff. That is reflective, I think, of this business model that we've now moved to.

The director of nursing from nursing homes has changed to a director of care and has now changed to faculty managers, so we're actually losing that clinical governance that is so vital in aged care to ensure quality. We are strongly advocating we must move back to that clinical model, have clinical governance in place and re-balance back to ensuring of course the budgets, the growth strategies, the developments have to be managed, but we want to focus back on it and have that clinical model as the number 1 governance scenario. So we would support nurse leadership funding. We would support programs, a mentoring system and clinicians leading the quality and safety agenda as a very strong focus. We just think it's moved too far into the business model sector.

I'll keep moving to training and learning then to follow on from that. We support and we believe you've heard from Prof Andrew Robinson today. We work very closely with Andrew and fully support the teaching nursing home hubs and centres, believing that that can actually really change the culture of aged care. We strongly advocate for funding for more of the teaching nursing home hubs so that we can actually really start bringing in learning, start ensuring students have a positive placement in aged care, that we have some real succession planning in aged care.

MR WOODS: If anyone has any objection to being photographed, WIN are going to take some footage, but not audio. So if anyone wishes to leave before that, you're most welcome to do so, but I assume you have no objection to being filmed giving

evidence to us.

MS ELLIS (ANF): Not if you don't.

MR WOODS: Please proceed.

MS ELLIS (ANF): So growth in regards to the teaching nursing home hubs to build capacity. That is right across the board. $1 million is our understanding of the cost of implementing a hub and we would say at least 30 hubs must be built across Australia. It's actually imperative now for a long-term sustainable cultural change. We've got some research going, but we need to build up that whole culture. So it's not only for the students; it's for the carers, it's for the ENs, it's for the RNs, it's for ongoing professional development so we can actually really have innovations of practice back into aged care, which really has been put to the side of people's desks at the moment without the appropriate ability to deliver. There are some wonderful things happening in aged care. There's no doubt about that. But we would like to see those innovations shared right across through that framework.

MR WOODS: That is certainly something that we keep puzzling about, that there is a lot of innovation, there is a lot of dedicated pursuit of improvement, of changes of scope of practice, of models of care but we don't find much dissemination of that. Now, partly it's a responsibility, let alone a feature, of the professional bodies in nursing but also of facility operators of peak bodies. But it's not happening to the extent that you would envisage it should. The teaching nursing home concept would be part of it, but any further thoughts you've got on what's preventing this dissemination of innovation and good practice would be quite interesting from our point of view.

MS ELLIS (ANF): We are quite amazed actually how many aged care nurses and carers come to professional development. We offer weekly clinical updates et cetera and every single session we run over half are aged care nurses coming to those sessions. On Friday we ran an aged care day with our two nurse practitioners in aged care coming to prevent innovations et cetera, 80 aged care nurses and carers came to that which in Tasmanian standards is quite extraordinary actually.

MR FITZGERALD: That's terrific.

MS ELLIS (ANF): Most of them in their own time. So it is actually ensuring that that learning culture is right across the board so people actually have a better mentoring and networking system and it will become more part of the normal culture.

MS PHILLIPS (ANF): Yes, that's true, the culture becomes - the aged care nurses

have a thirst for knowledge. Quite often they're too busy at work to attend education during work hours because their workload doesn't permit it and there's a general feeling of being undervalued also. So when the opportunity arises outside of work they grasp it but at work it's, "I haven't got enough time, no-one is going to free me up to do it. I won't go to this session," so it doesn't happen. They become more then more apathetic, so they need to actually be feeling valued in their workplace so they're given time to go to education during working hours.

MR WOODS: Is it partly also because they don't work in a large institutional environment, because they are scattered through the community in their own institutions that there is that lack of communication?

MS ELLIS (ANF): There is modern networking now and we have videoconferences for all our rural nurses and a lot of those working in multipurpose centres et cetera. There are aged care nurses working in the James Scott Wing at Scottsdale or down in Queenstown and they come - it's a matter of actually facilitating that and also having that supportive environment again. We have very few clinical nurse educators in aged care and that is normal practice in any other setting, you have clinical nurse educators attached to every ward. We are really down to bare bones. It's direct care hours and there's not much indirect care hours available or funding for such.

Whereas in our model that we produced for the public sector we have direct care hours and in addition to that we have a clinical nurse educator and a nurse unit manager for every ward that indirect and they're funded and that's black and white. It's an industrial mandate that they're funded. So we do know that then clinical nurse educators will facilitate programs every handover period. The other big issue now for aged care is that we don't have handover period. We have 15 minutes handover now and in general areas now all other nurses have an hour and a half. That is your networking time, that is your debriefing time, that's your sharing of innovations of practice that normally nurses have. But, unfortunately, due to funding the aged care providers have cut back that to 15 minutes that handover time which is only just - it's not even long enough to do a proper clinical handover.

MR WOODS: Thank you.

MR ELLISTON (ANF): I just wanted to reiterate that the aged care sector is running on social capital that the trust, good nature, goodwill, dedication of the workers - nursing and non-nursing workers - in the industry and that's been buoying up the whole sector. But that is a store of capital that is pretty much exhausted and people are getting exhausted, as Louise said, apathetic because they don't get time for continuing education, they don't get appreciated, they don't get the respect, let alone the wages that they really deserve.

MR FITZGERALD: Have you got other points you want to run through?

MS ELLIS (ANF): Yes.

MR FITZGERALD: I only say that because I just want to get to some of these other ones.

MS ELLIS (ANF): In relation to the training and learning, if I can just maybe continue with that theme.

MR FITZGERALD: Yes.

MS ELLIS (ANF): In addition to that we believe certificate III courses are a valuable entry level for carers and carers must have a minimum certificate III entry course. We have been concerned that some of the quality of the certificate III courses has been not as we would like to see the outcomes.

MR WOODS: Are you talking about the quality of the content or the quality of delivery or a bit of both?

MS ELLIS (ANF): Quality of the delivery; the content is set but potentially how it's delivered. I'm looking at Alison who is our RTO coordinator. Since then we have actually started off our own registered training organisation because we believe as nurses we could actually deliver the quality that was required.

MR WOODS: Do you deliver cert IIIs as a nurse RTO?

MS ELLIS (ANF): Yes, RTO deliver certificate IIIs.

MR WOODS: Yes, I know but does your RTO deliver the cert IIIs?

MS ELLIS (ANF): Yes. We have only just started but we have delivered our first group and we're on to our second group now. But as part of this and part of the stress we saw that was part of the poor delivery was that now we have a lot more face-to-face time and a lot more clinical skills time. But we actually also send nurses out into the clinical placements so a nurse works with that student as opposed to other settings where students just have to go in as part of the workforce with everyone being flat chat already and then the student actually doesn't get the correct sort of assessment and monitoring. Whereas our nurses going out to work with those students, we've had a lot of positive feedback from the facilities to say that is so much more preferable. So there can be better models.

MR WOODS: Do you have a view on the content of the cert III.

MS ELLIS (ANF): Maybe if I just ask Alison Salisbury.

MR WOODS: Yes. Do you want to come forward so we can record your comments.

MS ELLIS (ANF): Alison is a registered nurse and she is working as our RTO coordinator. We will also be offering the advanced diploma for nursing in aged care and the transition from certificate IV to diploma for enrolled nurses.

MR WOODS: Could you give your name, please.

MS SALISBURY (ANF): My name is Alison Salisbury and I work for the Australian Nursing Federation as the registered training organisation coordinator. In terms of the content of the course itself, the certificate III courses, the content is mandated through the training packages and the industry - - -

MR WOODS: Yes, we understand that. We're just curious as to whether you think it's any good.

MS SALISBURY (ANF): Okay. It's probably about the rigour of the way the AQTF framework is able to be administered. We believe there should be strict guidelines so that when the auditors go into a registered training organisation they can assess against guidelines to see what the content of the delivery actually is against the nominal hours for each of the units of competency in the package because every unit has a nominal hour but there is no actual way of monitoring whether or not this is actually delivered by a registered training organisation against that standard. Also the assessment process is undertaken, whether or not it be a clinical assessment, a simulated assessment and how vigorous is that component as well.

MR WOODS: Okay. Thank you very much.

MS ELLIS (ANF): In addition, if we just go back, when students go into the aged care environment they do have to go and work with current nurses and carers and enrolled nurses et cetera who, as I said, have got incredible workloads and we find now that many facilities are refusing to have students any more and in fact have removed the previously agreed $2 an hour preceptor allowance that was in the industrial agreement that would actually compensate nurses for the additional workload. A lot of the providers are saying, "Let's remove it because we're not going to have students any more because we haven't got enough ability to actually have students any more," which is a real shame for the future.

We also wouldn't want to see students go into an area that there is not the appropriate support format that has been an issue and we do believe now that the research - and I'm sure Andrew Robinson has provided that research - in regards to the 200-student experience and all 200 students had a feeling of fear and anxiety during their clinical placements during that time. So that does nothing for recruitment for building up of the profession of nursing in aged care. There has been a model in the ICU where UTAS actually provides the funding that they receive for clinical placements directly to a co-joint position in that area and we think there could be some review of the Commonwealth funding for clinical placements going directly to providers in a transparent manner to ensure that they could then employ the appropriate support clinic nurse educators et cetera. So there are some options there in regards to clinical placements.

I would like now to go into medication management and just briefly say that in Tasmania we have a Poisons Act like every state, a state act. We have had recent amendments to our regulation where we now have the ability for aged care workers to administer medications but only under the direct supervision of nurses. To us it was absolutely imperative to ensure, from a safety and quality perspective, that we maintained a registered nurse on site 24 hours a day if carers were actually going to be administering medication.

So we believe our model and our guidelines that are in your pack - and I'm sure you will read every word of the pack - but maybe if I could just take you to the relevant section for your information. It is on page 10 of the 21 pages of the guidelines which are enshrined in the regulations. So they are law. They have to be upheld. It does talk about at 3.3(b) "The registered nurse on site is responsible for the management, the initial and ongoing assessment" - so if it is an PRN dose ordered or as required, the RN has to do that assessment and assessing it and being on site at all times. That has actually protected in legislation - it's very sad that we had to protect in legislation - a registered nurse to be on site. New South Wales has got legislation determining that a registered nurse must be on site, but apart from Tasmania and New South Wales, we believe that is the only legislation protecting us.

This was essential for Tasmania because prior to this we were finding that no registered nurse was on site on night duty and after hours in some facilities and that the carers would actually call Hobart District Nursing Service and ask for advice and assessment over the phone. So that those nurses on the end of the phone had no idea who the residents were or what their medical and nursing assessment was and yet they would be giving out instructions to administer medication based on the carer's information over the phone. That clearly was one of our major concerns to continue that practice in light of the change to medication management and poisons bill. So we are very pleased to see that now we have got protection, that we do need to have a registered nurse on site.

MR WOODS: To what extent will that get affected by removal of high and low care? This reads as if it's independent of that whereas in New South Wales of course the - - -

MS ELLIS (ANF): Facilities will be impacted. In Tasmania legislation or this particular section is around residential aged care facilities. So it's not related directly to high care, low care.

MR WOODS: So you don't have the New South Wales issue?

MS ELLIS (ANF): No. But we obviously have got concerns that it was limited to this grouping because previous - high care in ageing in place et cetera that it's a different situation. So we have got some concerns there. In closing I'd like to also talk about wages.

MR WOODS: I'm sure you would.

MS ELLIS (ANF): Clearly it's an issue.

MR WOODS: We're supportive.

MS ELLIS (ANF): For a young nurse choosing their career pathway and going public, private or going into aged care, they look at the environment they are going to but one of the factors has to be wages. If I could just take you to the spreadsheet on the second-last page of this document and it does talk about equivalent rates for equivalent classifications. So talking about enrolled nurses at the top of the scale of the enrolled nurse in the public sector gets $52,000. St Anne's - a large not-for-profit facility here in Hobart and I think you may have heard from the acting CEO - is $7000 less for an enrolled nurse in that facility which is $133 a week. However, The Gardens, for profit, is even in a worse scenario of $11,000 difference for that particular classification or $210 a week less for that nurse who could work in either TCU, acute care, private care or aged care.

Registered nurse, the same sort of scenario. We've got the top of the range of the base-grade registered nurse before a promotable position, 67 in the public; 59 at St Anne's, again $8000 difference over the year, $153 a week less. In The Gardens it's $13,000 difference in the for-profit facility. Carers or extended care assistants et cetera $43,000 in the public sector, $33,000 at St Anne's and that's the modern award so well and truly below the levels of their colleagues working in - - -

MR FITZGERALD: Can I just understand the chart completely. Where you say "public sector", are there public sector aged care facilities or is the public sector here

referring to hospital?

MS ELLIS (ANF): No, right across the whole public sector we get the same pay rates so whether you're working in a rural aged facility or whether you're working in a multipurpose centre, you're getting the same pay rates.

MR FITZGERALD: Okay.

MS ELLIS (ANF): So nurses working in TCU, which is an aged care area, gets the same pay rates.

MR FITZGERALD: But are there any government-run aged care facilities other than those that are part of multipurpose centres? In Victoria, as you know, the state government runs quite a large number. Here, is that the case or not?

MS ELLIS (ANF): No, it's different. The majority are not-for-profit here with a very small percentage of for-profit. The only one that's similar to an aged care is the TCU/GEM which is a set-up for aged care, waiting placement et cetera and it's out at the repat centres.

MR FITZGERALD: As you have indicated, the multipurpose centres where they have both got health and aged care combined, the pay is across the board.

MS ELLIS (ANF): The base is the same. So a nurse or a senior care assistant working in James Scott Wing, which is an aged care facility in Scottsdale, attached to but a different wing of a hospital, totally aged care, same sort of acuity as any other aged care residential facility is paid these rates.

MR FITZGERALD: Okay, thanks. The second question, just in relation to these rates, are there any other factors - this is salary or total remuneration? It doesn't make any difference.

MS ELLIS (ANF): No, this is just base grade salary.

MR FITZGERALD: This is just base salary. There is nothing else that would in fact make a difference beyond that. In other words, we understand these differentials but beyond that in terms of other terms and conditions it doesn't improve the position. So where you've got The Gardens, for example, and a very substantial differential, there's no other factors that would say, "Yes, there's a differential in salary, however, there's some ameliorating factors."

MS ELLIS (ANF): It's the same super. The public sector would get better conditions in regards to study leave, professional development leave, uniform

allowances, they get better conditions all round. Look, salary packaging is an issue but not everybody accesses that. It depends on your own individual taxation implications, whether you opt to go in. Public sector can salary package and aged care have an improved salary packaging system, however, again not everybody can opt for that, it depends on your own taxation situation. So that's not what we incorporate into a package because not everybody accesses it.

So we go on base salaries. Of course, in public sector you get 27 and a half per cent for night duty. Aged care 15 per cent penalty for night duty. So significantly all round, even on a base rate plus conditions, they're well behind. One of the implications with the differing industrial systems we have had over the last 10 years is we had one agreement with aged care, ACST and ANF, where we had around 43 facilities all combined into one agreement where we had some consistency of wages and conditions. That finished in 2007. Some facilities haven't negotiated a new agreement so still paying back to 2007 or giving an ad hoc payment. Other facilities have negotiated new agreements. But now we're finding we have to negotiate every single agreement. So the small providers have to either employ a negotiator for them, which most of them have to do because it is such a complex world now with Fair Work, or they have to spend a lot of resources trying to negotiate with us around a new agreement for both nurses and carers.

So there is a lot of resourcing that goes into individual agreements for each individual facility. Obviously some of the bigger groupings have got three or four facilities but one agreement. But the majority are small, one-off agreements and may only employ 10 or 15 nurses but you still need to go through the whole process of the agreement making.

MR WOODS: So the two not-for-profits you've got there - and there is quite a diversity of wage rates and I'm thinking even amongst personal care workers. Rates can be down to as low as $17 an hour in some facilities but in others who are also either not-for-profit or for-profit - and it doesn't particularly matter which - they can be up $21 an hour because of the different enterprise bargaining agreements that they have struck.

MS ELLIS (ANF): Correct.

MR WOODS: Are these two both towards the bottom end of what is provided in the not-for-profit or even the for-profit sector? Presumably there is quite a diversity depending on what the EBAs have come up with.

MS ELLIS (ANF): It's a very small range. Potentially with carers, the aged care workers, most are on modern awards in Tasmania. They haven't got agreements and haven't traditionally had agreements, they've got nursing-only agreements

traditionally. We have only just started changing that.

MR WOODS: But for your nursing agreements, are these two at the bottom end of that are they - - -

MS ELLIS (ANF): No.

MR WOODS: Where do they strike in the spectrum?

MS ELLIS (ANF): St Anne's would probably be in the middle of this grouping. They haven't negotiated a new agreement but gave 4.8 per cent last year sort of as a token - because they haven't give a pay rise since 2007 so they were trying to catch up. They couldn't recruit otherwise. The Gardens is another one that we're struggling to negotiate in and the only other for-profit is ACSAG which is the northern two facilities and they're around this sort of rating as well. We always find the for-profits are less than the not-for-profits.

MR FITZGERALD: One of the issues that the Health and Community Services Union made today - and it has been made by other unions in other environments - is that at first glance this is caused because of the financial constraints and the funding models that apply to aged care and yet there has been a recurring theme by some in the union movement that even if you increase the financial arrangements and improve it, which our model absolutely does, there is no question about it, there is no guarantee that this flows on to actually increasing wages. So the question we asked the Health and Community Service Union today, and I'll ask again, what is the mechanism by which you believe you can ensure both - well, firstly, an adequacy of financing which is probably outside of your province, but the second thing is that there can be an effective flow on to moderate the very substantial differentials.

MS ELLIS (ANF): ANF has provided or is providing a framework in regards to industrial - - -

MR WOODS: We have seen the draft industrial framework.

MS ELLIS (ANF): Certainly we support that framework and the linking of salaries directly in a very transparent manner to ensure that if those sign up to that framework then they get the relativity to the state's public sector wages, so that we actually can have some - it's a framework that actually enables open, transparent funding mechanisms.

MR FITZGERALD: Is this the national agreement framework or is this a different one?

MR WOODS: No, the ANF gave us a draft industrial framework agreement that is being developed with employers. We've got a copy of that.

MS ELLIS (ANF): And the mechanism behind that and that is part of our national submission, it is a solution. It is directly linked to funding because otherwise if you don't pay the salaries, you don't get the funding.

MR WOODS: Can I ask different question. One is that - and here in Tasmania some very clear examples of where you go to a residential aged care facility and you ask them about the use of agency nurses and they say, "Oh, yeah, we did need one about six months ago for a short period because there was a particular set of circumstances," but they have a dedicated core group of staff and then they have either X staff or staff who they draw on for meeting particular vacancies but very little use of agency staff. Then we've talked to the staff themselves and said, "What's it like here?" "Good, the rosters are negotiated. We've got good PD. We're part of the process." So what's falling down in management in some facilities that don't get to that point whereas others are very good organisations? What can we do to help encourage good management which seems to be part of the answer. I understand the salaries gap but good management has such a big impact.

MS ELLIS (ANF): Absolutely.

MR ELLISTON (ANF): You are absolutely right. The work environment, the culture and mind-set of management makes a big difference. Many management groups that I have encountered have a hierarchical, dictatorial sort of approach and that tends to alienate people a lot. These days people want to feel part of a team and if they don't feel included as a team, their morale goes down and sick leave goes up and people don't want to come to work when they're called in. At the aged care facility that I'm working at the system depends a lot on being able to call in people when a shift is not filled and, again, it's the dedication of the staff that makes that possible. If that fails, then they go to agency. But, of course, the agency people don't know the residents or what is entailed so they are an expensive and a less than adequate alternative to having the core pool to tap for unfilled shifts.

But if the management culture is one that is collaborative and collegial, it makes a big difference despite the poor wages and conditions because that sort of approach means that people feel valued and it boosts what I call the social capital, that sense of trust and belonging and dedication.

MR WOODS: The only question we would like you to bend your mind to is we have put some recommendations in about management training and the like but if there is more where government could usefully intervene - and I don't mean just throw money at things - but a strategic contribution to that issue, any further thoughts

you may have in that area would be very helpful.

MS ELLIS (ANF): There are some wonderful facilities where it is culture, leadership and clinical governance again where we actually see inclusion, we see professional development, we see support, we see most of those actually employ clinical nurse educators. You can walk in and you know the sort of culture and you know the people are very happy to work there. Whereas you can go into other facilities and it's just bare bones and it is a grind, it is every day and people burn out with that sort of workload et cetera. So that is when you start having higher sick leave, higher turnover and that's where you need to agency. Tasmania traditionally isn't like other states, we don't have a lot of agencies. However, we do now see that aged care keeps our agencies alive in Tasmania. The public don't use agencies very much, only for remote areas.

MR WOODS: But interestingly they're all doing it within the one financial framework. They are all getting paid according to ACFI and the like so it's not as if one has more money to spend than the other, it's just how they allocate their budget and how they manage their facility.

MS ELLIS (ANF): The person who would actually lead that would be the nursing clinical governance and nursing leader will actually set that. The business managers actually can't do that.

MR FITZGERALD: Can I just ask a question. Have you got any figures - you may have put it in another submission - that shows the difference between the turnover of registered and enrolled nurses in the public sector facilities, vis-a-vis the aged care facilities, the non-public sector aged care facilities, because one would expect if you have both a better remuneration pay and you've now got these almost clinical hours requirements as you have indicated to us here, that the turnover rates within the public sector should be considerably less than in aged care. Do we have those statistics available for Tasmania?

MS ELLIS (ANF): One of the hardest things we find is actually getting open, transparent data from aged care. I can give you those statistics for the public sector - we've got those statistics.

MR FITZGERALD: Just to compare it up.

MS ELLIS (ANF): We would have to go to Aged Care Services because we just cannot get that data. There's no transparency of data.

MR ELLISTON (ANF): My impression is that the turnover is higher; definitely turnover is higher. A few months sometimes is all that people last.

MR WOODS: If you had one or two big providers that were cooperative, that would be interesting and without naming them in terms of - - -

MS ELLIS (ANF): We would like to see a lot of transparency of data as part of the outcome here, it's essential. Why shouldn't people in the public know how many nursing hours per resident is being provided at this facility versus this facility. I know where I would want to put my mother, it would be the one that has the greatest nursing hours per resident.

MS PHILLIPS (ANF): Just in regards to use of agency staff and core nursing staff in a facility. I think most aged care facilities only have a limited amount of RNs and if you do have a spate of sick leave in a facility which quite often happens, you cannot continually call on those RNs to come in. I think poor management would be to continually say, "Can you do a double shift? Can you work on your days off?" You have to stagger them a little bit and I feel that the use of agency staff is used to give those core nurses a rest so they don't burn out and they say, "I can't do it. I can't come in." You have to value and recognise that those few nurses that are working in the facility also need a rest, therefore, there are times when agency staff are used.

MR FITZGERALD: Can I ask a question about agency staff salaries, it's just out of ignorance. Is an agency nurse paid - her remuneration or his remuneration, what's that? Is that at the rate the aged care worker gets or is that at the public sector worker or is that a completely different rate?

MS ELLIS (ANF): They get a premium, so they get paid more than the aged nurse than in the facility, that is in the facility of being there. Normally the loading is 20 per cent for a casual shift which the aged care would also provide that 20 per cent, however, there is a premium on top of that and I'm sorry I can't accurately tell you. We've heard anecdotally 30 per cent on top of what the - - -

MR WOODS: Is that received by the staff?

MS ELLIS (ANF): Yes. That is anecdotally. We could certainly try and get that information.

MR FITZGERALD: It may be relevant. Nobody has ever mentioned to us what the salary and remuneration packages are for agency nurses - not the agency itself but the nurses.

MS ELLIS (ANF): In Tasmania they actually do ring us to find out what the going rate is at that facility because they're all different and then we give that advice and then they put their premium on top of that and probably the providers could probably

tell you exactly what they are paying them in regards to that. I am very comfortable to provide the public sector turnover rates, if you are interested, in Tasmania.

MR WOODS: Yes. If you can encourage one or two aged care providers to help. We're out of time but just one brief one. We have had evidence from In-Reach nurses who go to facilities and are surprised at either the lack of competence or the lack of confidence - and sometimes it can be a combination of the two - in administering palliative care and even more simple things, catheter replacements and the like in facilities by RNs. What is happening and why is that occurring and what can be done so that those sorts of things are being done in the facility by the staff who are trained and accredited to undertake those functions?

MS ELLIS (ANF): That is reflective of our system failing at the moment. It's not those nurses or the carers. It's really not their fault. It's the system that is failing and the teaching nursing home whole culture, if you bring those in, then you have a constant ongoing learning culture, then sharing of innovation and that is one of the answers.

MR ELLISTON (ANF): Continuing education is what is needed. In the facility that I work at that has stopped in recent years because they realised how big their debt was. So I actually think that the nurses and carers are really quite confident and competent but they don't have the continuing education that they really deserve and need because the employer can't provide it and can't support it.

MS PHILLIPS (ANF): I think sometimes there is a lack of confidence.

MR WOODS: That is what I say, it's not just competence, it is confidence as well.

MS PHILLIPS (ANF): It's not necessarily competence, it is the confidence. My experience is that in catheter change and palliative care if you put the evidence behind on how it's done, you teach the nurse in question how to do it, they're more than happy to go and do it. They say, "Yes, I just haven't done it for a while," but it's the lack of confidence. They may not have had those skills reinforced in recent times and they just need that ongoing education.

MS ELLIS (ANF): The role of the nurse practitioner is vital here. The nurse practitioner can have a cluster of facilities - - -

MR WOODS: Absolutely.

MS ELLIS (ANF): - - - that can be resourced, they can work outreach from hospitals or they can work independently.

MR FITZGERALD: We are a big supporter of nurse practitioners.

MS ELLIS (ANF): Good. Fund one per facility and we would be really happy.

MR FITZGERALD: We have run out of time and there is one issue we haven't talked about at all and that is community based nursing. I presume in relation to the remuneration there are similar issues between - or are there, perhaps I should ask the question. Is there the same between a community based nurse that is employed by the public sector and a community based nurse that isn't and are there any other issues - in the very, very short time we've got available - that we should be cognisant of that hasn't come out?

MS ELLIS (ANF): The community nurses are paid under the public sector; the majority are public sector. We do have Hobart District Nursing Service is the only private community service that actually pays similarly to the public sector community. So they are paid higher than these rates. They are considered speciality nurses so they actually are paid higher. This is base grade positions, so community are valued at a higher rate in Tasmania.

MR FITZGERALD: Thank you.

MR WOODS: Any matters that we haven't covered?

MS ELLIS (ANF): No, I think as I said, our framework in our submission is through the ANF federal submission. We do support all recommendations arising out of that and contributed to that. So I just wanted to certainly contextualise the Tasmanian conditions here. Thank you very much for the opportunity.

MR WOODS: Thank you.

MR FITZGERALD: Thank you.

MR WOODS: That concludes the scheduled presentations. Is there anyone present who wishes to make a short unscheduled presentation? That being the case, that concludes the hearings in Hobart and we resume tomorrow in Brisbane. Thank you very much.

AT 3.34 PM THE INQUIRY WAS ADJOURNED ACCORDINGLY