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TRANSCRIPT
OF PROCEEDINGS

PRODUCTIVITY COMMISSION

DRAFT REPORT ON CARING FOR OLDER AUSTRALIANS

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

TRANSCRIPT OF PROCEEDINGS

AT BRISBANE ON FRIDAY, 25 MARCH 2011, AT 8.29 AM

Continued from 24/3/11 in Hobart

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MR WOODS: Welcome to the Brisbane public hearings for the Productivity Commission inquiry into caring for older Australians. I'm Mike Woods and I'm the presiding commissioner on this inquiry. I'm assisted by Associate Commissioner Sue Macri and also Commissioner Robert Fitzgerald.

The commission has been requested to undertake a broad-ranging inquiry into the aged care system, with the aim of developing detailed options for a redesign which will ensure that the current weaknesses are overcome and that the future challenges can be met. In developing the draft report, the commission travelled extensively throughout Australia, holding over 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 already made in the course of this inquiry.

These hearings represent the next stage 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, I will provide an opportunity for any persons present to make an unscheduled presentation should they wish to do so.

Could I ask John Fox to come forward, please. Thank you very much. For the record, could you please state your name and, if you are representing any organisation, what that organisation is.

MR FOX: My full name is John Kenneth Fox and I'm a member of the Centenary branch of the National Seniors Australia.

MR WOODS: Thank you very much. We have received several submissions from you, but if you would like to make a presentation to this inquiry.

MR FOX: I don't wish to expand on my submissions unless you have an inquiry. The salient points have been mentioned in my supplementary submissions. What I would like to do is to give my background and ask two questions.

MR WOODS: Please proceed.

MR FOX: As I said, I'm a member of the Centenary branch of the National Seniors Australia Ltd, having spent two years on the executive committee. I have a diploma from the Royal Society of Health for public health inspectors overseas and I've been employed by the Brisbane City Council continuously for almost 38 years as an environmental health officer.

Since retirement in January 93, I have done volunteer work at the Inala Day

Respite Centre for about four years, which deals with aged care predominantly. I've been a bus driver and care provider for the Wesley Mission Brisbane at Hadden Place, which was a brief period, and for disabled persons' respite. I've been a volunteer bus driver and care provider for Blue Care at Merriwee Court Care Services, 31 Jackson Road, Hamilton. It's a hostel for aged care and dementia patients, and I was only employed for a brief period.

Currently I'm a volunteer bus driver for the Sherwood Neighbourhood Centre, having been in that role for approximately nine years. An effort was made to contact the chief executive officer, Mr Michael O'Neill, of National Seniors Australia Ltd, and I was advised indirectly that I can make a submission on the subject. Also, I am an active member of my general community in the Centenary suburbs - and I'm not a bad bloke.

The question that I have to ask is, is it the intention of the commission to compile a list of achievable goals, many of which are cost-effective and some are revenue-neutral? Also, will a wish list be acted upon in a timely manner? And the second part of the question: will the interested parties who have made a contribution be advised of the progress?

MR WOODS: Well, thank you very much, and also, as I say, thank you for your earlier submissions. I don't know if you've had a chance to read our draft report, but there is available a draft report, and if you haven't, we'll make sure that you get a copy of it because that will answer your first question. Yes, we have developed a list of, we trust, achievable objectives. It's a draft report and that's why we're testing that with a range of participants, to make sure that in their view it is achievable. And, yes, by now having registered your interest, put in a submission and come and made a presentation to this inquiry hearing, you will be provided with circulars which keep you up to date on the significant milestones of this inquiry and when our final report is lodged with government.

You've asked a further question, "Will it be acted upon?" That one is out of my hands. That one is very much up to the government, but our process is such that it is a very transparent and open process. It involves extensive consultation with stakeholders, and government is required to respond to all of our recommendations and they are required to table our report within 25 sitting days of parliament and to give a response on each of our recommendations as to whether they accept them or reject them. So it's a very transparent process. You do get to see what we say in our draft report, you get to see what our final report to government is, and you get to see the government's response to all of our recommendations.

Whether they are acted on is in large part up to the participants of this inquiry as to what they do by way of responding to government when we lodge our final report and encourage, or otherwise, government to act according to our

recommendations. But we don't have the power to implement, and it would be inappropriate for us to have both the power to recommend and the power to implement.

MR FOX: I realise that, and one of the points that I made in my submission was that the federal government should bite the bullet and be responsible for all health matters. I see an impediment in the process as relying on two forms of government: the federal government and the state government. As you know, we have elections from time to time and budgets from time to time and - yes, say no more.

MR WOODS: But in that respect, in terms of aged care it is predominantly a federal government matter, although state governments, to varying extents, deliver some services and have responsibility still at the moment for - I'm thinking in the case of Victoria and Western Australia; they have retained policy as well as operational responsibility for the Home and Community Care Program. But, as a broad rule, the Commonwealth government has primary responsibility in aged care. It then has to interface with primary health care, which again is predominantly a federal government issue, but also with acute care, and the running of that is predominantly a state government matter but there are various programs and negotiations to try and consolidate responsibility there. The ground rules are changing and there is a very deep understanding, if not a resolution, by governments of the inefficiencies that come from cost-shifting and lack of clarity of responsibility across health and aged care.

On aged care, given your experience in this area - and, as I say, you have helped us by providing several written submissions which will be available on our web site for all to see and read - what would you describe as the key issues where you think reform is most important? What are the two or three that stand out? You've raised a number of issues, but which ones stand out to you as where we should really direct our attention?

MR FOX: The one that really stands out for me is bowel cancer screening - - -

MR WOODS: Thank you. That's the latest one.

MR FOX: - - - which is the subject of my supplementary; additional to my supplementary. It's really important. People are suffering and they're dying. My best friend died of bowel cancer. I've visited people in palliative care, and currently the Oxley Hospital at Seventeen Mile Rocks have a palliative care ward and the state government are trying to close it down. The local people, about 4000-odd people, signed a petition to keep that palliative care section of their hospital open.

MR WOODS: Because it serves the local community, and people didn't want to have to leave the local community for palliative care?

MR FOX: They want to centralise the palliative care in another place.

MR WOODS: The reason for the petitions though was that the local people wanted - - -

MR FOX: Wanted to retain that, yes.

MR WOODS: If they needed palliative care, they wanted to stay in their local community?

MR FOX: Yes. They want it to stay there. The decision by the state government to close it down has been temporarily rescinded, but it's going to be reviewed. As I've pointed out in my supplementary submission, I have bowel screening once a year at a cost of $30, and the federal government have decided that they've got limited bowel screening. But what's the cost of keeping people in hospitals, and doctors, and human suffering and death? It can be prevented.

Put simply, if you have bowel cancer and if you have an early diagnosis, what they do is just cut out a piece of the bowel and connect you back up again and bob's your uncle, and you don't die.

MR WOODS: Yes. An important outcome.

MR FOX: You know?

MS MACRI: Yes.

MR FOX: It saves a lot of money for the government and for the people concerned. It helps prolong life. That's what we're all about.

MR WOODS: Sue, did you have a question?

MS MACRI: Yes. Just on another tack, John, you read your history out and you've got a very significant background in volunteering.

MR FOX: Yes.

MS MACRI: I'd be really interested to hear about any of the problems or concerns in relation to being a volunteer. We have got a chapter on workforce and volunteering and encouraging people to volunteer more. I'd like to hear your experiences around that.

MR FOX: Well, I did have a problem with volunteering for a particular group of

people, when I was the bus driver. The regular person who was, shall we say, the director of that particular service, went on long service leave and she appointed a young lady, probably 23, 24, in her place, and she had no experience in that position. She accompanied me on the bus and she was trying to direct me as I was driving the bus - and other problems - and we had a heated exchange of ideas, which is not my bag. I like to be known as Happy John.

But anyway, I subsequently wrote a letter and complained to that other manager, who came back, and we had a three-way meeting and it was resolved in favour of the employee. What I should have done was make a complaint or ask for adjudication by Volunteering Queensland Ltd. But as a result of that, I ceased working for them as a volunteer, and I was sometimes driving two days a week for them. But apart from that I've had no problems.

MS MACRI: How do we get more people to volunteer?

MR FOX: That's a difficult question. With being a volunteer bus driver, one must have a current driver's licence of course, and also have a driving authority issued by Queensland Transport. The people who are interested in doing volunteer bus driving have got to go through the process of getting that authorisation from Queensland Transport.

MS MACRI: Is there a cost to that?

MR FOX: The Sherwood Neighbourhood Centre have said that they will assist people to get that authority, but sometimes the volunteers put it in the too-hard basket. Sometimes when you're a volunteer bus driver - it's a minibus of course. What they do, they get experience and then they move on to paid employment. I'm really not interested in paid employment. I'm living the carefree life.

MR WOODS: Very good. Is there anything else that you want to draw to our attention today?

MR FOX: No. Only that I think that my submission should be condensed into book form.

MR WOODS: Okay. Thank you very much for coming and also for providing these submissions.

MR WOODS: If I could ask UnitingCare and Blue Care to come forward. Thank you very much for coming. Could you please, each of you separately, identify your name, the organisation you represent and the position you hold.

MS BATTEN (BC): Robyn Batten, the executive director of Blue Care, and I'm also speaking today as the chair of the UnitingCare Australia Aged Care Network.

MR OLLEY (BC): Richard Olley. I'm the director of residential care for Blue Care in Queensland.

ASSOCIATE PROF PARKER (UQ): Deborah Parker. I'm an associate professor of the University of Queensland and I'm the director of the UQ/Blue Care Research and Practice Development Centre.

MR WOODS: Thank you very much, and thank you for contributions already to this inquiry. I found particularly memorable, when it came in, the submission from Blue Care; the extensive detail. Somebody had put a lot of work into this, so whoever they were - and I suspect probably a number of people - we were very grateful. It was excellent. I should also put on record that we have been badgering you for more information since and you've been very helpful and willing all the way through, so again to put on record thank you very much for your contributions and we will continue to press you for detailed information. It's very, very helpful. Please. No doubt you have a submission to make.

MS BATTEN (BC): Thank you, commissioner, and thank you for the consultative process. As you've pointed out, we've had many opportunities, both in writing and in person, to meet with commissioners over recent months and I feel that we've been well heard, so thank you for that. It's been a very good process from our point of view. I can speak for UnitingCare Australia in relation to that also. We've had many meetings with you, which has been great. But today, particularly in the public hearings, I just wanted to highlight perhaps some higher-level priorities rather than present any of the detail which you've already received.

For the public record we'd like to say that Blue Care started as a bush nursing service in 1953 and has grown into one of Australia's leading providers of community health and residential aged care. It's a not-for-profit organisation. Blue Care supports the elderly, people with a disability and others in need in the community to remain independent for as long as possible.

Blue Care staff and volunteers provide care for more than 12,500 people every day through the nursing, allied health, personal care, domestic assistance, respite, social support, pastoral and volunteer services. This support is offered to people in the community and in Blue Care's residential aged care homes and retirement living units across Queensland and northern New South Wales, and nationally UnitingCare

is the largest provider of aged care in Australia, with over 12 per cent of all residential beds, spread from Darwin to Hobart.

As service providers, we clearly have a significant vested interest in the recommendations, but we also work closely with communities across Australia, and we believe, as part of the Uniting Church in Australia, that we have a responsibility to advocate on behalf of disadvantaged communities and, as I said, while I don't intend to address many of the recommendations, we'll focus on areas for major reform, areas we'd like to see strengthened, Indigenous services, and a bit about some of the financial arrangements.

We really want to emphasise in these hearings that, like many stakeholders, we strongly support the need for major restructuring of the industry. We also strongly support the principles articulated in the Productivity Commission's draft report and we believe that if these principles underpin an industry restructure, we will see a transition to services which offer greater choice to clients, support maintenance of independence, are more flexible in their response to community needs, and are financially sustainable and can therefore respond to the increased demand that's before us.

In relation to support for independence, in the final report we'd like to see some more specific recommendations in relation to the development of evidence based services which will result in people avoiding residential care; services which facilitate community connections, such as virtual communities; more day centres, with intensive short-term rehabilitation and longer-term maintenance services, such as those in On-Lok in the USA; a greater role for aged care services in chronic disease management, such as implementation of the Stanford model; and further telemonitoring and telehealth. While many of the above are certainly discussed in the draft report, we'd like to see support for independence have equal prominence in the recommendations to, say, the financial restructuring of the industry.

To move then to the financial arrangements, we certainly support those who can afford to contribute to the cost of their housing and living expenses doing so. We also support the recommendations in relation to the release of people's equity in their greatest asset, their home. But if these recommendations are adopted, the differences between concessional residents and non-concessional clients who can contribute will probably increase. This is not a bad thing per se. However, under this system the level of government funding for concessional clients must be adequate to ensure that providers continue to provide care for concessional residents and that that care is at the same standard as those who are paying fee-for-service.

MR WOODS: We will pursue that, because I don't understand the concern. So put an asterisk there.

MS BATTEN (BC): Sure. We recognise that, through life, people have different standards of housing, depending on their financial means. However, we do not accept that concessional residents should be required to share bedrooms with strangers as in the original recommendations of the Productivity Commission, suggesting that the government only funds two bedrooms in residential care for concessional residents, but we were very pleased to note your - Commissioner Woods - later advice that the final recommendations - well publicised in the sector - may see a ratio of 1.1 to 1.5, and we do believe that ratios closer to one to one would afford concessional residents sufficient choice.

In the commission's implementation plan requiring residential aged care providers to set accommodation charges consistent with cost of supply, we would like to further understand how the cost of supply is determined and we do believe that the disclosure of charges and equivalent bonds is a desirable thing. But over many years residential aged care providers have sourced a proportion of capital through accommodation bonds and, typically, these are used to retire debt and are critical for a sustainable sector, and the draft recommendation 6.4's requirement for equally attractive accommodation charges and bonds runs the risk that more people will prefer the charges and that bonds will dry up.

While we support consumers having the greater choice, we submit that the commission should amend 6.4 to enable providers to set bond and accommodation payments not only related to the cost of supply. But they should be published and clearly transparent. Publishing of the accommodation charges and the implicit interest rates on the charge and bond amounts, as well as the Australian Pensioners Bond Scheme, we think will have an effect on the bonds and we have concerns about our sustainability and ability to rebuild residential care without the same level of bonds.

Just to move to competitive tendering of concessional places, the provision of aged care we believe is an essential service and by no means a free market. The government controls market entry, the price of service and regulates the services. In this context, competitive tendering we don't believe is an appropriate mechanism to determine who provides services to concessional residents.

In some rural areas UnitingCare is the only service provider and we are in these areas as our mission includes a commitment to equity for all. Other providers do not find these geographical areas attractive. For us to sustain our critical services in remote Australia, we must be paid the real costs of care, which are significantly higher than in cities. A competitive tendering process is no guarantee of sustainable services being provided to the largely concessional clients, and independent determinations of costs of care is of course strongly supported, with those costs of care reflecting the geographical variations.

To speak briefly about services for Indigenous clients, Blue Care and UnitingCare, Frontier Services are major service providers to Indigenous communities. The current service models, funding arrangements and regulatory framework mitigate against the provision of culturally appropriate services for Indigenous people. We support block funding for Indigenous services to enable maximum service flexibility and to ensure sustainable supply of services and regulatory framework. For example, many of our services in remote areas, particularly within Indigenous communities, don't support employment of Indigenous people. Criminal record checks, for example, frighten people and they may not even apply knowing that, whereas it would be entirely appropriate for them to be employed in their communities - those sorts of regulations.

MS MACRI: Yes. That has come up quite frequently through Frontier Services, and I think was highlighted also in their submission.

MS BATTEN (BC): It is a big issue for us. Just to move to transition arrangements now, to what we hope will be a new era in aged care, we are very keen to work of course with the Productivity Commission through this stage and then with the government to ensure an appropriate transition to radically restructure the aged care industry. We believe the first steps in the transition should result in longer periods of independent living in the community and less admissions to residential aged care. Therefore, some of our priorities for reform are increased capacity in and simplification of and less fragmentation of community care; the independent cost of care study to determine and have government paying the real costs of care, both capital and operating and appropriately indexed; and this will assist the ongoing sustainability of the industry during a period of major restructuring and change.

We would also like to see early increases in the support services, as I've emphasised, for independence and chronic disease management; then with the restructuring of residential care, where we believe there are higher risks to come at the next stage. Thank you for the opportunity to make those opening remarks.

MS MACRI: Thank you.

MR WOODS: Thank you. You've raised a number of issues. Why don't we take a little time to go through each of those. I take it from your presentation that the broad architecture is one that you're comfortable to work within and then it's a matter of exploring these issues.

MS BATTEN (BC): Yes, that's correct.

MR WOODS: The first one, if we take them in the order that you raised them, you did put forward various models of care that could be offered by providers and we fully support having greater independence by those needing care, and in fact we want

to see a greater emphasis on rehabilitation and restorative care. We see that people's needs should be assessed from time to time and not assume some sort of linear progression of greater frailty but, if there is intensive service delivery that can restore somebody to a greater level of independence, that investment should be made.

People at the moment hang onto having a HACC program, even if they don't need it for a while, because they fear that they may not get back in. Well, we want to remove all of those issues so that you receive the services you require at the time but, if you then at a later stage re-require some services, you get your entitlement, you take it to a provider; you have your services delivered. So I think we're fully in support. What I wouldn't want us to do in this report, though, is to start prescribing specific models of care; we would want to see innovation, we would want to see providers competing on quality and delivery, while at the same time all of them getting the agreed standard price for the service. But how it's delivered and the manner in which it's delivered would be negotiable with the clients. I think it would be unfortunate if we started to prescribe today's crop of innovations and therefore cut out the opportunities for tomorrow's burgeoning opportunities under the system. I don't know whether you were wanting us to elaborate and propose new and innovative models of care.

MS BATTEN (BC): I understand that it's not the commission's role to provide detail of models of care. I think it's more around the emphasis in the report on the current residential and community care restructure, which is I guess the predominant flavour.

MR WOODS: Is the heart of it.

MS BATTEN (BC): Yes, is the heart of it. So we would like to see some more prominence for a range of services that aren't within the current traditional aged care sector and we're concerned that if they're not prominent in the report - because we hope that the report will lead the restructure of the industry over the next perhaps 20 years and that if the more active models are more person not only centred but directed models and don't have the same prominence as, say, the financial arrangements for residential care and simplifying the current community care offerings, then they may not get a look-in in the government's implementation.

MS MACRI: You mentioned On-Lok, which I'm a huge proponent of, too, and had the opportunity to visit. That model is very much in our mind and probably one of the things we've talked about. We certainly see, when we talk about that restorative rehab model as residential aged care in the future, having a different and a far greater role in terms of that restorative transitional care, subacute care, where in fact people that have their entitlements, besides being in the community and receiving community care, in actual fact from time to time might require some respite care in that type of model. It may be some palliative care in terms of some pain

management, medication management, back out into the community.

So certainly our intent in terms of what that care model is going to look like, a more integrated service is certainly in our thinking. You're not the first to raise it and I'd suggest that it's one of the things that we've said that we need to probably articulate a little bit better in the report. But I think you can be reassured that our intent, when we looked at those sorts of things, was exactly what you're talking about. If you've got some other thoughts around that, we'd really welcome that, but we do have a vision of going forward and this is when Mike talks about not wanting to stifle innovation, because we'd see residential aged care providers in the future perhaps having models where they're looking after some mental health problems; it could be some palliative care; dementia-specific - those sorts of issues.

MR OLLEY (BC): I think one of the things that the industry and those who look at the industry sometimes mix up is the difference between what is a model of care and what is a service model.

MS MACRI: Yes.

MR OLLEY (BC): Because a service model could be not necessarily prescriptive, but would align with consumer choice and all those principles that go with consumer-directed care. The model of care will be different in the palliative care area to the - be it fast or slow-stream rehabilitation.

MS MACRI: Absolutely, yes.

MR OLLEY (BC): So I think we need to get some kind of common language that says, "Well, we're talking about what the service model is," which is about consumer choice, which is about the ability to deliver the very person-centred care, but the delivery of person-centred care comes through a care model that matches the care situation.

MS MACRI: Yes.

MR OLLEY (BC): And I think when people read "models of care" they think "service model", or when they read "service model" they think "model of care", and they're actually two different things.

MS MACRI: Yes.

MS BATTEN (BC): Yes, that's right. I think that also we would like to focus more on the very front end, on community connectedness.

MR OLLEY (BC): Yes, absolutely.

MS BATTEN (BC): And some of us in our network are going to see things like virtual communities, which are very resource-lean. With two EFT you can support a couple of thousand people in a community and make a difference to people being able to remain in that community - so that really front end. In Australia across our health sector we have so much trouble moving any resource to a more preventative end. But we have done a bit of work on an overall service model in the terms that Richard asked about, particularly with our Victorian colleagues, and we certainly now have worked it up to a point where we would be very happy to come and meet with the commissioners and lay out that model.

MR WOODS: That would be good and, again, by removing limits on community packages and the rest of it. But our whole emphasis is to try and assist people who wish to and are able to to remain in their homes, but also to adjust their accommodation to better suit their circumstances, so both parts of that process, so that the residential care offering is for those who specifically need it, not because it's a default because there's nothing else to support them.

MS BATTEN (BC): That they haven't got housing, for example.

MS MACRI: Yes.

MR WOODS: Yes. So hopefully these reforms will reinforce a lot of that. We are conscious of the importance of very low-level but strategic interventions, or assistance more particularly, for people living in the community and the savings that that can offer for them as well as for the broader taxpayer if that's properly done. So if you're finding our draft report could be extended in some way on that, draw that to our attention in addition to these hearings. That would be very useful. But it's certainly our intention.

A comment you made about concessional versus non-concessional: you made the point about different standards of care. We don't propose different standards of care. The care component: people have an assessment for the need for care and that is delivered to them, whoever, wherever they are in the financial or wealth spectrum, but also in terms of where they live, and so that care delivery occurs either in their home or in a residential care facility or in a changed accommodation environment if they so wish, and it is the one standard of care and the one price for that care that is offered to all providers. There's no differentiation.

The only thing that differs is the amount of that cost that is provided by the individual according to their wealth and income. So if we can just keep the care bit, because that is a separate and standard issue for all care recipients, versus the accommodation. People who live in the community choose all sorts of different accommodation options. Those who don't have the means get support from the

taxpayer through a whole range of things - supported accommodation assistance programs, public housing, assistance with private rental, et cetera. People in that situation would continue to get support through this supported resident proposal.

Your views on our proposition of a two-bed standard are clear and we are reviewing that actively, and I've gone on record with my particular view on that, so I don't think we need to debate that bit any further unless you want to.

MS BATTEN (BC): No.

MR WOODS: Yes, so if we can keep the accommodation and the care - - -

MS BATTEN (BC): Separate, yes.

MR WOODS: Yes. On the cost of supply and periodic charges, for the non-concessional people what we're proposing - and, again, maybe it was the language we used in the draft report that may cause us to clarify and refine it, but it is up to the provider to determine what standard of accommodation they wish to offer for non-supported residents. You make the decision. Looking at the demographics of a particular region, do you want to focus on a particular part of those demographics and provide accommodation options for part of that market segment? The reality is Blue Care and UnitingCare do.

MS BATTEN (BC): Yes, absolutely, we do.

MR WOODS: In fact, your proportion of supported residents would be higher than the 40 per cent in a lot of your facilities and clearly in rural and remote it's way above. We understand all of that.

MS BATTEN (BC): Yes.

MR WOODS: It's up to the providers to choose what market segment they want to address, but we are requiring that they all have to either meet the quota for supported residents or choose to trade that quota to another provider, and only if there is a willing provider would that trade occur. There's a separate question, which we'll come back to in a minute, of whether all of that quota or only part of that quota should be tradeable, or none of that quota; we'll get your comment on that in a minute.

When we refer to the cost of supply, that was a comment intended to say that to the extent that you set charges, which are entirely up to you, that are significantly different from the cost of supply, don't expect the market to follow. People will not want to be purchasing or renting your accommodation if it's significantly different from the standard that you are offering, but you're not prescribed to be tied to the cost

of supply. You set the charge, and you set the periodic charge and that has to be published, and you set a bond and that has to be published.

The question of sustainability is the issue of, in part, having to do what most of the economy does and that is, you have a bankable proposition that you can go to a bank with and say, "We think our income stream will be this. Some of it will be bonds, some of it will be daily or weekly charges, and we need so much debt and we need so much debt offset through bonds." The rest of the economy seems to work that way quite satisfactorily. There is a transitional issue about the wind-down of bonds, but I think that's a transitional issue, not a long-term structural issue. But talk to us further about your concerns.

MS BATTEN (BC): There are a few things. If you're talking then about people who are contributing, you are I think largely, commissioner, talking about people who are making their own contributions.

MR WOODS: Yes. Let's put aside the concessional.

MS BATTEN (BC): Yes - and how that's set by the government. Just go there for one second, though.

MR WOODS: Okay.

MS BATTEN (BC): If the cost of supply becomes the benchmark and if we were paid the cost of supply of some of our old facilities by government for concessional residents, they're not worth anything today; they're fully depreciated, for example. So what that means - - -

MR WOODS: What's suggested is that older facilities that don't meet the standards would continue to get the 28.72 type figure.

MS BATTEN (BC): Yes.

MR WOODS: Some providers have come to us and said, "We've got very old facilities and they're cash cows, but we'd really like the new $40 or $50 rate," and we've said, "That's interesting, but no, thank you."

MS BATTEN (BC): That's right.

MR OLLEY (BC): One of the things that I guess concerns me with some of the discussion is the economic basis behind the discussion. A simple economic analysis knows that the more that you regulate the industry, you fail the market. A lot of the language and ideas that have come through the report seem to give an impression that we sit in a free market, and we certainly don't sit in a free market. Our market

has absolutely failed because of the degree of regulation. I'm not arguing against regulation. That's another argument.

MR WOODS: No, but let's again differentiate between regulation of care and regulation of accommodation. They're two separate things.

MR OLLEY (BC): Whether it's accommodation and care charges or accommodation charge alone, we still don't sit in a free market. The assumption that you can have supply and demand principles applying in this situation I think is very difficult, even at a basic economic level. So when you talk about "if an organisation chooses to do this", there are many cases where there is no choice because there is a high degree of concessional residents because people simply don't have those bonds. Those providers that are in that space - and we're in the space and proudly in that space - will never really be able to compete in what is not even a perfectly competitive market but a competitive market, because it simply doesn't exist.

MR WOODS: Far be it for me to suggest how you run your business - you know that much better than I do - but given the space that you are in, and we do understand it very well, I would have assumed that you would provide a modest but good-quality accommodation option for a lot of your potential client base who are non-supported. You'd look at the demographics and what are the house prices in the area.

MS MACRI: Like we do with our retirement villages.

MS BATTEN (BC): Yes, of course we do.

MR WOODS: Yes, and that's your business.

MS BATTEN (BC): It is.

MR WOODS: Well, we don't see why, in setting your accommodation charges for your residential care facilities, it would be any different from the approach you take to your retirement villages, your independent living units, your supported accommodation apartments.

MS BATTEN (BC): I understand that. To go back to the charge versus the bond for people who are - - -

MR WOODS: Yes, so people have a daily or weekly rental option.

MS BATTEN (BC): Yes. I think it's what's included in the charge to compensate for the bond, so the interest rates that are applied, for example, to the borrowings that we'll now have to make because we don't have the bonds to fund ongoing capital development.

MR WOODS: Exactly.

MS BATTEN (BC): Also the loss of interest on the investment of bonds - those sorts of things.

MR WOODS: We won't be recommending to government how to prescribe the daily charge. That's a market decision that you make, just like you make with all your other accommodation options, and you're very good at having a range of accommodation options and we would encourage you to grow and flourish in that respect. But you set that charge.

MS BATTEN (BC): Yes.

MR WOODS: There is no requirement upon you from government to demonstrate how it ties back to interest rates or anything. You put yourself in the marketplace, you offer a periodic charge, you publish that charge and, if you wish, you also offer a bond option.

MS BATTEN (BC): Yes.

MR WOODS: And that's up to you.

MS BATTEN (BC): As long as it pans out that way.

MR WOODS: Well, that's certainly our intention.

MS BATTEN (BC): When we read an equivalent accommodation charge - I think people who have read it - and your explanation is helpful. An equivalent accommodation charge to a bond: I think there is a bit of concern, not just with us but in the industry. If that's a required equivalent, then what will be included in the accommodation charge to bring it up to the equivalent? There are a lot of factors that would need to be included to make it equivalent to a bond to sustain the industry. I think it's that issue.

MR WOODS: Okay. Well, you set the periodic charge and you set your bond and you publish them.

MS BATTEN (BC): Right. Well, there's no government control or intervention in that?

MS MACRI: No.

MS BATTEN (BC): Then that's another thing and that can happen.

MR WOODS: Right. This feedback and interaction is helpful in that respect.

MS BATTEN (BC): Sure.

MR WOODS: Anything else on that one before we move down the list?

MS MACRI: No.

MR WOODS: The next one I was thinking of discussing was rural and remote. Is there anything before then, Sue?

MS MACRI: No. Just in your rural and remote, there are the issues around staffing, cost of staff, replacement of staff, all of those sorts of issues, and then exacerbated in terms of your Indigenous services and the police checks. We've had it fairly well put to us through submissions, and I was lucky enough to spend time with Frontier Services up in the Northern Territory. We've been pretty well exposed to those sorts of issues. Just how to get around some of those is the other question, especially around the police check and those sorts of issues. We're back sort of talking and looking at it, but I just want you to be aware that we are aware of certainly those difficulties.

MR WOODS: Is there anything in elaboration that you'd like to give today on either the rural and remote or Indigenous beyond your - - -

MR OLLEY (BC): We've had some experience in the last couple of years of supporting an Indigenous-owned facility within the state - well, two actually. One of the things that I think absolutely confronts them is the ability not to have people come in and do the stuff and leave it but to build the capacity behind. What needs to be I think factored into the funding for not just Indigenous but particularly Indigenous services, but also some of the more remote services - like, we have a facility at Emerald. There needs to be some consideration in the funding of what it means to leave capacity in the local area, rather than just buy the expertise, let those processes rip and then go.

Our experience has been that unless you can build that capacity, have time to build that capacity, which means funding to do it, then we're just going to keep topping it up, rather than having these facilities owned by the Indigenous community, managed by the Indigenous community, supported by those who have the skills, knowledge and abilities to do that support, but grow that locally so we don't have to go and do it again.

MR WOODS: Including governance?

MS BATTEN (BC): Yes.

MR OLLEY (BC): All of the above. Yes, absolutely.

MS BATTEN (BC): All levels.

MS MACRI: How do you feel that accreditation fits into - we're getting varying sort of - - -

MS BATTEN (BC): I know Sharon would have given you some strong words about that.

MR OLLEY (BC): Yes, and we've had a similar experience where an Indigenous facility was found to be noncompliant in so many of the standards. But to give you an example of how those standards are not culturally appropriate and therefore will never really be met: in one of the facilities that we assisted they were found to be noncompliant because part of their activities program - poorly called "diversional activity" - was that some of the residents sat looking out to the sea and they were very much engaged in their activity, their Dreaming, and yet that was considered by the assessors as them having nothing to do.

MS MACRI: Or being bored.

MR OLLEY (BC): And the facility was found noncompliant in that particular outcome. That's just crazy, because if you don't put that into the program, the program is completely irrelevant to those people who will partake of it.

MS MACRI: We're getting a little bit of that message around the CALD community too.

MR OLLEY (BC): Absolutely. Same deal.

MS MACRI: It's the same thing.

MR OLLEY (BC): It may be a little off topic, but part of that comes to the fact that there is a monopoly over accreditation processes and therefore, without competition, it becomes absolutely prescriptive. So if we are to make that journey, whether it's CALD clients or whether it's Indigenous clients or whether it's the difference between what people do in North Queensland to what people do in the south-east corner - and we see differences there as well - there needs to be some degree of being able to fit the accreditation process and program. You're still going to achieve that same outcome of striving for continuous improvement, quality, care governance and overall governance of the facility, but it just doesn't have to be through one way of doing business.

MR WOODS: Is that an issue of ensuring that the accreditation process is sensitive to the circumstance or is there a fundamental necessity to have a competitive accreditation process? I think the second step is a very big step and I'd rather not take it unless needed.

MS BATTEN (BC): It would be a good start to move to more outcome based accreditation and risk based accreditation. There are different risks with different areas of service delivery and across different providers. In our network we'd support a more risk based approach to accreditation but also a more outcome based accreditation because so much of its inputs and processes is not related to quality of life and outcomes for residents. Richard's example was a great one and the outcome for those residents would be a good outcome which could be demonstrated actually, so it is a good example in that sense.

MR WOODS: What's your experience in delivering community based, home based services to Indigenous communities, and any lessons from that?

MR OLLEY (BC): I think a very similar experience to that in residential aged care. You'd be aware of the number of standards that are sitting there that must be complied with that are duplicates. There's an attempt to have an overarching set but that hasn't really worked terribly well. Again, the standards are about outputs, they're not about outcomes. So, for instance - and I guess I could even use a personal experience - my mother gets some HACC services. When the provider fails to have the staff to be able to supply the amount of contact hours that have been allocated - and I'm sure you've heard this before - they simply say, "Sorry, we can't do it this week."

So they count the outputs of how many hours are done but there's nothing about what difference that's made to the independence of the individual, their ability to connect with their community and socialise and have those higher-order things that people have been used to before they got old. Why should that not be the case? As soon as there's insufficient staffing, as there are chronic difficulties in recruiting staff - and I know you've heard that before because it's in your report, but the reality is it isn't the organisation that doesn't recruit that really suffers. The people that suffer are the consumers of that service, as their service shrinks. Yet they're still ticked off as meeting the outputs.

So if we really are about outcomes then those standards need to be expressed as outcomes, and maybe less outcomes and more focus on achieving them, because in residential aged care or any of the other community based standards for the various types of community services, it does just tick off how many times you do something, not how efficacious it is, not how appropriate it is, not how safe it is.

MS BATTEN (BC): And just in terms of the Indigenous communities, I think a couple of the areas are of course travel and the distances that need to be travelled, so that we can engage in their communities.

MR WOODS: The same with rural and remote, so talk to us about that.

MS BATTEN (BC): The travel is just horrendous. It might take a day to see one client because of the travel involved and that needs to be paid for, really, in both time and the actual travel expense. I think one of the big areas where we're making some progress and that does need ongoing support is the employment of Indigenous people. We have just again, through DEEWR, signed up last week for $750,000 over two years for trainees - for 125 Indigenous trainees.

MR WOODS: That's personal care workers?

MS BATTEN (BC): Yes, and they often progress.

MR OLLEY (BC): Hotel services, all sorts of things.

MS BATTEN (BC): Yes, hotel - across the range.

MR WOODS: Support services.

MS BATTEN (BC): Yes, but certainly carers as well, and they receive training and they're guaranteed a job, and I think that they're guaranteed the job is a very important part of the program because this is the second time we've been through this and people have stayed with us, so both creating the employment and the benefits to the communities, of course, is one side of it. But us having and developing over time a workforce across a range of roles and across the structure, having career advancement, will help us provide culturally appropriate services to Indigenous communities through Indigenous workers.

MR WOODS: Are there any particular lessons that we should reflect in terms of our recommendations in that respect? I'm conscious that our recommendations are well intentioned and sort of at a high level, but if they could have more specifics that would be useful? Even simple issues like the success rate when you can get a small cohort so that they're reinforcing each other and that they're supported by an elder adds value.

MS BATTEN (BC): We have Indigenous coordinators, which is hugely important because they reach out into the community and recruit for the programs, for example, which Richard or I couldn't do. It's some of that detailed mentoring that has to go on. And I think they have to be ongoing, not episodic as well, because these programs come and go.

MR WOODS: Quite true. Nothing worse than a two-year program and then the uncertainty.

MS BATTEN (BC): So a good part of this program is that we have to guarantee employment and we're very pleased to do that, so I think that's an important component of it. But the funding of mentoring and community outreach is very important too, so that people can remain in - it's life skills support and it's preparation for employment and it's not just coming into a cert III, it's literacy, so having a broad view about the range of supports and the type of training that can be included in those programs I think is very important.

MR WOODS: You mentioned the dreaded cert III. Two questions on that: what is your view on the quality of the content - the adequacy and scope of the content of it - and what is your view on the delivery of it by the variety of RTOs that exist?

MS BATTEN (BC): I think everyone would agree, to go to the second point first, that the delivery is variable - very variable.

MR WOODS: How do you then personally sort of work your way through that variability? Do you have preferred providers?

MS BATTEN (BC): Yes, creating partnerships with providers, with RTOs, and developing ourselves. Part of our organisation is - Lifeline Community Care is an RTO but we're also speaking - if, for example, talking about the Indigenous communities - with Indigenous RTO up north here and working in partnership with them for a cert III course, but Deborah might want to - - -

ASSOCIATE PROF PARKER (UQ): I guess the universities don't really dabble in cert III but I think one of the things that you need to always be aware of is to ensure that the competencies that are built into those certificates are keeping pace with the changes that are occurring within the sector. My particular area of expertise is palliative care and I know that there are some components in some of those cert III and cert IV areas, but they're fairly basic, but that's core business for residential care and so I think there is some scope to improve on really tailoring to make sure that people who are going to go through these systems are coming out with the skills that match the clients that they're seeing. If we're going to be moving into the more independent support or restorative care, as well as badging ourselves as palliative care, we need to ensure that those qualifications keep pace with that.

MR WOODS: So what's your ability to contribute to the content of the cert III as it goes through its permutations? Do you feel that you are adequately listened to and that therefore the cert III is an absolutely fantastic product?

MR OLLEY (BC): I would say no. I don't think we are adequately listened to. There are the national training standards and framework that go through that and there's opportunity I guess to have had some input when that happened. It really is high time to have a look at the curricula that are around the place, and I guess even look at not so much individual content - there's certainly some core content that's required but, again, you're going to need different content depending upon what part of the sector you - - -

MR WOODS: Yes, so you'd have core and then optional modules.

MR OLLEY (BC): Yes, and I think articulation through to undergraduate studies ought to be much clearer and partnerships developed. We've got a great partnership with UQ, in that there is a research and practice development centre that sits within our organisation and its physical offices are within our head office. So to be able to use some of the evidence based processes that we're more used to at other levels, we also need to tap into that even at the cert III and cert IV level, because when I look at the framework and some of the curricula that are developed I'm not seeing an evidence base to that, yet all other education is heading towards an evidence based framework that underpins what they do. So I think it needs to be enriched and valued. Of course, then with that comes that concept of does it need to be further regulated, and if you're starting to get down that track, that's a whole other problem.

MS MACRI: Yes.

MR WOODS: Do you have a view on whether the third layer should be a licensed or regulated entity, or should they just be appropriately skilled and competent?

MR OLLEY (BC): Personally I think there should be a degree of regulation - whether that's for licensure or not - but I think it has to be more than, "We're an accredited RTO, and if you've got a certificate that comes from this RTO then you're okay."

MS MACRI: Yes.

MR OLLEY (BC): So whether it's a full-blown registration as we see with other health professionals, or whether it's some entity that sits across and says, "We've checked this and, yes, it does meet all the requirements to work in that sector." Maybe that's the degree of regulation that you go with, where you're more than - - -

MS MACRI: So you're talking really a combined regulation or accreditation of the RTO and the end product coming out has the competencies and skills.

MR OLLEY (BC): That's been certified by a third party.

MS MACRI: That's been certified by a third party.

MR OLLEY (BC): Yes. That might be that first step. Whether you need full registration, however that's defined - I think we need to see the first bit first, but at the moment you could have somebody with a cert III and we could see enormous gaps in some products of those curricula, and then others come absolutely work-ready and hit the ground running. Some of that is the same between all educational institutions, but at least there is an accrediting body that looks at what the curricula is within our tertiary education systems.

MS MACRI: And a bit of consistency.

MR OLLEY (BC): Absolutely.

MS MACRI: It seems some RTOs are taking six months for cert IIIs and others are taking four weekends.

MS BATTEN (BC): That's right. Can't be the same outcome.

MS MACRI: Can't be the same outcome.

MR WOODS: So why does that happen and what do you try and do, as a user of the product, to try and ensure that what is being delivered is usable to you?

MS BATTEN (BC): Because we're large - and I was doing this in Victoria too - we formed partnerships with RTOs so we could both influence the content and people were actually trained to our policies and procedures as well. So it's a partnership at that level, where we're able to inform curriculum, and then people were much more work-ready because they already had a familiarity with the way that we went about our services, and that was, I think, very helpful.

MR OLLEY (BC): There has to be something more than, "We can demonstrate it meets the framework."

MS MACRI: Yes.

MR OLLEY (BC): There has to be a review of contents and competencies that come out of the delivery of the content.

MR WOODS: Very good. Sue?

MS MACRI: No, I think that's been extremely useful. Thank you.

MR WOODS: Are there other things that you want to address that we haven't pursued? The transition issues, I think we can just continue to sort of iterate through those, but - - -

ASSOCIATE PROF PARKER (BC): I'd like to just raise the issue of the workforce and how we're going to address the - we've got already issues with workforce, but how we're going to address the workforce planning requirements for aged care, and looking at new models and possibly even new roles in aged care, and how that might be supported as part of this role. Nurse practitioners is an obvious one.

MR WOODS: Yes, absolutely, and we're strong advocates of the merit of that.

ASSOCIATE PROF PARKER (BC): Yes, and people are strong advocates for it, but actually the rubber doesn't hit the road. So Australia is a strong advocate for it, but we need more money - - -

MS BATTEN (BC): There are two in Australia, I think.

MR WOODS: No, we have a number of nurse practitioners now.

ASSOCIATE PROF PARKER (BC): There are nurse practitioners in other areas.

MR WOODS: Yes.

MS MACRI: In aged care?

ASSOCIATE PROF PARKER (BC): But there are not many in aged care. So we need to certainly have some sort of incentive and scholarship program. We need - - -

MR OLLEY (BC): Funding.

ASSOCIATE PROF PARKER (BC): - - - services such as Blue Care to be able to offer positions. That comes at a cost to the service, particularly if you - the areas of greatest need, of course, are in the rural remote areas where you have difficulties getting access to general practitioners. So I think the workforce issue is a huge one, and I guess I'll just put in a plug - because I'm a university partner - for the evidence based practice to support this new move forward, and Blue Care is very generous, in that they partnership with the University of Queensland, but that comes out of Blue Care money.

MR WOODS: Yes.

ASSOCIATE PROF PARKER (BC): And there's not a lot of national money that goes into looking at researching evidence based practice in aged care in a coordinated manner, in terms of collaborative research centres and things like that. I think we can demonstrate over the last five years that we've valued added to Blue Care by having that close partnership, but it's come at a cost to both the university and Blue Care.

MR WOODS: But presumably Blue Care has also benefited - - -

MS BATTEN (BC): Yes.

MR OLLEY (BC): It enriches our services.

MR WOODS: - - - as have their procedures and services.

ASSOCIATE PROF PARKER (BC): Yes.

MR OLLEY (BC): There also needs to be some consideration given to how such services as nurse practitioners - or alternatives to the diminishing supply of medical practitioners, so it doesn't necessarily even have to be a nurse practitioner; it could be a range of health professionals.

MS MACRI: It could be a clinical nurse consultant and, yes, even at that level - - -

MR OLLEY (BC): But there's no opportunity in that funding to look at alternative models, where we have a diminishing supply of general practitioners, legislative requirements or statutory requirements that have to be met as a result of that, and you get between a rock and a hard place between what you have to do by regulation and what you can do according to supply.

ASSOCIATE PROF PARKER (BC): I think a good example of that is that, with the current recommendations' requirement in ACFI, to claim the palliative care component you must have a clinical nurse consultant with five years' experience in palliative care or pain management or a GP. There are not many of those around, in terms of the clinical nurse consultants. Palliative care is state-funded, it's not Commonwealth-funded, and you won't get specialist palliative care services expending their state dollars to come into a Commonwealth-funded facility. So that's a good example of where the legislation that's in there isn't matching the reality of the workforce.

MR OLLEY (BC): I guess that's exactly the example of a gentleman that spoke before, with a service that is there but we don't know for how long, because federally there's a push for the services to happen but they're controlled - they're another level of government.

MR WOODS: Clearly we could continue a lengthy discussion, but we do have other participants. Thank you for your input to date and, in anticipation, thank you for your ongoing contributions to this inquiry.

MS MACRI: Yes, thank you for that.

MS BATTEN (BC): Thank you for the opportunity.

MR WOODS: Could we ask Dr Wayne Herdy to come forward, please. Thank you for coming. I have my - - -

DR HERDY: Yes. Commissioner Woods remembers that last time we met, we were both wearing Aboriginal ties that we both bought at Yulara.

MR WOODS: Yes.

DR HERDY: So we were great mates from the word go, which is in contradiction to his usual position as being recognised as public enemy number 1 of the AMA.

MR WOODS: Indeed, but Mukesh and I are good friends now.

DR HERDY: Yes. A badge that you wear with some honour, I might say.

MR WOODS: Could you please for the record state your name and if you are representing any organisation.

DR HERDY: I'm Dr Wayne Herdy. I'm a general practitioner from the Sunshine Coast. I'm not representing any organisation. I do disclose that I am the chair of the AMA Committee for Healthy Ageing, but I specifically don't appear in that role because of two things. First of all, some of the opinions I'm going to state have not passed through our committee. Secondly, some of the opinions I'm going to put before the commission today would not be and could not be supported by a membership organisation.

MR WOODS: Very good. Well, we do like frank responses. Thank you for your - and it was very early - first submission. It was one of our very first contributions and that was quite helpful to us. Do you have a presentation you wish to make?

DR HERDY: Sure. First of all I'm going to reflect the AMA position - having said I'm not here for the AMA, but I'm going to reflect the AMA position that the medical profession as a whole is somewhat disappointed with the relative lack of stress on clinical services. I'm not going to reiterate the AMA position but I am going to point out two areas of particular concern to myself.

One is with regard to dental care, which is skimmed over very briefly in your report. We forget that lack of dental care is one of the most serious single sources of problems in residential aged care and, to a lesser extent, in community based aged care. The other profession that I note is not represented, and not even mentioned in your report - the terms "chemist" and "pharmacist" do not appear in your report, which is probably the fault of the pharmacists, who didn't represent their position adequately, but I do point out that the role of the pharmacist in residential aged care,

and particularly when a patient is transiting from one sector to the other, is crucial to safety.

MR WOODS: Yes.

DR HERDY: I wanted to talk a bit about home ageing. A strong theme throughout your report is ageing at home rather than ageing in residential aged care, and I recognise the reasons for that. First of all, patients would want to be there, and secondly, the public purse doesn't have to pay for the bricks and mortar that's going to house them. However, I have a real problem in how we're going to deliver clinical services if people are staying at home.

There are really only two options. One is that the clinicians - now, this is not just doctors but clinicians - are going to go out and do home visits to the patient. If we're going to be relying on doctors doing home visits, then we've turned a 10 or 15-minute consultation into a 50 or 60-minute impost on the doctor's time, and it's not only doctors but nurses and allied health and anybody else who's going to go to the patient's home. They're going to be faced with the same difficulties of leaving wherever they were, transport, parking, access through the front door, getting into the patient's location in the bedroom or wherever they are, and all this takes a considerable amount of time.

Not only are there poor remunerations for this time, but this would be a huge impost on a workforce, and I think we do not have the workforce to make a radical change in at least getting doctors - and probably not also nurses, and certainly not physiotherapists, occupational therapists, dental hygienists, whatever else you want to mention - we do not have the workforce to supply, in the home sector, what we can supply in the residential aged care sector.

The second alternative is to have the patients come to the place where the service is being delivered, and that requires two things. First of all it requires transport, and your report does refer to transport. You don't dwell on it very much, but you do recognise that transport from a patient's home to the place of consultation would be necessary. This needs to be safe; it needs to be reliable; it needs to be economical, and a lot of patients will require an escort. This is not going to come cheaply.

The second thing it requires is that the patient can get into where the service is being delivered. Most GP services are wheelchair-friendly. Surprisingly, not a lot of x-ray clinics are wheelchair-friendly; not a lot of pathology services are wheelchair-friendly. Surprisingly, not a lot of physiotherapy services are wheelchair-friendly. So we will have difficulties getting the patient in and out of wherever they're going to be getting the service.

One of the partial answers to this is the GP super clinic model. I do not support GP super clinics but I recognise that a lot of GPs are already doing what the GP super clinic model purports to provide, and that is having not only the GP but other health professionals within the same rooms, and I think building on that model is probably a way that we're going to have to look at going forward.

Just getting away from my problems about home ageing, my next problem was with nurse practitioners, particularly in the residential aged care sector. They are still experimental. At present the evidence from overseas is that they are not cost-effective and I'm a little disappointed to see that you are so keen on nurse practitioners in your report. We do not have the critical mass necessary to sustain the industry and we haven't sorted out precisely what role these people are going to have in the aged care sector. As I understand it, most nurse practitioners in the aged care sector are actually employed in emergency departments and that may well be a place for them, but as a GP who goes to nursing homes, I'm mulling over how on earth I can work hand in hand with a nurse practitioner.

There are two models that are possible. One is that they're going to be employed by somebody - usually the nursing home. If the nursing home is going to employ nurse practitioners and is going to have a reasonable spread of cover over 168 hours in a week, they're going to have to employ three or four of them, which is going to come to a cost of about half a million dollars, and I don't think the nursing homes have the budget to pay for that.

The second alternative is that, instead of being employed by the nursing home, they will be self-employed contractors, professionals, visiting the facility, the same as I am, in which case under the present legislation they would have to work in a collaborative agreement with another practitioner, usually a general practitioner, and I have difficulty seeing first of all how they can extend my service, how they can make me more efficient for the range of patients and the range of problems that I see on each of my nursing home visits. I also have difficulty seeing how it would be cost-effective and how it would be economically viable for them to try to run a business, running side by side with me in a collaborative agreement. It may well be that they will be able to do that, but at present I have difficulty seeing how they could do that. That's probably enough about nurse practitioners. I just see a lot of problems with them and I'm not sure how they could work with me. One of the things I'm leading to I'm going to address in my fourth area of discussion.

The third area that I want to talk about is teaching nursing homes. I'm strongly supportive of these. I see that they are mentioned in your report. How they're going to work is still speculative. My concern is, teaching nursing homes are going to teach not only doctors but the full range of health professionals, I presume, especially nurses and palliative care physicians. But, just concentrating on doctors, we're looking at undergraduates and postgraduates coming to nursing homes and maybe

going on a ward round or using the patients as teaching tools, talking points, which implies that we have to have the consent of the patient or their relative. We'll take that as a given for the time being. But who's going to do the teaching?

Are you going to have a full-time academic employed by a university, which is going to be the cheapest way for the university, but he won't know the patients and he will have to collaborate with the treating general practitioner to find out, "What patients have you got in here? What physical signs have they got? What are the teaching points here?" So the general practitioner is going to have to be fairly closely involved there.

The second obvious alternative is the general practitioner himself. Some GPs have a lot of patients in nursing homes; they have a lot of material to choose from; they can take an extended ward round. Who's going to pay them for that?

MR WOODS: We do have that issue for GP teaching and the divisions of GP at the moment.

DR HERDY: There is also the even greater problem that, with all due respect to my 38,000 colleagues out there, not every GP is interested in teaching and not all of them are good at teaching.

MR WOODS: Absolutely.

DR HERDY: So we will have to be fairly selective in how we apply the GP teaching model, but I regard that as being a focus that has a lot of prospect for the future.

MR WOODS: Good. So is that one out of three so far?

DR HERDY: No, no, we're onto three out of four. The other alternative about who could teach: the profession has been struggling with what we're going to do with retired doctors who want to still have part-time practice. With the new national registration, part-time practice or retired practice is no longer recognised. You have to be a full-time doctor or you're not a doctor at all, which means that they're stuck with problems of continuing medical education indemnity, the high costs of registration and so on, when they say they only want to have very limited prescribing and referral practices. We have discussed the possibility of a lot of retired doctors who have a lot of accumulated knowledge being used as teaching material - sorry - - -

MR WOODS: As the teachers.

DR HERDY: So retired doctors certainly offer a pool of experienced and skilled

practitioners of admittedly variable quality who might become teachers of the future.

MR WOODS: But again would need to work with the treating doctor in some form.

DR HERDY: Would need to work with the treating doctor and would need to work through a university facility.

MR WOODS: Some of them like being called adjunct professor or associate professor.

DR HERDY: One of the issues that I mentioned in my original submission is if you take the GPs who are out there in the community going to nursing homes, and they have a lot of nursing home patients, you could reward them by giving them honorific academic titles, which wouldn't cost anybody anything but would be a great incentive, particularly for younger GPs, and that is my ultimate thrust - getting younger GPs into nursing homes as doctors, not as patients.

My biggest problem, and the place where I would come into greatest conflict with my 38,000 GP colleagues and would come in conflict with the College of General Practitioners and with the AMA, is the question of GPs who have small numbers of patients in nursing homes. If you have a GP - you've got a nursing home with 100, 150 beds and you've got two patients in there, you are a nuisance. You're a nuisance to the patient, you're a nuisance to the nursing home, you're a nuisance to the pharmacist. You don't have good communication channels with the nursing home, you don't have good communication channels with the pharmacy or the allied health.

When you go in there you don't really know your way around the office, you don't know your way around the paperwork, you don't know where to find the patients, you don't who the nurses are, you don't know who's the chief nurse on the floor. You're unfamiliar with the environment and you don't work well in that environment. I personally think that GPs who have small numbers of nursing home patients in a particular nursing home really should not be there. I think that's a problem that this commission really needs to address.

On the other side of the coin, the solution to that is for each nursing home to have a relatively small number of GPs - and I think three is the optimal number because that way you can cover one another when you're absent - who share the burden of the total number of patients in that nursing home. If the average nursing home has 100, 150 patients, that means each doctor would have 30 to 50 patients, which is not an onerous load. You don't have to go there a lot. You're still going to get a lot of telephone calls. I get three to five telephone calls from nursing homes literally every day - I'm going to get more than that - but telephone calls I can handle.

The problem I can't handle is GPs who go in there, who make a mess of the patient's care because they don't know that particular environment.

Those nursing homes where there are only three or four GPs who go there, they get good arrangements. The know one another face-to-face and when there is a need to cover a doctor who's absent - or, as frequently occurs, I will go along to a nursing home and they'll say, "While you're here could you see Dr X's patient?" and I know Dr X, I've worked with him before, and I know he won't be offended if I do something to give some interim care to this patient and send a note back to him. That arrangement works very well. How you can do that ethically I do not know because the ethics of the situation require that every patient or their carers or family will have an absolute right to determine which doctor, which other carers care for their loved one, but it doesn't work very well in practice and the ethical issue is one that somehow we have to get over to solve this problem.

I come back to my main thrust and that is what we really need to do. I take exception, by the way, to one of the previous speakers who talked about a diminishing supply of general practitioners. There is an increasing supply of general practitioners. The number of graduates is doubling rapidly. The rapid increase in graduates started two years ago. They will appearing as fully-fledged GPs on the marketplace next year and exponentially over the coming decade we're going to see a rapid increase in the number of GPs. To offset that, these are gen X and gen Y graduates who are growing up with a 37 and a half hour flexi week, not the 90-hour week that I used to work with, so they won't be working quite as hard and, with all due respect to the gender balance in the room, 51 per cent of them are going to be females who will not be working the hours that a male practitioner does over their working lifetime - but the number of GPs is increasing, not decreasing.

MR WOODS: True, but those who are involved in aged care is probably the particular perspective that they were drawing.

DR HERDY: The continuous thrust of the committee of which I'm chair has been getting more GPs into the residential aged care sector, not so much into community aged care because I think that's fairly well accommodated with general practitioners - - -

MR WOODS: Through primary care.

DR HERDY: - - - but into residential aged care and that's a mix of two things. First of all, it's created some carrots that produce incentives, and inevitably there we're talking about money, and it's removing some of the barriers. We are in constant discussion with the providers of residential aged care services to help them remove the barriers or at least identify which barriers we want removed, most of which are no cost to the provider but they have been very reluctant to remove those

barriers.

MR WOODS: Including consulting rooms and good IT facilities.

DR HERDY: Consulting rooms, IT, making sure that the nurse is there, making sure the patient is there, making sure the nurse is somebody who actually knows when the patients bowels last moved, and so on and so on - being able to get in and out of the place, particularly after hours. In my car I have one of those remote locks that will open the security gate at one of the nursing homes I go to. I think I'm the only doctor who has one of those.

MR WOODS: You've raised some very relevant, pertinent issues, just a small one on the chemists/pharmacists and the importance of medication reviews and the interaction between the patient, the nursing staff, the treating GP and the pharmacist. These are very important things and their omission is not a recognition that we don't see those as fundamental. If that can be overcome by a small section that recognises the importance of that, we're entirely happy to deal with that. I'm not sure that it requires a recommendation to change that relationship, and that's something that you could give us advice on.

DR HERDY: I think this commission should be recognising the role of the pharmacist. There are two roles I'd like you to look at. One is the one you've already mentioned, and that is the residential medication reviews. Pharmacists are critical there and even with our fairly high-powered but as yet not totally sophisticated software on our computers - which, I add, are not available at nursing homes. They're only available in GP surgeries at present. With our software we do identify conflicts in medications, but the pharmacists are somewhat better than we are at identifying those conflicts.

MR WOODS: Absolutely.

DR HERDY: So I think that that is an essential part of the safety within the residential aged care sector. More importantly, the pharmacist has a fairly critical role, as I mentioned before, when a patient transits from one sector to another. When they come from particularly the acute hospital sector directly into the nursing home, there are significant medication issues that a pharmacist can identify more rapidly than a GP can.

When a patient is sent back from a hospital to a residential aged care facility from which they were referred, some 30 per cent of them are readmitted within two weeks and 80 per cent of those readmissions are due to medication errors. That could have been avoided - if not completely, certainly the majority of those errors could have been avoided, had a pharmacist - that is the community pharmacist, not the hospital pharmacist - been involved at the time of that transition.

MR WOODS: Yes, we fully understand.

MS MACRI: I just pick up on your comments around the number of doctors with small client loads, which I agree and we've heard is a problem, and you also alluded to really the user rights principles and the regulatory requirement that every resident has a right to choose their own doctor and this is what's caused - I mean, the nursing homes are telling us the same as you're saying, that doctors with small client loads and not a great interest in aged care possibly don't provide the best care. Nursing homes are also saying to us how difficult it is to have 15, 20, 30 different GPs in a metropolitan, particularly, region visiting and trying to look after the requirements of each of those different GPs.

I just wonder how we get around that. A lot of people have had such a long relationship with their general practitioner, and the general practitioner often feels, when they're going to a nursing home, I guess, an obligation and a want - because they've had this relationship - to continue caring, even though it may not be in the best interests of the person. What are your thoughts around that? Because you have very special relationships with people that come to your surgery, and then that flowthrough and people wanting to continue that relationship.

DR HERDY: The simple answer is I don't have an answer to your question without breaching the patient's ethical rights. There are a number of minor inducements that could shift the balance a little. Probably the simplest inducement again is money, which is probably best expressed in terms of allowing the nursing home to have a financial relationship with a limited number of doctors so that there are, say, three doctors or four doctors to whom they pay a retainer to have a special relationship with that nursing home.

That special relationship will probably include things like appearing at medication advisory committees, being on call to answer generic questions such, "Doc, we've got an outbreak of norovirus in the west wing. How do you think we should handle this right now?" - so they become a medical adviser to the nursing home. So that way the nursing home could formally identify, "This nursing home has a specific relationship with Dr A, B and C" - without stating that they are the preferred providers in this area - or "You could have your own GP or GP of your choice, if you wish."

That will put some subtle and, I think, ethical pressure on the patients and the family to choose a GP who has a close relationship with that nursing home, rather than a GP who has a less than fleeting relationship with the nursing home. So there are subtle things that could be done. But I'm really troubled by the necessity to support the patient's ethical right of choice, because I would never go past that.

MR WOODS: No, and we understand that.

MS MACRI: Yes.

MR WOODS: But we also have visited a number of residential aged care facilities where they do have a close relationship with a nearby practice and they make all patients aware of that, and they find that over time people come to find that the availability, the promptness, the presence of that GP in the facility more often, gives them confidence and allows them to make that individual choice to move across. So it does work in a number of places.

DR HERDY: I think you'll find in practice that practically every nursing home has one particular GP that's adopted that nursing home and has a special relationship with that nursing home which is totally informal. In my case, I have that close personal relationship with four nursing homes.

MR WOODS: Yes, but I think your other point, that having one GP who is prepared to make that effort is not quite the same as having a group of GPs who work closely with each other and can support the totality of services - so it's not the problem of called away to deal with emergencies or being on leave or getting some time off some nights or - so having a group of them seems, from casual observation, to work particularly well.

DR HERDY: It does work well in some of the places that I've seen - whether I've worked there or not - and the number of three or four seems to be the optimal number.

MR WOODS: Yes.

DR HERDY: It's not too few, not too many; especially when they all work in the same area, they all know one another personally.

MR WOODS: You've been very clear in your views, for which we're grateful, and you've provided us with an early submission, and also our attention has been drawn to an article that you wrote about how staying home won't cure the predicted aged care shortfall. So we're conscious of the views you express there, which are as you've put on the record today, but is there anything else in particular that you want to raise with us?

DR HERDY: Harking back to something that was raised with the previous group that was here, rural and residential, particularly Indigenous health. One of the things I'm aware of in the rural Indigenous health is they are much more attuned to their skin group - and there are some 200 skin groups or language groups throughout Australia - and particularly when I was working in Alice Springs, the nursing homes

there had some Aboriginal carers with whom they had an avoidance relationship with some of the patients, which meant that this was impossible for the patients and for the carers to provide care. Among urbanised Aborigines that is not nearly so much the case.

MR WOODS: No, quite true. They have to be acceptable to those patients and to those communities, if we're talking about community delivery.

DR HERDY: I think you and I have already had a brief discussion about the YOP Program, the Yuendumu Old Person's Program, which is a non-residential aged care community-controlled facility in Yuendumu, a town 280 K's north of - - -

MR WOODS: I've been there, yes.

DR HERDY: I've worked there a number of times. That points out one of the weaknesses with the Indigenous community-controlled resources; that is, as they become family-controlled, the other families in the area then will avoid using them. So they need to be truly community-controlled, not family-controlled.

MR WOODS: Yes, and we did raise the issue of governance, because that's the heart of it. You have to get buy-in from all of the relevant groups into a government structure that they can all cope with and accept; yes, a challenge. Thank you very much. If there are further contributions that you wish to make, we're running out of time but we would certainly welcome any particular insights as you go through our draft and follow our progress.

DR HERDY: Thank you for your time.

MR WOODS: Thank you.

MS MACRI: Thank you.

MR WOODS: Can I call forward Aged Care Queensland. Please, could you for the record state your name, the organisation you are representing and the position you hold.

MR BEGG (ACQ): Sure. My name is Steve Begg. I'm representing Aged Care Queensland, particularly the Aboriginal and Torres Strait Islander Aged Care Network. I'm here today to represent the views of Aged Care Queensland as well as draw on my experience working with the HACC branch in Queensland as well as a consultant over the last few years.

MR WOODS: We understand you were drafted at fairly short notice and we're very grateful that you have been able to make time to come and present some evidence. We were particularly keen to get your contribution given your background and your practice, so thank you for making that time available. Please proceed.

MR BEGG (ACQ): It's an absolute pleasure. Thank you for the opportunity. I've just handed you there a brief PowerPoint that outlines some dot points and I might just go through those and talk through them as I go.

As I was saying, my experience has come from working with the HACC branch and working as a consultant, and one of the things the HACC branch asked me to do when I first started was to develop an Indigenous service development strategy. I said, "I'd love to do that and work on the previous version, but first I'd like to go back to the service providers and listen and hear and understand what the issues are so we can capture them clearly." So their view - and my strong view as well - is that one size doesn't fit all; it's not an appropriate model for Indigenous service providers.

I spent 18 months going around to the service providers all through the Cape, in the Torres, the Gulf and Central Queensland, along the coast, speaking with nearly all of them and visiting most of the communities.

One of the things, I suppose, before I get into what I learnt, was it was quite clear that aged care, particularly from the perspective I was looking at in the home and community care, is a really important component to Indigenous communities, particularly because it prolongs the life of the elders, and if it does that the influence that the elders have on the community in terms of stability, in terms of community development, in terms of law and governance plays a much stronger role. If the elders are no longer in community because they've gone away because they're ill, or they pass away, then the influence and the impact they can have is severely restricted, which I think is an important point to make.

The outcomes of it were that there are many common issues across the service providers but there are different priorities for each service provider, and the answers

and solutions are very different for each provider in their own community. So what I've done is, with the HACC branches, I've developed a mapping report and I've got that before me, but I've sought the Department of Communities permission to release that to the commission and they've at this stage asked me not to do that but have advised that the commission is more than happy to seek that directly through them if they wish.

I'll just show you so that you can see. This is basically about a 120-page mapping report that looks at a whole range of issues over 18 months and I'll go into the major areas in a minute. Then I developed from that a service development strategy that tries to crystallise the issues, and therefore the solutions, so goals and strategies, and then a summary which highlights across seven major themes and about 45 different particular strategies. What I'll do today is, I'll go through those in essence because since leaving the HACC branch those things haven't changed, in my consultancy experience, so at the moment I've got all my clients - Indigenous service providers, except for one which is a multicultural provider - and the knowledge that I have and what I talk about today is really in line with what I've done in my consulting experience but very much confirmed by the work I've done with the HACC branch.

One of the first issues or themes that came out was the service delivery model and, importantly, for services to be effective to Aboriginal or Torres Strait Islander people, they're most effectively provided by Indigenous service providers and not through mainstream or generic service providers. Even though there are a lot of Indigenous people that access through mainstream, equally there are a lot of non-Indigenous clients that access services through Indigenous service providers because they feel they get a very high-quality service and a relational service.

The flexibility in delivering the services is absolutely paramount and in the Productivity Commission's draft report it talks about the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. Probably from my perspective, the beauty about that program is that it funds a service provider from community care and residential, gives the provider the flexibility to deliver services that meet the clients' needs over time, as well as then report what they've provided, so it provides valuable data back to the government in terms of what actually is required in that community. That offers a very valuable tool, both in terms of meeting client needs and providing valuable data.

The other thing is that services must be culturally appropriate. If they're not then there are going to be significant issues, and we heard the last speaker talk about that in terms of skin groups and cultural laws, and there are issues in regard to males doing personal care for males, and females for females, et cetera. The other thing in the whole process which the commission has taken on board is the integration across the aged care packages, which is absolutely essential. The reason, partly, is because

there isn't funding for enough CACPs or EACH or EACHD or residential packages in a lot of service providers or communities, so everyone stays on HACC and the HACC just gets bigger and bigger and bigger.

Nearly all of my clients have got funerals every week - maybe two, three, four clients die a week. The can't go on to another provider because they aren't culturally appropriate or they haven't got a package, or they haven't got the funds to pay for a higher-level package and so they just stay on the HACC package and they stay there indefinitely with a view that this is their long-term aged care support program.

Access is a really important issue and I'll come back to that in a minute in regard to the Gateway, but in terms of the cultural assessment tool, there are ones around and the report has indicated about the KICA, the Kimberley Indigenous Cognitive Assessment tool. Dr Eddy Scrivens in the Cape has taken that tool and validated it up in a number of Cape communities in the last 18 months. I'm aware that Victoria also has a culturally appropriate assessment tool and I believe Lauriann Trevy, who's the service development officer in Mackay, has just been put offline to help to develop a cultural assessment tool for Queensland as well. So there's a lot of work that has been done and there are a lot of people out there that know how to do it. But simply at the moment in Queensland there's an ONI tool and - - -

MS MACRI: A what tool?

MR BEGG (ACQ): Sorry, an ONI.

MS MACRI: ONI?

MR BEGG (ACQ): Ongoing needs identification tool. That tool is a generic tool across Queensland and even though the HACC branch doesn't dictate that you have to use it - they say you have to use an assessment tool - it is a tool. So what everyone does in Indigenous communities is that they either take that tool in their head or leave it back in the office and go and talk to a client - sit down, have a good yarn, talk about family and issues - and through that general conversation can identify what the needs are. They don't come up and say, "Have you got incontinence problems?" which wouldn't be culturally appropriate, they glean out the important information through conversation, which means that by its nature the Gateway is going to be fraught with issues because Indigenous people just won't front up over the phone and get an assessment.

MR WOODS: But the Gateway will be using appropriate assessors, not the assessor themselves. We're not suggesting that the Gateway actually employs every assessor. We're suggesting that the Gateway has assessment undertaken and in most cases in these situations that life would continue as is.

MR BEGG (ACQ): I suppose that's the point I just wanted to make; that, yes, it does remain very much culturally appropriate. In light duties the Cape communities have an assessment team for HACC and they go out to communities; there are one or two or three people that go out to a range of Cape communities.

MS MACRI: What I'm hearing - because on our building block model, that basic care model, which is your HACC model, we advocated it would be a telephone-type interview. You're saying that's not going to work for - - -

MR BEGG (ACQ): No.

MS MACRI: Okay, that's important.

MR BEGG (ACQ): It won't work.

MR WOODS: No.

MR BEGG (ACQ): It needs to be one on one.

MR WOODS: Yes, sit down, have a talk.

MS MACRI: Right.

MR BEGG (ACQ): Sit down, talk through it.

MR WOODS: Establish relationship, trust.

MR BEGG (ACQ): Exactly.

MS MACRI: Yes.

MR BEGG (ACQ): And if there's a need to make a phone call, people just won't access it. They'll say, "I won't go there. I won't do that," and then you'll get a lot of people that won't be receiving services.

MS MACRI: Okay.

MR BEGG (ACQ): Workforce issues: the whole range and raft of workforce issues, but besides some of the ones that I've talked about in the report, like wages, there's a real need for a mentoring program across service providers because key staff or managers, coordinators, leave and then there's no-one who has a capacity to start again, so it's almost like the business starts from scratch every time someone leaves; and in light of that, succession planning to make sure that we're thinking ahead of time. Mobile relief - - -

MR WOODS: Sorry, can I just go back to the mentoring? A lot of that is about, again, ensuring that the elders are indicating to the members of the community that these deliverers can be trusted, so they create an interface and indicate respect.

MR BEGG (ACQ): Yes. I'm thinking more in terms of a new coordinator starts up in Aurukun and they've never done HACC before or aged care before. They haven't got any experience and they just come in cold and they don't know what to do; either they may not have a relationship with the community in terms of what you're saying or they have a relationship but they don't have the knowledge to understand how to run this new business, this aged care business.

MR WOODS: One wonders why they were employed in the first place, but putting that aside.

MR BEGG (ACQ): I totally agree, and part of the reason for that - like, for example, in Aurukun the coordinator left. They took over 12 months to employ a new one and they ended up employing someone at two times the wage rate of what other coordinators were getting, just to get someone to come to Aurukun, and I'll bring it up a little bit later, but one of the reasons why it was very difficult was because there was no accommodation.

It's no-one's fault in this regard, but particularly in the Aurukun example, the coordinator's wife was a nurse who worked in the clinic and lived in a house. Then Aurukun Clinic employed three single nurses, so it was more appropriate that they then go into the house. So they moved this particular nurse into a donga, which is a single bed for her and her husband, so her husband said, "I can't live in that with you, so we're leaving." So they left and, on the basis of that, the HACC service didn't have any coordinator for 12 months. So there are accommodation issues, especially in remote communities.

That relates a little bit to the mobile relief coordinators. In some instances coordinators haven't had a holiday for 10 years. There's a particular lady in Wujal Wujal who just couldn't ever get away. There was never anyone who could replace her, so whenever she went into town or Cairns, everyone would bump into her and still ask her about things, so she never really had a holiday. Recently asked me to do a funding application, because she did have a proper holiday and then the funding round came out and she couldn't do it, so it made it very difficult. So there is a need for, in some capacity, a relief coordinator.

MR WOODS: Yes.

MR BEGG (ACQ): Workforce: so working very closely with Indigenous health workers, particularly because they have a role in the community being Aboriginal or

Torres Strait Islander, but because it's very much primary health care, the health workers could have a very strong role.

In regard to governance there is very significant work that needs to be done across the board in building the capacity of the board to govern. Often the board members are quite elderly. Some, if not most of them, are clients in their 70s, 80s, 90s. Their experience has been as an elder in the community. They haven't had long-term managerial or business experience, but they've put their hand up because no-one else has. They take all the responsibility that we as a government place on them in terms of governance and responsibilities and they don't have that knowledge and that skill.

MR WOODS: But it's also important to make sure that the board is representative of all parts of the community so that you get acceptability and - - -

MR BEGG (ACQ): Yes, exactly, and that still is another issue in regard to trying to make sure that a service provider provides services across the whole community, not to particular families or clans.

MS MACRI: Yes, so some sort of supporting - - -

MR WOODS: Yes.

MR BEGG (ACQ): Yes, easier reporting. The reporting mechanisms, as the Productivity Commission report has indicated, can be quite difficult and onerous, so streamlining those across the aged care programs is critical and would help them to more easily provide the accurate data that they need to provide. Also, the audits are very important, but often I've heard that they're not culturally appropriate or even business-appropriate. Like, on Mornington Island where they have 10 clients, they failed because they didn't have a complaints policy. They needed to document very clearly how they would deal with complaints, and there are only 10 clients and everyone knows each other quite well.

MS MACRI: So you're really talking about accreditation there, the accreditation model and - - -

MR BEGG (ACQ): Yes. In Queensland, every three years the Institute for Healthy Communities goes out and does an audit on all of the service providers, so they have to comply with standards; like, now it's the common standards.

Planning and funding: often the unit cost which is funded doesn't match the actual cost, and historically, if they have been underfunded and then they get another funding round and get the new funds at a higher unit cost, it averages out, so there's only a very small increase. There isn't any real mechanism to bring it right back up

to actual cost, because they've been so far underfunded for so long.

Some service providers receive more money than they need in particular service types and way underfunding in other service types, so the mechanism in terms of determining how service providers get funding needs to be reviewed so that it matches what needs to be done.

A lot of the buildings and vehicles are run down and I've suggested to the HACC branch that what we needed to do was do an audit of all the Indigenous communities, work out what buildings they have, what are the occupational health and safety concerns, and then fund based on priority rather than just on an application, because it then relies on them having the capacity to put in a quality application that then competes with Blue Care or anybody else.

We've got an upcoming issue in terms of vehicles. To date the HACC Program in Queensland has funded the replacement of vehicles on a term life, so it might be 12 months or two years for cars and buses, and now they're looking at not continuing that, which means all the service providers out there haven't had a system in place over the years for building up additional resources to replace or maintain vehicles because there's been a commitment in the past, "When they come to their due date, we'll replace them." So there's going to be a fairly significant impact across the program there.

Funding applications: if funding is sought for both operational and capital, there needs to be consideration in regard to the capacity of the service providers to do that. They don't always have the capacity or the time - the skill or the time - to do it. In some cases when they do put an application in, it might be 12 months or more before they receive the go-ahead. And I talked earlier about accommodation.

There need to be very strong links and partnerships with Health and Disability. And communication and networking: one of the most important mechanisms that I believe is needed is a mechanism to relate issues and solutions from a local to a regional to a statewide to a national level for communication, consultation and support. The current national Aboriginal and Torres Strait Islander Reference Group is great, but there needs to be a mechanism for those representatives to hear what the service providers around the state or the country say and then disseminate that information. That mechanism is not in place at the moment.

MS MACRI: Is that a Commonwealth-funded advocacy body?

MR BEGG (ACQ): Yes. The HACC Program has a national HACC official group, where the heads of all the states - - -

MS MACRI: So it comes under the HACC rather than the Department of Health

and Ageing at this point in time.

MR BEGG (ACQ): Yes.

MS MACRI: Yes, okay.

MR BEGG (ACQ): So if that crosses across all aged care, that mechanism should occur across the way.

MS MACRI: Yes.

MR BEGG (ACQ): Then just in terms of more particularly the draft report: fully support the flexibility and breakdown across the aged care categories of HACC, CACPs, EACH, and the need wherever we can to try and keep Indigenous people in their communities for as long as possible so they don't leave. I've said here the Gateway will not work, but in regard to the access, communicating over the phone is going to be a barrier, so the verbal relationship basis is really the way. In some places there's only one Indigenous service provider in any case, or they know people, so they're going to go to people they know and culturally are going to get cared for, in a way.

MR WOODS: Can I just go back to this one about cultural safety. Is that your earlier point about maintaining the elders in the community?

MR BEGG (ACQ): Yes, and if they have to go to a mainstream service they may not receive the same culturally appropriate services.

MR WOODS: Okay, so it's two different bits. Yes, thank you.

MR BEGG (ACQ): I really thank you, in the report, for talking about the support mechanisms needed for Indigenous communities before more intervention methods are taken on board. The support is absolutely critical. I don't know any service provider out there that doesn't want to do the right thing and isn't really trying very hard to support their clients, but they come from a background of not having the business knowledge of how to run it in a business sense, and they don't have the support mechanisms to help them do that as well as they need to. So that support is absolutely critical in a culturally safe way.

MR WOODS: If you were able to elaborate on that in a short bit of paper, as to just what, in a tangible sense, those support mechanisms should actually look like and the scope and scale of what the need is, that would be very helpful to us.

MR BEGG (ACQ): Love to.

MS MACRI: Can I ask you too, just quickly, when you're doing that, when you go back - and you talked about the governance issues and building board capacity to govern - just perhaps some of the things that you would see there in relation to support or how that could be done.

MR BEGG (ACQ): Yes.

MS MACRI: Because I think the two probably tie together.

MR WOODS: Absolutely.

MR BEGG (ACQ): Yes. I'd absolutely love to. We've talked about payment, that there needs to be an assessment of capacity - and you've included that in the report.

MS MACRI: Yes.

MR BEGG (ACQ): The consultation, planning, listening, hearing, understanding. It's absolutely critical that, for it to work really well, there needs to be local leadership and ownership and locally driven solutions; the involvement and the engagement, the less regulation; and again, as the commission has noted, not a "one model fits all" approach. In regard to competition, I read and hear and understand the commission's view on competition and support that wholeheartedly. However, in terms of Indigenous communities, where there's only one Indigenous community in a town or where there's competition between Indigenous services - - -

MR WOODS: You did, without referring to the specific name, mention a large provider in the state - in fact nationally - and Indigenous service providers. If the community choose - once they have the entitlement which will empower them, they then choose the mainstream provider because they have culturally appropriate staff and they deliver quality service and the like, is there a problem with them making that choice, or even family groups within a community making that choice, rather than telling them, "Here's your Indigenous service provider and you have to take those services"?

MR BEGG (ACQ): I take your point. I think in that regard, yes, having that choice and that option they'd value very much - and having that ability - and I know some would definitely go to a mainstream service because, for whatever reason, they're more aligned or they know people or whatever.

MS MACRI: Yes, they may have built that relationship and trust up, which are the two things - - -

MR BEGG (ACQ): Yes, exactly. Yes, in some regards it would be good.

MR WOODS: We don't want to destroy the viability of the Indigenous service providers, and in some communities it makes sense that there is only going to be one provider, and that's where the block funding - but for the larger communities or the communities that are semi-integrated into a related urban area, I would have thought that in fact it would be better for them to have the choice of several different providers and then they can - through word-of-mouth and through experience and through trust, et cetera - work out who they want to provide the services.

MR BEGG (ACQ): Yes, I agree with that. I suppose my view, just in terms of the competition, is if they're fighting for the same dollars, then you have the Blue Care service - - -

MR WOODS: They're fighting for the same clients, not for the same dollars.

MR BEGG (ACQ): Yes, fighting for the same clients is fine.

MR WOODS: Yes.

MR BEGG (ACQ): I'm thinking of in terms of if you've got a pool of funds - - -

MR WOODS: Yes, if it's block-funded, then you've got to work out who it goes to.

MR BEGG (ACQ): Yes, and in that regard I'd support block funding for Indigenous services, because they just don't have the skill and the capacity to compete in funding applications with the mainstream.

MR WOODS: Okay.

MS MACRI: Yes, that's a good point actually.

MR BEGG (ACQ): Because I know some of the big guys have got teams of five or 10 or 15 people that sit there and write applications for funding when they come out, whereas the small Indigenous guys, they're called away to go and do a domestic assistance or a personal care call when they should be writing the application. So in that regard, there is a lot of benefit for having cooperation and collaboration between the Indigenous service providers.

MR WOODS: Presumably at least one of the major mainstream providers has, in itself, a sort of mentoring role with some of the Indigenous service providers so that they don't own them or run them but they provide back office support and higher-level advice and guidance, or not?

MR BEGG (ACQ): No, not in my experience.

MR WOODS: Why? It does happen in other jurisdictions we've come across.

MR BEGG (ACQ): There's only one that I know of. That's up outside Cairns. Everyone else is very much trying to keep to themselves - and there are brokered services, but when it comes to that level of involvement in the management or the finances or providing that governance support, I've not seen it.

MS MACRI: Okay.

MR BEGG (ACQ): There's only one case where I know that someone - another one - and that, I think, is because there's family in both - that they've put this family in the mainstream service and so they have that relationship.

MR WOODS: Right, yes. We are running out of time, but let's press on.

MR BEGG (ACQ): Sorry.

MR WOODS: That's all right. We're asking you lots of questions.

MR BEGG (ACQ): The aged care split that has been talked about between aged care and disability: the issues there for some of the smaller - or for all of the Indigenous service providers - is that there are not very many people under the 50 years of age category. So for the small numbers - so there might be 5, 10 or 15 clients - that would mean that they would have to have two lots of funding arrangements, two lots of contracts, et cetera. So if there's a capacity for all the Indigenous clients to be either Commonwealth clients or state clients or a brokerage arrangement, that would be worthwhile. I talked about this briefly before, but some of the impact is that when clients get too old they either die on HACC or there's no residential; they have to move to Cairns or somewhere.

MS MACRI: Right.

MR BEGG (ACQ): That has big impacts. There's a strong need within the sector for residential aged care within communities, and also within Brisbane North, so they don't have to leave the community - and the point about trying to strengthen Indigenous service providers rather than getting mainstream to take over. In regard to the Indigenous presence in the report, I'm thinking in terms of the things that I've spoken about today, the "one model fits all" approach - - -

MR WOODS: It's certainly not our intention.

MR BEGG (ACQ): Yes, absolutely.

MR WOODS: That's an area where we do need advice from people such as yourself.

MR BEGG (ACQ): Yes, and then aligning with the Close the Gap and all the other - - -

MR WOODS: Yes.

MR BEGG (ACQ): Absolutely. So perhaps there's a need for further consultation or a day on it, or however you'd like to see - - - -

MR WOODS: Yes, sure.

MR BEGG (ACQ): The last two slides might capture what you were saying earlier about practical support. These are some of the things that I've been doing as a consultant in the last few years that, in some ways, capture some of their desires.

MR WOODS: Okay, yes.

MR BEGG (ACQ): So a service development strategy which captures a whole range of different issues across governance that looks a bit like this, and then an action plan that gives them targets to meet each month. I've developed a software package called ROCS that helps to collect the data and then report both to the Commonwealth automatically and the state. So that helps with their reporting and their data collection.

MR WOODS: Presumably that's your intellectual property that sits in those.

MR BEGG (ACQ): Yes.

MR WOODS: And rightly so; you have a living to make. But if there was some way we could understand the content in it - - -

MR BEGG (ACQ): Yes, sure.

MR WOODS: Yes, this is a helpful list.

MS MACRI: Yes.

MR BEGG (ACQ): So, yes, the software program is really helpful, because often they have it on a scrap piece of paper or they have it on an Excel spreadsheet that doesn't work - so a program that helps. But also they have to report the MDS. So they've got an MDS program that doesn't collect everything they have, it just is pretty awkward to use. This program then does both, where they can have it all on one

system and track service delivery, funding applications as well, contracts and job descriptions, policies and procedures, governance training, preparing them for their audits, financial management, bookkeeping, budgets, managerial-type services and HR issues.

MS MACRI: Must be pretty busy.

MR WOODS: You have answered a lot of that question that we were heading towards, so maybe we'll just come back to you if we want further elaboration on those.

MR BEGG (ACQ): Yes.

MR WOODS: That's been excellent.

MS MACRI: Yes.

MR WOODS: Thank you. That's exactly the input we were hoping for and you've delivered well.

MS MACRI: Yes, fantastic.

MR BEGG (ACQ): Thank you.

MR WOODS: And we will stay in contact with you on that.

MR BEGG (ACQ): Yes, all right.

MR WOODS: Have you got any final questions, Sue?

MS MACRI: No, not at the moment, but really useful, yes.

MR WOODS: We'll stay in touch.

MR BEGG (ACQ): Okay.

MR WOODS: But that's been excellent. Thank you very much.

MR BEGG (ACQ): Thank you very much.

MS MACRI: Thank you.

MR WOODS: We will resume at 11 o'clock.

MR WOODS: We welcome our next participant, KinCare. Could you please for the record state your name, the organisation you are representing and the position you hold.

MS ADAMI (KCS): I'm Therese Adami, general manager at KinCare Community Services and I'm representing KinCare.

MR WOODS: Thank you for your early submission, which had lots of very helpful information, so congratulations to whoever wrote it.

MS ADAMI (KCS): It was a team effort.

MR WOODS: It reflects that, given the extensive nature of it; and also for your subsequent submission to us. We're grateful for the ongoing support that you are giving to this inquiry. So thank you very much for that, it's been well appreciated. Talk to us.

MS ADAMI (KCS): Just to give you a background, KinCare are 100 per cent community. We do come from a health focus and we provide services in four states and will be soon commencing services in Queensland. We have 626 packages, 200,000 hours per year of HACC services in New South Wales, ACT. We do DVA nursing, veterans' home care and National Respite for Carers live-in program as well as fee-for-service programs.

MR WOODS: You're a part of the service delivery that we do want to emphasise and to see grow, so it's very helpful having you here.

MS ADAMI (KCS): Well, we welcome the draft report that you put out and we are generally supportive of the nature of the proposed changes. We feel there are some areas that warrant further consideration. Most importantly, the report acknowledges the interconnectedness of the aged care and health systems, but does not explore the possibilities of greater integration of these systems. We believe there's a tremendous opportunity for aged care to play a much stronger role in the delivery of health services, thus avoiding unnecessary hospital admission and facilitating earlier and smoother discharges after hospital.

I'd like to just make a broad comment around the boundaries of the report. As I mentioned, we believe that there's a greater variety of health issues which can be and are being managed in the community instead of a hospital environment. There is a boundary issue, as aged care packages can already provide some health services but there is presently no clear definition of what the health support expectations are within packages and there are many conditions that could be managed in the community more cost-effectively than in a hospital, that cannot be reasonably managed within existing aged care packages the way that they're set up at this point.

MR WOODS: What sort of examples do you want to offer for that?

MS ADAMI (KCS): Preventing hospitalisation, so a broadening in terms of the whole range of health services. For example, there's physiotherapy at the moment: could that be a greater prevention and integration? And how the boundary occurs within the hospital environment and in the community environment and within the community aged care package and the way the funding is structured currently.

MR WOODS: So you see that with our sort of building block approach to identification of needs and the delivery of services to focus on those needs, that will go - - -

MS ADAMI (KCS): That will assist with that, yes. So more mapping of the different - more detail around the services, obviously, that's gone into the report. So once you go into the second stage of looking at, "Yes, the building blocks are there," just the detail under those building blocks - for example, the continence services and the palliative care services - and how it sits and where the funding sits and where the responsibility sits.

MR WOODS: Well, the funding sits in the sense that it's the individual who has the entitlement to the service and there's a price that is associated with that entitlement, so they take it to the providers - both their care contribution and their subsidy from government.

MS ADAMI (KCS): Yes. So then, for example, when a client has continence issues, it's different in different places. Do they go to the continence nurse at the hospital? Is that provided through the continence service in the community aged care provider?

MR WOODS: We'd prefer in the first instance, if at all possible, for it to be delivered as part of their service delivery in the community, and only when you need specialist intervention would you go to the hospital.

MS ADAMI (KCS): Yes.

MR WOODS: But obviously based on the particular circumstances.

MS ADAMI (KCS): So we'd suggest a whole lot of health spectrum conditions to be looked at.

MS MACRI: Can I just ask in terms of your packages, are they all Commonwealth-funded?

MR WOODS: You do HACC.

MS MACRI: And you do HACC.

MS ADAMI (KCS): Yes.

MS MACRI: And DVA, but do you do any - - -

MS ADAMI (KCS): Transitional care?

MS MACRI: - - - transitional care?

MS ADAMI (KCS): Yes, we do.

MS MACRI: And subacute, post-acute care?

MS ADAMI (KCS): We do transitional care. We have some direct funding in New South Wales and we also do it on a brokerage arrangement.

MS MACRI: With Area Health Service.

MS ADAMI (KCS): With Area Health Service.

MS MACRI: That's great.

MR WOODS: So you are that full spectrum.

MS MACRI: So it's that really integrated model.

MR WOODS: It's great, isn't it?

MS MACRI: Yes.

MS ADAMI (KCS): In terms of the scope of services under the new framework, you mention packaged care, HACC and residential aged care. I think there's one reference to transitional care and we should all, we suggest, go to an examination of that. The early discharge program - - -

MR WOODS: The same as subacute, early discharge.

MS ADAMI (KCS): Yes, the early admission. There are different names in different places. Early admission avoidance program; community nursing.

Moving on to consumer choice, the current Commonwealth initiatives are one

option for increasing choice, with the trial that's on at the moment, and we believe that real consumer-directed care will only occur when consumers can generally choose and change their provider service models and service features, and that would stimulate innovation and focus on developing and delivering what consumers want.

I'd like to talk a little bit about the Gateway Agency. Much of the Productivity Commission focus is on improving consumer choice, uncapping places and taking advantage of the market. However, introducing a single gateway may conflict with this objective. Consumers should be able to contact the Gateway in a variety of ways: we suggest face-to-face, by telephone, and online.

We suggest that it could be developed in two stages. In the current environment where supply is constrained and providers are only able to deliver services in locations in which they have won tenders or packages, a single gateway agency as proposed creates a focal point for people seeking aged care services and assessment and helps identify and access the service they need. However, stage 2, where supply is not constrained so service providers can make rational decisions about what care they're delivering and where, more of a network may be needed than an actual gateway. A competitive environment by models of choice and consumers gateways is likely to get better results.

MR WOODS: I read that with interest in your supplementary submission. I wouldn't mind exploring that a little, and perhaps if I can take up a minute just to share the vision that I had and that the collective membership of the commission have had.

MS ADAMI (KCS): Sure.

MR WOODS: That is that the Gateway is the entity that authorises the entitlement and that is responsible for assessments being conducted, but it would not necessarily be the conductor of assessments, and I don't know if you were present when we had earlier discussion, but it's so that in Indigenous communities, for instance, you would draw on the trust and relationship of people to do assessments who were acceptable to the communities and are more likely to reveal the actual truth, rather than have a government official come with a clipboard and tell them nothing - so all those sorts of issues.

The Gateway has the responsibility for the assessment to be conducted but is not necessarily the conductor, and in fact for a lot of it, on day one you'd just use the ACATs and ACASs and other panels and teams and capacities right through the nation and then the Gateway would work out who is best at doing assessments and use them. So that's that side of it.

Then on the entitlements, because it is expenditure of taxpayer funds, you still

need authorisation of expenditure.

MS ADAMI (KCS): Sure.

MR WOODS: And so the Gateway would be the final determiner of what the entitlement is. But, as circumstances change for people, the providers - and particularly providers who the Gateway Agency trusts and has a good relationship with and knows that they have a good track record - if that provider changes the mix, all they would need to do is get authorisation for that changed service delivery, but they would have done their follow-up assessment themselves - the provider, that is - and made the changes in agreement with the recipient of the services and notified the Gateway, and then there would be your normal risk audits somewhere down the track just to keep an eye on things. So it would be a much more flexible entity and process than what you're envisaging, I think, by way of these statements.

MS ADAMI (KCS): I'm just wondering. One of the other comments that we did put in is the flexibility and the administrative burden. Currently there are some good aspects to the system in terms of a package. There is flexibility. You have a portfolio. Some clients, as they come out of hospital, may actually require more service, and you have the ability to do that. If we're too over-prescriptive and administratively - and again, with the HACC funding, if someone deteriorates and they now need a hoist, for example, and more services, you have that ability and you don't need to go back to an administrative place to get that. So we just need to be cautious of what that will create.

MR WOODS: Understand that. The trade-off on the other side is that those who have need of services should be getting the services they need.

MS ADAMI (KCS): Sure.

MR WOODS: And some of that cross-balancing may inadvertently result in other areas being squeezed a little to cope with those situations. It's got to be sufficiently broadbanded so that you've got flexibility within that, but there's that other balance.

MS ADAMI (KCS): I also think we need to look at the outcomes that we're achieving as a way of looking at some of the health outcomes around clients living at home in terms of their falls, hospital preventions, their quality of life.

MR WOODS: Social isolation.

MS ADAMI (KCS): So we could do clinical assessments, we could do general satisfactions, we could do auditing, and there would be a number of mechanisms that we could set in the market. Obviously consumer choice is one that will drive

satisfaction in terms of if they're happy with the services that they're getting from one provider or another.

MR WOODS: So the fact that they could then choose a different provider because they now hold the entitlement and hold the government subsidy, is that an issue for your organisation, rather than you being funded so you - - -

MS ADAMI (KCS): No. We believe that that will create a lot of innovation. Obviously if it needs to be funded - and we talk a little bit about funding appropriately - - -

MR WOODS: Yes.

MS ADAMI (KCS): But I think it will cause consumers to go out to the market, so that consumers know about what services are available to them. We feel it will create innovation within the market, yes.

MR WOODS: And by not being limited to the number of packages that you get funded for at the moment and your annual HACC budgets and that, do you envisage that you would continue basically on your same business model or do you think you would expand into different areas? What does this reveal for you in terms of your thinking?

MS ADAMI (KCS): We feel that there will be much greater connection with consumers; so going out to consumers about what are the services, what we can do in terms of that offering. I think there will be much greater focus on that. Obviously the range of services that can be looked at will be also - if the funding changes, that creates opportunities. You know, if you lose it, it will create different market dynamics that we'd need to look at. But, yes, we would see that as a positive for the Australian consumers.

MR WOODS: Okay. Sorry to have interrupted your flow.

MS ADAMI (KCS): No, no. So, yes, in terms of the Gateway in the draft, we did put a little bit about just having a single gateway and whether other places or organisations could be a gateway.

MR WOODS: Well, the front end of the Gateway.

MS ADAMI (KCS): The front end, yes. Does it need to be just one Gateway per region, or how does that need to look?

MR WOODS: You'd access it through your GP, through your Centrelink office, through your local council. There are all sorts of ways in which it would ensure that,

within each region, people knew how to access the services, and through a whole range of intermediaries and - - -

MS MACRI: Yes.

MS ADAMI (KCS): Just to get back, we do need to look at the administrative burden of over-prescriptive categories around services that are authorised through the Gateway, and clinical judgment and going into the home and constant evaluation. People's lives change, as well, quite frequently.

MR WOODS: But both ways. It's not linear.

MS ADAMI (KCS): Yes, that's correct. Thank you. In terms of regulation or deregulation, regulation is your target areas that the market just doesn't address well. For example, minimal standards should be regulated and enforced, providers should be accredited for the types of services they wish to provide the guarantee of certain standards around, and points of market failure that may emerge in some regional areas or special needs groups may need to be addressed through a combination of incentives and regulation as well.

So in terms of the base support, we do believe that it is an early intervention health service, not simply a cleaning service. Aged care staff, including those providing domestic assistance, need to be screened, trained, understand the importance of restorative interventions and trained to identify reports in consumers' changing needs.

MR WOODS: You talk about "trained". What does that mean for the cert III? Do you have a view on the content of the cert III and also on the delivery of the cert III?

MS ADAMI (KCS): I haven't looked into the detail. We have a training organisation as part of our KinCare group that does our training.

MR WOODS: So you're an RTO?

MS ADAMI (KCS): It's very much developed with - I mean, the way that they do the training is they work with the provider on their policies and procedures and integrate the training in that way, so it's very much how you see you would like the material developed in the best way, in the best mode at the best time.

MR WOODS: So you've taken control of your own destiny on the training?

MS ADAMI (KCS): Yes.

MS MACRI: Just on that "providers should be accredited for services being provided", we're talking about, at the moment, the requirements under approved provider status under the Aged Care Act and the requirements for key personnel. So are you saying that's enough or you would be looking for further accreditation around services being provided?

MS ADAMI (KCS): Yes, in terms of you're providing specialist services in evaluations, best practice guidelines, those sorts of things.

MS MACRI: As the approved provider?

MS ADAMI (KCS): Yes, as the approved provider.

MS MACRI: All right; simple. So you're saying that really approved provider status, as it currently stands, and key personnel requirements are not sufficiently - - -

MS ADAMI (KCS): Well, when I'm looking at the whole health spectrum and I'm looking at much broader community - so based on that, yes.

MS MACRI: Do you see accreditation being linked?

MS ADAMI (KCS): In terms of ISO external quality accreditation?

MS MACRI: I mean, at the moment your CACP, your community care, is through just the Department of Health and Ageing Quality Framework.

MS ADAMI (KCS): Yes.

MS MACRI: So are you seeing something beyond that as well? In terms of the services being provided and approved provider status - - -

MS ADAMI (KCS): Yes. I feel that obviously, if we choose to have currently the external - like ISO, for example; KinCare is accredited - that provides benefits to us to know that our staff are providing systems and processes. So actually that's, I guess, management monitoring for - - -

MS MACRI: Yes. Sorry to labour it, but it was just around - because at the moment you go through approved provider status and key personnel.

MS ADAMI (KCS): Yes.

MS MACRI: And then you obviously select to do ISO, which is a quality accreditation type system, so that's what you're talking about. I was just trying to get that approved provider status - - -

MS ADAMI (KCS): And what that means?

MS MACRI: - - - and what that means. That's adequate?

MS ADAMI (KCS): You would need to look at the way funding - yes, the way that it's looked at. I'd have to probably understand a little bit more detail.

MS MACRI: Yes, okay.

MS ADAMI (KCS): But there may be some benefits. Obviously, to be an approved provider you go through a process and you need to win packages and then you go through a process in that, so there's a lot in that process that if you did need to go through would need to be covered in some other way.

MS MACRI: Okay.

MS ADAMI (KCS): So things around dementia. There are standards of care and best practices, so you would need to look at that.

MS MACRI: Got you, yes.

MS ADAMI (KCS): I'll move on to complaints now. The Department of Health and Ageing is presently conducting a review of aged care complaints processes and we support the model proposed by the Productivity Commission to increase the range of mechanisms to deal with complaints. We also support the external agency for complaints.

MR WOODS: We offer thanks for the Walton report.

MS ADAMI (KCS): Yes. It would be important to look at consumer rights as well, particularly for people who are vulnerable in terms of advocacy, services and providers working with whoever the consumer wants to advocate for them. We're very comfortable with that process being put out by the departments, so a big improvement on the complaints process as well, so it's happening together. The building block - I think you mentioned that, Mike - that clients don't also always progress in a linear manner.

MR WOODS: You had it there and I had agreed, and two ticks.

MS ADAMI (KCS): Okay. Thank you.

MR WOODS: The whole point of our approach is that you deliver the services that they need at this time but you constantly look to see whether you can restore a

level of previous independence or at least maintain current functionality, et cetera, rather than just plan for the progressive frailty.

MS ADAMI (KCS): In terms of pricing, the pricing and financing options are likely to be more effective than the current system. Improving financial arrangements for the industry, resulting in innovation, in-services and increased choice - we support means-testing for some service types, high co-payments, the stop-loss mechanisms and a government-supported equity release scheme. In terms of consumer contributions, it's unclear - and you may be able to clarify that - whether the regulation will apply to the whole fee including consumer contributions or only the government portion of the fee.

MR WOODS: There were several different bits to that question. Can you - - -

MS ADAMI (KCS): It's regulation on the fees that are paid - - -

MR WOODS: For the care component?

MS ADAMI (KCS): Yes.

MR WOODS: For a particular care service there would be a transparent process of setting a price for it, and that price is delivered equally to whichever provider delivers that service, so there is no competition on price by providers. What that price does, though, is get subdivided into two parts. One is the care co-contribution from the person according to their assessed capacity to pay, so it might be 5 per cent or it might be 25 per cent, depending on where they are on the wealth and income spectrum. The rest of it then would be the government subsidy. So the price is fixed. The proportion of that price that is paid by the individual and the proportion that is paid by the subsidy will vary according to the income and wealth.

MS ADAMI (KCS): Okay. We feel that in terms of the regulated system it would be good to have the services within the regulated system and people who can afford or want to pay more for more features, that that's able to be - - -

MR WOODS: Absolutely. Totally out of it. That's totally separate.

MS ADAMI (KCS): Okay.

MR WOODS: All providers must provide the approved standard of care for the price that is set. If somebody, for reason of managing their personal hygiene and capacity, is approved to have one shower a day, they want somebody to come in at night and give them a second shower before they go to bed but that's not approved as necessary for their personal hygiene and wellbeing, but it's just another feature they would like, they can negotiate with the provider and that can be delivered.

MS MACRI: It would be on a fee-for-service basis.

MS ADAMI (KCS): Okay.

MR WOODS: It's an additional service and that's unregulated. We don't have extra service, we don't have - - -

MS ADAMI (KCS): Our feeling was that it would be good for that to be under the regulated system in terms of guaranteeing service standards.

MR WOODS: There would be the normal consumer protections that apply for them, whether they purchase car maintenance or whether they purchase massages or additional things in the normal marketplace that they do - that the service that is being offered has to be what is being promoted and has to be at the price offered so that normal generic consumer protection remains, but they're just buying services additional to what is the approved set of needs. So we really don't see why there should be an additional layer of regulation on those. That's a normal market transaction that people do every day of their lives.

MS MACRI: If it's not satisfactory, they stop buying it.

MR WOODS: Yes, and go somewhere.

MS MACRI: And go somewhere else.

MR WOODS: If they don't like the price, they don't like the quality, stop it; don't do it.

MS ADAMI (KCS): Okay. In terms of fees that reflect the underlying cost, you propose the independent pricing authority that sets prices based on the underlying costs.

MR WOODS: Recommends.

MS ADAMI (KCS): Recommend.

MR WOODS: Because obviously government, being the fiscal gateway, has to finally decide. But, yes.

MS ADAMI (KCS): It's important in calculating the cost that it is set at a level that reflects the cost of capital as well. Is that - - -

MR WOODS: Yes. It's the full cost of delivery.

MS ADAMI (KCS): Okay. In terms of based subsidies, in terms of supplements that pay for only their marginal cost - I think you talked a little bit about subsidies not being - being subsidised at the marginal cost. However, we feel in terms of direct and indirect, that costs are ultimately variable and should take into account overheads and the cost of capital; that costs associated with more complex care go significantly beyond the direct costs; so, for example, more skilled staff such as clinical nurse specialists, nurse practitioners, so it is incorporated into each of the costings.

MR WOODS: It's the cost of delivering that level of care in all its components, and the point we quite often make to those who represent the staff or the workforce is that, in setting that price, you're going to have to have a view on what is the skill mix you need to deliver that, as well as the hours involved in delivering it. So, in effect, it starts to be a more flexible way of determining what should be the involvement of RNs, ENs, AINs or PCWs, or however we want to describe the third layer.

MS ADAMI (KCS): Okay. We would suggest that supplements - obviously, if we're looking at the whole scope of services, some of those services do have supplements, if we're looking at base minimum services, but some of those more specialist services, that they are subsidised.

MR WOODS: After this you can point to particular parts of the draft where that was causing some confusion. Can you let us know.

MS ADAMI (KCS): Sure. Okay, thank you.

MR WOODS: Sue, do you have anything on that - - -

MS MACRI: No, because that's the intent, but obviously again, because we talk about palliative care, wound care, end-of-life care - the specialised areas - that (a) might be episodic or (b) may be for a short period, somewhere on the care continuum. So if we haven't sort of got that message and articulated it, if you show us where and we can have a look at that.

MS ADAMI (KCS): Yes. I'll look at those; so within those range of skills, what is the supplementary and is that going to be funded at the base cost.

MS MACRI: Yes.

MS ADAMI (KCS): How are we going for time?

MR WOODS: Yes, it's all right.

MS ADAMI (KCS): Nearly finished. Block funding: you proposed block funding in areas of unmet need and a variety of other circumstances. We feel if block funding is available, it's important that there are transparent guidelines around that for competitive tender and expression of interest. We do feel it would be helpful to have block funding for options for innovative models that require significant up-front investment or require significant research components in terms of that. We suggest that block funding should not be used routinely for special needs groups in areas that have a flourishing market, as generally the market will respond to the demand if the pricing authority sets the pricing accordingly for that service to be offered, and obviously evaluating that over time.

In terms of special needs groups, it is important that additional service-related costs occur to a variety of different groups, as well as some of the special needs groups - for example, mental illness - in terms of costs and training. You talk about the interpreter for the Gateway, but there's also that consideration for service providers in terms of interpreting services, and when we're looking at special groups, costs include different management approaches, specific training, specific communication tools around the different groups, I guess, there are the official special needs groups but there are other groups we could look at.

In terms of the aged care workforce, we support better competitive rates for nursing, allied health and other care staff to be reflected in the pricing and allocations to attract strong clinicians and a more direct workforce so that aged care is positioned as a cutting edge and doing research and governance and all those things.

MS MACRI: Can I just ask you, going back, in terms of delivering care in the community - and you were just talking about interpreter services at the Gateway.

MS ADAMI (KCS): Sure.

MS MACRI: But more around delivering that care in the community to CALD residents. I'm just wondering about how you manage that and whether you have relationships with particular associations or ethnic groups and how you manage that whole delivering care in the community to CALD people.

MS ADAMI (KCS): That's a good question. We do have memorandums of understanding with a number of CALD groups; also, I think in our first report we strongly endorse the PICAC that's in place. It's a very good resource for service providers about connecting with community groups that give you help; deliver training. So in terms of interpreters, we have an interpreter that comes to the assessment. We feel that that's important; not just to have a family member there in terms of understanding what's needing to happen, what are the service requirements. So they're engaged in that process. Obviously family supports over time, but we feel that when we're doing health assessments - you know, things with daughters and

ethnic differences, that's a much better - - -

MS MACRI: Is that an additional cost incurred generally with those - - -

MS ADAMI (KCS): Yes. So that was all that I had.

MR WOODS: Workforce issues? Anything further on those?

MS ADAMI (KCS): Just that we certainly support funding of those: additional training of the aged care workforce; and opportunities for career pathways. We see aged care as an integral part of the health system, so I guess we're coming from that level of reward, remuneration, skill training so we can deliver that within the community setting.

MR WOODS: All right. Other questions?

MS MACRI: In terms of in the brave new world, if you have an increasing resident capacity, how do you see marrying that up with the workforce and some of the workforce issues? I'd be interested in how you go about your attraction and retention, because we hear a lot about it in residential aged care. Is it an issue in community care, that high turnover, attracting, retaining?

MS ADAMI (KCS): The issue in community care is the utilisation of the staff. For example, in terms of the times that clients want services to when the staff - so a lot of people want services in the morning. We've got a scheduling software package that we use, which is based on a geocoding to match workers, skills, times, locations with clients' preferences, needs and locations; and working with clients who need the exact time and what is the preferred time. So, for example, if your daughter has to go to day care and you've got dementia, you definitely need someone there at that time. But if you're at home three days a week, do you need to have your respite service at that time or your social support? So it's being creative within the expectations of both workers and clients, doing a whole lot of forecasting. We have a business analyst that has to analyse all of the requirements and looking at the process from on-boarding and bringing workers through the system.

MS MACRI: The other one that I'd be interested in just quickly is: when your staff are out in the community caring for a resident, are they at the same time tuned in to the capacity of the carer to continue coping, because a lot of the complex care around your EACH and your EACHD really requires a carer, and we're getting a lot of messages around carers often being under stress, not coping, with the care.

MS ADAMI (KCS): Yes.

MS MACRI: How do you manage those?

MS ADAMI (KCS): There's a number of mechanisms for assessing that. The careworkers, as definitely part of the packaged care, are in tune to that. As part of the care plan, there are strategies to look after the care recipient and the actual carer and what that means, so the staff are trained in that. They also have a feedback mechanism, where there are specific questions that the workers need to fill in - I think it's every fortnight - around the actual client and that's part of one of the questions, or that's one of that suite of questions. Also, our program managers or registered nurses go in regularly and review that aspect to the service. But, yes, that's typically the biggest issue that we've had, certainly, from when we've looked at feedback. It's typically the carer and the exhaustion and that support and managing when you've got a lot of workers in your home and a lot of things associated with looking after a loved one. Does that answer your question?

MS MACRI: Yes, it does. We're getting a lot of messages from carers about the increased expectations and their capacity to cope, so I'm just wondering about organisations, how they do that so that they're not just looking after the care recipient but they're ensuring that the carer, who's often elderly and pretty frail themselves, is also being assessed.

MS ADAMI (KCS): Yes. They're just as important because if they're not around and supported, the service won't work. So we've developed over the years in terms of engaging them much more in what they need; you know, how much communication they need. Some want a lot of communication about who's coming in and what time and other don't, so there are different expectations - so really understanding what their expectations and needs are and making sure that we deliver on that.

MS MACRI: And access to respite? What are your thoughts around that?

MS ADAMI (KCS): Yes, it plays a key role obviously.

MS MACRI: Good, bad or indifferent at the moment?

MS ADAMI (KCS): In terms of is it available?

MR WOODS: The quality?

MS MACRI: Is it available?

MR WOODS: How well does it work?

MS ADAMI (KCS): It works differently under different programs, so there are different programs that have different needs and entitlements. I think we've got a bit

more creative over the years in terms of how respite is done. Our service provides respite in the home. We don't have day service respite, different facilities. But certainly in making it meaningful, we've done a project looking at sensory stimulation so the respite can be enhanced, so it's not just a worker going in there. They're actually doing meaningful activities for the carer or for the client in terms of that.

MR WOODS: Do you have relationships with day centres - - -

MS ADAMI (KCS): Yes.

MR WOODS: - - - and with residential care facilities so that there can be overnight respite but that you're also sort of part of so that the care recipient and the carer don't have this fragmented, "Oh, if we need overnight we can't go through KinCare any more, we've got to go to X or Y"?

MS ADAMI (KCS): It's worked out depending on what package we have. Obviously under package care you provide a lot of case management, so you coordinate that. This is part of Sue's question about assessing the respite and assessing the respite needs that are required. So, yes, some clients do go off to day care, some have rest. Everyone is different. We have a live-in respite dementia program in a number of regions, which is, instead of the client with dementia going into a facility or a home, a careworker can go into their home for 24 hours and replace the role of the carer so that the carer can go on holidays and the person is maintained within their home, to not disrupt them.

MS MACRI: Within their home? Excellent.

MS ADAMI (KCS): That's funded through the National Respite for Carers program.

MR WOODS: Employing RNs and ENs: is that a big issue for you, and do RNs and ENs in a community care environment get paid a higher loading than those in resicare?

MS ADAMI (KCS): I'd have to look at this. Off the top of my head, I think that they're paid less than residential care. I'd have to go and look at certainly the awards. We don't have a large number of registered nurses. Our program managers are all allied health or nursing staff and they have community nurses that work within regions and see runs of clients.

MR WOODS: But do you have trouble recruiting sufficient - - -

MS ADAMI (KCS): It's about working what they would like. It's a flexible

environment. We don't have a lot of full-time nurses so it's again what I mentioned earlier about scheduling when would they like to work? I mean, depending on the nature of the service, it doesn't matter - if it's strictly an insulin that needs to be done at a certain time; but there is some variability in times and regions. Obviously if you've got volume, it's easier then; it's matching volume and demand. So if you've got volume you can then give attractive runs. Nurses have different work requirements in terms of what they need. Do they like a little bit of work? Is it substituting another job in terms of a career?

MR WOODS: Excellent. Thank you for your current and ongoing contributions to this inquiry.

MS ADAMI (KCS): Thank you for your time and all your work.

MR WOODS: For those who are present, I apologise for the heat; but if we put on the airconditioning, the noise is so loud that people can't hear. I apologise for the noise outside, but hopefully we've solved that and, as for the cheering, well, join in.

MS MACRI: That's the best we can do.

MR WOODS: So this room is fast disintegrating but while we are here, we will press on. I do apologise for the circumstances and I don't think we'll be using this facility again.

MR WOODS: Carers Queensland, if you could come forward, please.

MS COTTRELL (CQ): Good morning, my name is Debra Cottrell. I'm the chief executive for Carers Queensland.

MR WOODS: That answers the first question, thank you. Can I say thank you for what was a very early submission that you provided - you were one of the first people through the door with your initial submission - and then for your subsequent contribution based on our draft report. Both of those have been very helpful and add to our understanding of the situation facing carers, so we appreciate that. You no doubt have a statement you wish to make. Please proceed.

MS COTTRELL (CQ): I have. Just to inform people that Carers Queensland is the peak body that represents the diverse needs and interests of carers in Queensland and is dedicated to advancing the recognition of the carer's role. We promote the rights and needs of carers and a greater community understanding of the role of a carer. We also provide direct service provision through programs such as counselling, advocacy, a no-interest-loan scheme, carer support groups and retreats, information and guided referral. Carers Queensland also has specific programs for young carers, culturally and linguistically diverse carers and care recipients, and as a registered training organisation provides both accredited and non-accredited training specifically targeted to the learning needs of carers.

I don't have to tell the Productivity Commission about the fact that one in eight Australians are carers and that there are 2.6 million people across Australia that are currently caring. Over 90 per cent of carers in Australia are close family members of the person for whom they care. In June 2009, Queensland's population reached 4,407,000 people. 536,000 people are carers with an estimated 110,175 being primary carers. The replacement value of Queensland carers is an estimated $6.1 billion per year.

In regard to Indigenous carers, according to the Australian Bureau of Statistics' adjusted data from the 2006 census, Indigenous peoples number 507,200 or 2.3 per cent of the population. The state with the largest number of Indigenous people is New South Wales, with 28.7 per cent of the total Indigenous population, but Queensland isn't far behind. We have 28.3 per cent of the Indigenous population. And if we use the current carer ratio, that would result in 65,650 Indigenous carers in Queensland and approximately half of those are likely to be living in rural and remote areas.

Carers Queensland welcomes the report's recommendations relating to the needs of Aboriginal and Torres Strait Islander people, and specifically emphasise the need for assessment and services to be provided locally. It's very important for Aboriginal communities to relate and build up trust in their local communities.

Carers Queensland participated in the preparation of the submission by Carers Australia and supports all of the recommendations in that submission. I won't go through all those today. I know that Carers Australia representatives will be doing that with you. There were just two areas that have been raised as important by carers to me that I wanted to talk about today.

MR WOODS: Yes, please.

MS MACRI: Yes.

MS COTTRELL (CQ): The first one is about assessment and carers' inclusion in the assessment of the care recipient. A carer's knowledge of the care recipient is often not taken into account during assessment processes, particularly - it's been pointed out to me - by sometimes medical and mental health services. This is despite the fact that carers possess extensive knowledge and unique skills and expertise relating to the care recipient. Due to the carer's central role in providing care, carers are often the best source of information on the history, needs and resources of the care recipient. As such, the valuable knowledge possessed by the carer should be utilised during the assessment process.

A study commissioned by Carers Queensland in 2007 demonstrated the need for assessment and support pre discharge. Common experiences identified were disagreements about discharge options, with the carer being treated poorly as a result; premature release from hospital, resulting in negative outcomes for the carer and care recipient - that also could be compounded if a person in an aged care facility was taken to a hospital and returned; discharge being conducted in what they refer to as "a cavalier and ad hoc manner" without follow-through on discharge plans or at a time inconvenient to the carer, or in some cases without the carer being informed; and unrecognised impacts on the caring role. Many carers complain that patient confidentiality and privacy issues were used to frustrate their attempts to participate fully as part of the management teams of their loved one.

So we really support the role of carers in the care recipient assessment, but we also advocate strongly that carers have a right and needs of their own to comprehensive assessment. We support the inclusion of a comprehensive, holistic and nationally consistent assessment of carer needs. It is acknowledged that assessment of the carer is necessary to accurately determine whether the carer has the physical, psychological, emotional and financial capacity to effectively undertake the expected care functions, such as medicating, providing physiotherapy, bathing, feeding and transporting their care recipient.

This assessment will be able to inform what services may be required to ensure that the carer is properly supported in their role and that the care recipient receives appropriate care. Carer assessments need to address what the carer is willing to do

and for how long they are willing to do it, and the system needs to have the capacity to undertake regular reassessment of the carer's role, ability and willingness, because as the person they're looking after - in some cases in aged care - will deteriorate and the role becomes much more difficult, you need to be able to reassess them.

We were just talking recently about respite, and reports and discussions we have had with carers show that good respite provides a break from caring and is recognised as one of the most valuable services for carers, particularly when dealing with aged care recipients who may have dementia-related illnesses. Carers also talk about their need to have education and training, not only in the care that they're providing in their role but also in the future when they may choose to want to return to the workforce. Counselling is certainly a high need for carers, and it addresses the responsibility and difficulties sometimes associated with caring, such as making difficult decisions about a loved one going into care; struggling to come to terms with a loved one's long-term or sudden illness or disability; adjusting to the care situation and making decisions around nursing home replacement; and grief and loss.

Advocacy: many carers speak to me on the level of exhaustion that they feel from continuing to have to battle the aged care system and other systems to ensure the best possible services are provided to the care recipient, and they often need support in advocating on behalf of themselves and on behalf of their loved one. It was unclear, to my reading, in the draft report whether care assessment is contingent on the care recipient undergoing an assessment and/or the result of that assessment. Carers' needs can be related or separate to those of the care recipient, and their access to services and support must not depend on the willingness of the care recipient to have contact with the aged care system, nor should it depend on the eligibility of the care recipient for services in the aged care system.

MR WOODS: Yes, we probably should come back to that one when you've been through, because that does raise some tricky issues. So if I can just flag that as one that we'd like to come back to.

MS COTTRELL (CQ): Yes. Our recommendation is that individuals who are assessed as being able to care would not be obligated to do so; that carers' access to assessment services and support is not contingent on the care recipient; carer access can and will occur when required - for example, pre discharge; and care assessment will consider the capacity of carers across the life course.

The other one that I wanted to touch on was the mention about carer support centres in the report, because I see that they could have a major focus in undertaking the assessments of carers when they don't have that contact through the front end of the aged care system, or if they choose to be assessed in their own right by another organisation. We welcome the Productivity Commission's recommendation regarding carer support centres, and we noted that the Productivity Commission's

report into disability service supports a similar service development, so it was good to see some congruence there.

MR WOODS: One would hope so.

MS MACRI: It doesn't always happen.

MR WOODS: We do speak to ourselves.

MS COTTRELL (CQ): Carers Queensland believes that carer support centres need to provide a comprehensive carer assessment and guide-all referral process; provide a broad range of supports, including carer counselling, carer advocacy, peer support groups, education and training, respite, in-home support and advocacy; that they need to be adequately resourced to provide ongoing preventative support and assistance to carers, particularly during times of intensive care situations, rather than the current practice of focusing solely on the relief of stress and burden.

I gave an example there: I was with a group of carers recently and a lady was talking about how she had organised respite so that she could attend a work-related conference and just before she was due to go they rang and cancelled it, and she had had that experience every time she tried to pre-book care, but the other ladies in the group said, "No, you don't do that. You ring up and you say, 'I'm at my absolute wit's end. I'm in crisis,' and you'll get it like that," and I think that's a sad reflection of what carers have to do to get support.

MR WOODS: Yes.

MS COTTRELL (CQ): We believe that the centres need to provide support to carers regardless of whether the care recipient receives aged care service or is eligible for aged care services; that they be effectively linked with Medicare locals, local health networks, mental health services and other community and service providers; that they have demonstrated experience to deliver quality services and meet established service standards; demonstrate capacity to meet contractual obligations; and have the capacity and infrastructure to assess and deliver services in both metropolitan, rural and remote areas and in a culturally responsive way. I think the centres need to have that sort of focus and it needs to be spelled out in the report that they need to have the infrastructure and capacity to deliver services locally.

MS MACRI: Thank you.

MR WOODS: Thank you. We note then you go and elaborate a little further about Queensland-specific and the Indigenous and decentralised nature - - -

MS COTTRELL (CQ): Absolutely.

MR WOODS: - - - and we understand that fully.

MS COTTRELL (CQ): Yes.

MR WOODS: Even though we haven't for these hearings visited those regions, we have during consultations and at other times, so we are fully conversant with those issues. So if we can go back to this issue of carer support in its own right, rather than as a consequence of caring for an older person and that older person receiving or being assessed for their need for aged care services.

It is a slightly difficult area. There are generic carer services and support, allowances and the like. To what extent we try and deal with that through this inquiry, rather than more broadly, is something that we need to finally resolve. We understand the situation. We also understand that, if the carer is supported properly and has some training and access to skills and support and respite, that in fact may mean that the older person being cared for doesn't need additional services. So there's merit in that as well, by the carer being able to provide all of that service with the minimum of support, rather than having the older person necessarily receiving services in their own right.

So we understand the merits of that from both an individual situation facing the carer and the person being cared for, as well as from the point of view of the general taxpayer funding services. We take that on board and we will give further reflection to that in our final report, because there is a point, but whether this is the right window to deal with the broader generic issue of carers - we may be extending beyond our remit too far.

MS COTTRELL (CQ): I understand.

MR WOODS: So there's a balance in there lurking somewhere.

MS COTTRELL (CQ): Yes.

MR WOODS: But, Sue, do you have any comment more on that?

MS MACRI: No, not really.

MR WOODS: Where do you want to head then?

MS MACRI: Well, I just again talk about the assessment. I think the previous provider that was speaking was talking about the service they provide and the importance of assessing the carer as well as the care recipient going along. I'm just

wondering what the experience of carers is in terms of being in the community; whether they feel that assessment, through the care being provided to the care recipient, includes them or doesn't include them, or where they see the barriers to that. The other one on that, again, is just looking at when people are tied - it's around not just respite but, I guess, that socialisation for the carer as well.

MR WOODS: That ongoing engagement just in normal community activity.

MS MACRI: Yes, so that they can continue to engage even though they have the caring role, which seems to me to be a really critical coping mechanism.

MS COTTRELL (CQ): Yes, it is. On the first point, generally carers that I have discussed it with have said that if they're getting in-home services, the assessment for them is generally around their ability to undertake the care, not around those supports we talked about: their need for counselling and respite - well, respite a little bit, but not the counselling, the education and training or social part of it, mixing with other people that understand. It's generally around their ability to cope with the caring job that they're doing.

I've also seen some quite detrimental carer assessments that I don't think any of us would answer the questions to, because it really talks about, you know, "Do you feel you're at wits' end? Do you feel you're doing a good job? Are you about to break down?" I think anybody who ticked all the boxes would think they were probably going to lose the care of the person that they're caring for. So there are some concerns about the type of assessments that are out there. It really seems to be that they're trying to assess if a carer is at breaking point rather than put in preventative measures that would assist them to do their job. That's what I've heard from carers.

The social engagement aspect is really important. Many carers talk about social isolation, about thinking they're the only person, not knowing that there's help out there. The information and access is always a difficult one, because there is a lot of information around about what support is out there, but generally they are isolated and they don't have the information at the time they need it, or they're overwhelmed and they read it and then they don't remember it. So it's a difficult one, to make sure they're aware of services.

I was at a carers' consultation and one of the questions we were asking was around social life, and they just laugh. They don't have one as far as they're concerned. They don't have a social life. So that part of it really needs to be taken into consideration. Also, they've talked to me about matching respite activities for their care recipient. One lady had a son who loves the football, but the person who was there to take him on outings had no knowledge of football, didn't enjoy it, didn't want to go. It's about that. They wanted somebody who would share that with him.

So it's a lot about matching and what sort of social supports we can put in.

MR WOODS: Can I pick up that issue of who should be approved providers of respite. It comes particularly to the fore in rural, smaller communities where the providers may not be well represented but there is a strong social capital in the community, and neighbours know each other and have all lived there for years. Would you envisage that respite - I guess particularly emergency respite but maybe not only - could be provided by a broader range of people, that that might include neighbours or friends and that they would be considered part of the respite care delivery and therefore get paid whatever is the going rate? But, if so, would it need protections? Would they, because they are dealing with vulnerable people, have needed to pre-undergo a police check, some basic first aid training or something? What opportunities are there, and then what necessary checks and balances might need to be put in place to make it all happen properly?

MS COTTRELL (CQ): I think it's really difficult in rural areas, where you might only have one provider. Carers will take what they can get and they're too scared to make a complaint about a respite service they get, because they may be denied in future. So we need to put more funding into respite service provision.

I think what you're proposing could work on a similar model to our home day care system. We license people to do home day care and we trust them to look after our most vulnerable asset, our children, and there are checks and balances in place about how that works. I think we could do a similar model with respite, as long as those checks and balance similarly were put into place. The difficulty is for people who are looking after high-needs patients.

MR WOODS: Sure.

MS COTTRELL (CQ): Yes. There would have to be a range of what they could do, but we certainly need to look at a system where we can broaden it specifically in regional areas.

MR WOODS: Okay. Queensland is the perfect place to explore that model. If there is anything further, on reflection after this, that you would like to add, and what you would see as the opportunity for expanding the range of available providers, whether it would be particularly for emergency or whether also for plant - and why not? - whether it would have to be not inclusive of family, particularly family who live in the home and things, so that we're not just sort of, you know, turning - - -

MS COTTRELL (CQ): You're paying people - - -

MR WOODS: Yes.

MS COTTRELL (CQ): Sure.

MR WOODS: You understand the point.

MS COTTRELL (CQ): I do, yes.

MR WOODS: But also what are the minimum necessary checks and balances. That would be very helpful to us.

MS COTTRELL (CQ): Yes, we'll put some thought to that.

MR WOODS: Thank you. I know your national body is doing a bit, but Queensland is just the perfect sort of mind-set to understand how that could best work.

The other one is just a small point. You talk about being effectively linked with Medicare locals, local health networks and the like. It's probably just worth explaining briefly to you that we are conscious of the various health initiatives happening. We are trying to plan the aged care so that it operates in parallel, but until these initiatives in the health sector are actually (a) agreed, (b) up and running and (c) demonstrating that they're of value, we don't want to inhibit the development of the health reforms to be dependent on them. We're trying to create some, so that if all of this magically works and it's fabulous and in a few years' time you look at it, we would be able to easily merge the two. So we're conscious of them and we're not sort of trying to act in isolation, but we don't want to make the health reforms hostage to the fortunes of things that we have absolutely no control over.

MS COTTRELL (CQ): It's certainly a very interesting environment to be making recommendations on anything, because there's so much that's been reviewed and changed, isn't it?

MR WOODS: Yes. So we're monitoring them closely. We're trying to have arrangements so that in a few years you could just move into a seamless - but we don't want to do that just yet.

MS COTTRELL (CQ): Sure.

MR WOODS: Any other points you want to make?

MS COTTRELL (CQ): No. Just to thank you for your time.

MR WOODS: Thank you. That's been helpful and your submissions have certainly been very useful to us.

MR WOODS: If I could ask Mercy Aged Care Services to come forward, please. Thank you for coming. If you could, each of you individually, state your name, organisation you are representing and any position you may hold.

MR JARDINE (MAGS): Commissioner, I'm Peter Jardine. I'm the executive director of Mercy Aged Care Services.

MS SADLER (MAGS): Commissioner, I'm Kathie Sadler. I'm the chair of the board of Mercy Aged Care Services.

MR WOODS: Excellent. Thank you. We have your submission in response to our draft report and we're grateful for that, but do you want to take us through, please?

MR JARDINE (MAGS): Thank you, commissioner. Mercy Aged Care Services provides 191 residential and community care places in Brisbane. The service has a focus on integrated dementia care, care for people with intellectual disability who are ageing, palliative care, and care for people with complex clinical support needs. I'd say the service supports the commission's draft recommendations generally, and particularly relating to policy change based on maintenance of wellness and independence, person-centred care, economic efficiency and enhanced consumer choice and control. We also welcome the recognition of the higher care funding needs of palliative care, of care for people with a disability who are ageing, and for people with complex clinical and mental health conditions.

The service has a high ratio of supported residents and is concerned that choice of accommodation and care options are enhanced for people who are socially disadvantaged. Shared accommodation is generally not appropriate for many of this group who may have complex care needs, including challenging behaviours that require a higher level of care, emotional support and privacy. We see the barriers to choice for this group in two areas: one is a lower accommodation supplement, and the second is inadequacy of advocacy for this group, particularly people who are mentally ill, have a disability or are socially isolated.

Our suggestions to the commission in relation to this group is that (1) a role of the proposed Seniors Gateway Agency be to enhance independent advocacy services for people who are socially disadvantaged, particularly people in the public health system, which is a key exit point for people entering aged care from this group. Second, in conjunction with a gradual transition to a higher supported resident accommodation supplement, that the government review the eligibility criteria for this particular supplement and for supported resident status. The Australian government supported resident contribution for residential care accommodation should gradually increase to reflect the average cost of providing accommodation on the basis of a single room with ensuite.

Finally, we would support the continuation of regional supported resident ratios; that these be not transferable. We believe the transfer of supported resident quotas or tendering arrangements would limit the options and range of choice for people who are financially disadvantaged. Finally, the commission has asked for participant views on accommodation subsidy in relation to the standard of accommodation. I think that was on page 176. My personal view is that the pricing of accommodation for a continuing business is the present value or the future replacement cost, not the historical cost, and the accommodation subsidy should be the same for all accommodation and if supported residents have real choices and strong advocacy they will not need to accept below-average accommodation and providers will be compelled to upgrade below-standard accommodation to remain competitive.

MR WOODS: Thank you. Can I just get a little bit more background on Mercy Aged Care Services. You mentioned the number of licences and packages, but can you just give us the split of exactly what your profile looks like.

MR JARDINE (MAGS): We have 166 residential care places and 25 community care packages.

MR WOODS: Have you applied for other CACPs and not got them? I mean, is this meeting your need on the community side or would you see that if these reforms go ahead and that you were a provider of community care, that you would in fact expand that side of the business?

MR JARDINE (MAGS): Our aim as a service is to provide continuity through a range of care options, so we would consider expanding our community care program and - - -

MR WOODS: Do you run ILUs or other accommodation?

MR JARDINE (MAGS): We don't, no, not at the moment.

MR WOODS: And your 166 beds, is that in two or three facilities?

MR JARDINE (MAGS): That's in three facilities.

MS MACRI: I notice you talk about the socially disadvantaged and homeless, so do you have any specific facilities for homeless or do you have hubs or are they - - -

MR WOODS: Clusters or - - -

MR JARDINE (MAGS): We don't specifically for homeless. We focus on people

with an intellectual disability who are ageing. We try to accommodate those in a range of service options. We do have one small facility which is specifically focused on that group, and also that group - - -

MR WOODS: On the intellectually disabled group.

MR JARDINE (MAGS): Yes. And that group also integrate with our mainstream aged care so that, depending on what the needs of that resident group are, the two options are available.

MR WOODS: And the number of supported or concessional - however one wants to describe it?

MR JARDINE (MAGS): The ratio at the moment is around 52 per cent.

MR WOODS: And for the others, are they primarily high care or do you offer extra service?

MR JARDINE (MAGS): We do have extra service and I guess our extra service cross-subsidises the concessional resident numbers.

MS MACRI: How many extra services? Is that a facility or a wing of a - - -

MR JARDINE (MAGS): We have 37 extra service places.

MR WOODS: As part of the 166, yes.

MS MACRI: Is that a nursing home in itself or is it an extra service wing?

MR JARDINE (MAGS): It's actually two wings of a nursing home.

MS MACRI: Two wings of the service.

MR WOODS: Okay. That just helps us understand some of these issues. In terms of the supported accommodation payment, we're proposing - and there's a debate about what standard that should be and we understand that and we hear your views on what it should be, so I don't know that we need to rehearse that particular part of it. You're very clear there. But we envisage that it would be the one payment for the accommodation based on those facilities that meet that standard. There are some very old facilities around and there are still three-bed wards and the like. Well, we wouldn't envisage that the new payment apply to those: they're basically written-off capital and they're just a source of cash flow.

But certainly for new facilities or facilities that meet whatever the standard

finally aims to be, we envisage a transparent assessment process that reflects the actual cost of capital, and your point about the discounted cash flow, et cetera, we understand. But you do, as I recall, talk about a sort of group that are somewhere between the supported residents and those who have high wealth and/or income and can look after themselves. So what do you have in mind there? Could you go through that vision a little?

MR JARDINE (MAGS): I guess with a gradual increase in the supported resident accommodation supplement, if the government were to review the criteria for that particular category. At the moment it covers people who are financially disadvantaged.

MR WOODS: Yes.

MR JARDINE (MAGS): It also covers people who have an exemption for the family home because a spouse or a carer resides in the home.

MR WOODS: Yes.

MR JARDINE (MAGS): I think they're two quite different groups and both groups need protection and perhaps government support, but the latter group, I think, could be seen as a different group in terms of the way the capacity to co-contribute to the accommodation charge is determined, and particularly if the government introduces the equity release scheme that the commission has talked about; that there is then a capacity for the government on a budgetary basis to increase the supported resident supplement to a higher level than otherwise would be possible.

MR WOODS: For all groups? So are you saying that if there's some freeing-up of budgetary capacity it should be paying the supported resident accommodation component over and above the transparently assessed cost of delivering that accommodation?

MR JARDINE (MAGS): Well, I - - -

MR WOODS: Or are you just worried that the price paid may not actually refer the - - -

MR JARDINE (MAGS): Yes. I guess it's really trying to free up some budgetary capacity to get that standard accommodation payment up to a single-room standard.

MR WOODS: Okay, that clarifies that. I understand it. I think that picked up my - - -

MS MACRI: Just the regional supported resident and non-transferable - do you

want to tell us your thoughts around that and why you don't think that within a region - - -

MR JARDINE (MAGS): I guess the issues are that I think people who are in the supported resident category should have a wide range of choice. That choice shouldn't be limited by the particular facility type. I think if there is a review of the criteria for the supported resident status that group will come down to a smaller percentage and it shouldn't be a burden for providers to provide for that particular group. I also think that if the accommodation supplement moves closer to a single-room standard then supported residents will be as attractive to providers as non-supported residents, so there shouldn't really be a need to try to transfer the quotas. I guess as a provider of a service with a high supported resident ratio, I can't see any incentive for us to negotiate to increase our ratio by purchasing or having a transfer of places from another provider.

MS MACRI: In terms of that and being an extra service provider, and whilst you have a facility that I would assume is two wings extra service and one not, which is a combined model and lots of providers have gone down that track - but on the same hand there are providers that have just decided to be extra service facility in its own right - would you see that facility not being in a position or not being able to perhaps trade the supported residents because it's deemed to want to operate in the high-end market? Your thoughts around that?

MR JARDINE (MAGS): I would really prefer to see a situation where providers are not penalised if they bring concessional residents into an extra service place.

MR WOODS: Agree with the not penalising. It's whether people can then pick market segments over and above that baseline that meets the cost. So we agree with you that you shouldn't be penalised at the bottom end; that the price should be sufficient to meet the delivery of that accommodation, putting aside the care.

MR JARDINE (MAGS): I guess I'm reflecting, too, on the fact that the Commonwealth won't pay the supported resident supplement if someone comes into an extra service place.

MS MACRI: That's right, yes.

MR JARDINE (MAGS): Our philosophy is that we assess people based on need, and quite often people will come into an extra service place and we have to forgo the supported resident supplement.

MS MACRI: Yes.

MR JARDINE (MAGS): That shouldn't really occur.

MR WOODS: No.

MS MACRI: No, and we agree with that.

MR WOODS: And under our reforms all that gets washed away. You don't have extra service, you don't have high and low. You provide accommodation and you deliver care, and hopefully that will meet your requirements more flexibly. I take it that there is broad support for the architecture of what we're proposing.

MR JARDINE (MAGS): Yes, I think the issue of advocacy for that group is important because choice is really about having equal financial support, but also members in this group often - particularly if they don't have capacity - don't have choice because of lack of advocacy, and I think it would be reasonably straightforward to build that into one of the new agency's roles to ensure that advocacy, and independent advocacy, is there.

MR WOODS: We have proposed in the draft report that there be strengthened advocacy services and that it be independently funded to make sure that it isn't confused with provider requirements or the like; that it is there specifically for the individuals and to be available to them to help them understand the choices and to make the most appropriate decisions.

MS SADLER (MAGS): Can I just ask on that point: is that going to assist people, who at the moment are sort of stuck in the hospital, with their advocacy choices so that they can then transition into perhaps more appropriate aged care? Is that how you see the advocacy?

MR WOODS: They certainly have a need for that advocacy. We haven't spelt out that role in great detail and there starts to become a question about whether we enter our level of less competence by going further and further down the detail chain, but we'll take that on board as to whether we should try and design down to that level, but certainly it's an important point.

MS MACRI: Can I just ask you, in terms of your 25 CACPs, are they utilised just within your local community - would be the first question - and then, secondly, when care needs increase are you continuing to retain those people and overservice in terms of your funding or - - -

MR WOODS: Flexibly interpreting the package.

MS MACRI: Flexibly interpreting the package, or then having to move them on, and how you go about that?

MR JARDINE (MAGS): That definitely does happen, so you tend to try to support ageing in place as far as possible. The care demands of clients increase. We try to provide continuity in terms of people who need residential care moving and having priority in terms of entry into our facilities, but I think it's certainly the case that in community care you extend the package to meet the requirements of the client.

MS MACRI: And what about then if they need an EACH or an EACHD? Do you have a partnership or a relationship with another provider? And I would assume you would see that the recommendations that we've made around providers being able to go through the building block and continue that care would be an advantage for people such as yourself.

MR JARDINE (MAGS): We don't have any partnership arrangements. If that situation occurred, we would look at brokering in a service or referring the client to another service provider.

MR WOODS: Even though you might then pick them up later in your facility. So that you're delivering community care; they might have to go to a different provider if they still want to remain and can remain in the community but get high-level care, and then you - well, hopefully we can make all that go away.

MS MACRI: Yes.

MR JARDINE (MAGS): I guess the experience is that it's not a staged transition always, particularly for people who don't have a live-in carer. Each is really very dependent on - - -

MR WOODS: Absolutely.

MS MACRI: Absolutely.

MR WOODS: And you deal with a lot of clients who are living singly without carer support?

MR JARDINE (MAGS): Yes.

MR WOODS: So there's a fairly quick transition from going from CACP into needing residential - - -

MR JARDINE (MAGS): Exactly.

MR WOODS: Because there isn't that home based support.

MS MACRI: Carer support.

MR JARDINE (MAGS): Yes.

MR WOODS: Yes, I understand that. Anything else?

MS MACRI: Are you doing any work with the homeless?

MR JARDINE (MAGS): I guess in terms of people with an intellectual disability who are ageing, there's a group who are at risk of homelessness.

MS MACRI: Right.

MR JARDINE (MAGS): Our further program development I guess will explore how we respond to that group. We haven't at this stage targeted homelessness as a specific area.

MS SADLER (MAGS): Can I just expand on that? In another capacity I actually do pro bono work for a homeless charity and I had talks with them about how we could actually move this along because they're seeing a need in their community for care, but often with people who are migrants; and that's why I was so interested about the advocacy; somebody who can help people who are in that situation, then actually understand what their care needs are and what their choices are. So that's in its infancy. It's really been a few discussions that I've had and that's something that I'd like, certainly on a personal level, to look at further.

MR WOODS: If you have any further thoughts that you want to expand on, please, as long as it's in a timely manner, we would appreciate - given that you have that particular perspective of understanding both the CALD community perspective and the mentally ill and others, there are some nexus there that would be very helpful to understand.

MS MACRI: Yes. All right, I haven't got anything else.

MR WOODS: Anything else that you want to bring to our attention?

MR JARDINE (MAGS): Thank you.

MS MACRI: Thank you for your time.

MR WOODS: Excellent. Thank you; very helpful.

MR WOODS: Robert Jeremy. Please, could you state your name and any organisation that you may be representing.

MR JEREMY: My name is Robert Jeremy and I'm here as a private individual. I don't represent any group in this context, but I will say that I have been listening to what goes on in several aged care facilities by a woman who works as an AIN, night shift - she worked in three, to my knowledge - and I have been trying to find her another place to go to, to work in, where these things don't happen.

The essence of my submission is that I'm requesting that this inquiry recommends that the responsibility for the operation and management of aged care facilities, wherever possible, devolves upon the community, the local community, and that is because of my coming into contact with people at Cabanda in Rosewood, which is run by a committee drawn from the community. They've had their ups and downs, but you can tell, immediately you walk in there, the whole atmosphere is different than anywhere else that I've ever been into. I can't give you any information on why it is so well run because I've only fairly recently been involved - and in any case a lot of those people don't like people asking questions unless they're officials. I think you have a copy of my summary of everything that goes wrong?

MR WOODS: Yes.

MR JEREMY: I don't wish to expand on those. There are about eight or nine items.

MR WOODS: Yes, we have that list, thank you.

MR JEREMY: All been documented fully in the last, I don't know what it is, 10 years or so. So unless you have any questions, that's really all I wanted to do.

MR WOODS: You have provided us with a list and it relates to staff numbers and food and accreditation and management issues and the like. Are there any in particular there that you want to draw to our attention, or are you happy that we have this list and therefore we can take it on board?

MR JEREMY: I think they're all important, but I think one of the worst features of nearly all aged care facilities is that many of the nursing staff can't speak English and they can't understand English, so they can't communicate properly with the residents, and the residents know this and do not like it.

MR WOODS: I noticed that was one of your points, yes. The other one on which I'd be interested in your views are the problems with the complaints procedures. Is there a particular experience or history behind that point that you want to draw to our attention?

MR JEREMY: Yes. In the current place in which this woman that I know works, she has found that if she makes complaints nothing happens. They're either put into the too-hard basket or - I don't know. It's pretty hard to find out from her what actually happens to them.

MR WOODS: And she's a member of the staff?

MR JEREMY: She's a member of the staff, yes.

MR WOODS: Okay.

MR JEREMY: She's an AIN.

MR WOODS: Yes.

MR JEREMY: Very, very hardworking and carries a lot of weight in that place. I term it abuse of staff, because in the end the weight of running the place, doing the day-to-day work there, in this case rests on the shoulders of about three people, and this is known throughout the facility but nothing gets done about it.

MS MACRI: Does she understand there is an external complaints mechanism, if things don't - - -

MR JEREMY: No, I think she may be aware of it, but she is absolutely terrified of identifying herself in any way. She won't talk to the press. She'd be horrified if I mentioned her name - - -

MS MACRI: No, don't do that.

MR WOODS: No, we're not asking for that.

MS MACRI: We don't want that.

MR JEREMY: There's no need to.

MR WOODS: No.

MS MACRI: No. Through the complaints, there are internal and external mechanisms, and we're just asking that - - -

MR JEREMY: As well as being terrified of losing her job if her name is associated with anything like that, she also has very little faith that anything will be done in this industry.

MS MACRI: Right.

MR WOODS: Okay. Anything else?

MS MACRI: No.

MR WOODS: Is there anything else that you wish to raise with us?

MR JEREMY: No, not really.

MR WOODS: No? Well, we have your list and now we have you having coming forward. So thank you very much for your participation.

MR JEREMY: Thank you.

MS MACRI: Thank you.

MR WOODS: We will adjourn until 2 o'clock.

(Luncheon adjournment)

MR WOODS: Could I invite each of you separately to identify yourselves: your name, the organisation you are representing and any position you hold, please.

MR DE BRENNI (UV): My name is Mick De Brenni, assistant secretary, United Voice, Queensland branch.

MS ANDERSON (UV): My name is Kerri Anderson. Today I'm representing the Aged Care Committee, the United Voice.

MS JACKSON (UV): My name is Heather Jackson. I'm representing United Voice for the aged care sector.

MR WOODS: Very good. I am getting used to calling you United Voice, but it's taken a little while.

MS JACKSON (UV): Yes, it's taking a while.

MR WOODS: But we're getting there. We do have strong engagement with your national organisation and put on record how helpful they have been, and we've had a number of discussions and submissions, so that's all been very, very useful. Do you have an opening statement you wish to make?

MR DE BRENNI (UV): Thank you, Mr Woods, I do. We want to thank you initially for the opportunity to provide this further evidence to this inquiry. United Voice, formerly LHMU, represents approximately 70 per cent of the aged care workforce Australia-wide. We represent personal carers, support staff and, in some states, enrolled nurses. It's our view that no other union has the breadth and depth of coverage in this sector than United Voice and it's for this reason we feel obligated to come here today and ensure that this inquiry understands what we understand about the provision of quality care in our country.

United Voice represents 130,000 workers across Australia. That represents around 130,000 households, and if on average each of those households has a link to two or three older Australians, our members have a reasonably representative view about the care that is provided to over a quarter of a million older Australians. That's a very large proportion of the Australians that are in care.

It's for those reasons, as representatives of workers in aged care and representatives of workers who are currently or who will at some time consume aged care, that we come here today to share what we know about the industry. We do this because, for us, this inquiry has the chance to significantly reform a sector that we feel is in significant trouble.

The commission has recognised that the system is flawed on many levels and

the commission has also recognised that the system will be further challenged by an increase in the numbers and expectations of older people, and a relatively high number of informal carers and a need for a larger workforce.

Members of United Voice, including those we represent and those that are here with me today, join with the commission in calling for a new system that promotes and delivers high-quality care. As you're well aware, a key element of the commission's inquiry was to systematically examine the future workforce requirements of the aged care sector, taking into account factors influencing both the supply and demand for the aged care workforce, and develop options to ensure that the sector has a sufficient and appropriately trained workforce.

Today, commissioner, two aged care workers with significant industry experience will talk about quality aged care. They will tell you why they struggle every day to provide that care. They will explain why the market based system that operates in respect of wages means they struggle to deliver quality aged care. They will talk about why their colleagues are leaving the sector for better-paid jobs. They will also tell you why young workers they know will choose a job anywhere but in aged care, and, if they do choose aged care, why they last just weeks or months. They will tell you what they need in order to provide quality care to vulnerable older Australians.

Nearly two years ago United Voice initiated the Fair Share for Aged Care campaign. The campaign slogan was four simple words: better wages, better care. The campaign got aged care workers together to fight for a fair share for aged care. A Fair Share for Aged Care meant thousands of workers campaigning across Australia to get the government to prioritise the industry and urge employers to work with us on the solutions for quality. United Voice recognises the Productivity Commission's inquiry into older Australians is part of the government's response, recognising and prioritising our industry.

Quality care can only be provided through a workforce earning professional wages under manageable conditions. Poor wages and increasing workloads are putting pressure on staff, placing unnecessary impediments to the delivery of quality care and quality lifestyle for residents and clients. We think that it's important that this inquiry finds that quality is intrinsically linked to working conditions. Two years ago, in a publication we wrote then as the LHMU - and I quote:

> ... nobody can deny that there is a crisis in our industry. So far, none of the employer reports or government inquiries have done anything to fix the crisis. It's us who have to deal with the problems on a daily basis, and it's us who know what the solutions are, it's us who employers need to work with and politicians need to listen to.

It's our view that employers are starting to listen and so are the politicians, and we know that the politicians are listening to the Productivity Commission. That's why we're here today, so that you can share our message that well-remunerated workers make an impact on quality care.

Well-paid workers build trust with residents and clients. Workers who are underpaid and overworked can't find the time to do all of the work they want to do; a stable workforce, through a strong retention approach, delivers continuity of care; and current inadequate funding means that workers' wages are the first target for providers in cutting costs.

I want to introduce you now to two members of United Voice. These aged care workers are ambassadors for the United Voice Fair Share for Aged Care campaign. Speaking first today will be Kerri Anderson, a residential aged care worker, and she will be followed by Heather Jackson, a community care worker. So I'll hand over to Kerri.

MS ANDERSON (UV): Thank you, Michael. Good afternoon, ladies and gentlemen. I'm, again, Kerri Anderson. I work in residential aged care for Blue Care. I have been in this role for six years. What started out as a low-care facility, with the ethic of ageing in place has quite rapidly become a medium to high-care facility.

In my day-to-day role I take care of residents' personal hygiene needs - their showering, toileting, grooming, et cetera. In a lot of cases I feed these residents or assist them down to the dining room, which quite often requires you to hoist somebody into a wheelchair, move them down to the dining room, and the whole situation in reverse to go back of an evening. On these shifts there are two personal care workers taking care of 42 residents. The average age of the staff where I work is 50 years old, so it takes a toll on us physically.

Apart from our allotted daily tasks - apart from feeding, there are a lot of clinical skills that we're meant to employ, like wound dressing, taking care of skin integrity, assisting with medications, blood pressure, neural observations. We have to answer buzzers, and some days you're flat out doing nothing but the most immediate tasks. It is forcing people out of the industry. As I said, most of us are older, women in particular. The workload is phenomenal.

When we undertake training we are urged by our trainers to do a professional job. We strive to do a professional job. We're proud of the job we do, and the people that stay in the industry do it simply because they love the job. We stay because - we spend more time with these people than we do with our own families. We want to provide good-quality care and continuity of care, but people are leaving the industry.

One lady I worked with, 12 years she worked in the same facility, but the physical toll that the job was taking on her and the rewards that she was not getting financially for the hours given - and keeping in mind that it's largely shift work. You give up your social time and your family time in order to do this job, and get paid $17 an hour in some cases. This lady left after 12 years to take a job in a retail outlet, and this is happening more and more often. We are finding it difficult, if not impossible, to attract young people to the industry for just that reason. Why would they give up their social time and bother to learn the skills that are required to do our job professionally for $17 an hour? Funding and professional rates of pay are linked with quality care.

Blue Care has got a great reputation, and for a good reason. I am proud to work for Blue Care, but their funding is linked to our pay, and unless funding keeps pace with the required needs in the residential facility, we're going to find it more and more difficult to keep people on. The workloads are tremendous and the incentives to stay just aren't there.

MR WOODS: Thank you.

MS JACKSON (UV): Hi, ladies and gentlemen. My name is Heather Jackson. I work on the other vast triple side of the sector. I work in the community where I help people to stop in their homes, and what a rewarding job that is. I've worked in the industry for around 16 years and my day-to-day role is quite extreme. When I put it down on paper it's quite extraordinary what we need to do in a 10-minute to a half an hour run to an hour and a half run, as in assisting medication, your showering, your mopping. We've got the arthritic ones where we have to prep their breakfasts and do a shopping list for them, or might escort them shopping or escort them to appointments they need to be at; respite care, extended care packages and dementia as well.

See, in my sector we have community care packages that I'm under, extended care packages and extended care dementia, and I'm finding in the last five years it has really tripled. The volume of care and the volume of packages that are coming into the community is quite huge. I started 16 years ago when there were 19 packages and on the Brisbane North side we're just about to get to 160.

MR WOODS: And it will only increase.

MS JACKSON (UV): Absolutely, and the community is one of those - governments can't keep building facilities. They haven't got enough land to keep doing this and the older Australians really would like to stop in their homes, so that puts a lot more pressure on the quality. I mean Blue Care try very hard - and I'm sure other sectors try to as well - but it comes back to funding. It comes back to funding

so that we get better quality staff, better trained-up staff. The workloads are absolutely - they really have tenfolded.

I'm seriously saying in the last two years our aged sector in the community is between 40 and 75. We have a 75-year-old worker out there working because the market crashed, as we know, 18 months ago and of course a lot of their money went, so she said, "Oh my God, I've got to go back to work." Now, she did a certificate III. We do the qualities, we do the competencies every year to keep our skills up. Another one is the rotation of staff: like, we'll interview 50 people over a matter of one month. We are lucky to get six quality people out of that. They might come and do a shift with me and they go, "Oh my God, Heather, 16 or 17 dollars an hour?" I can go to retail, as Kerri said, and get $22 an hour. I would like to stop in this field but I've got a family to feed. I can't afford to live on 540 bucks a week.

And why we can't give the ability to give quality care is because of the time that they give. The community care package is five and a half hours a week. The extended care package is 12 to 18 hours a week and in some of that time the prime carer would like time out, so we go in for three or four hours so they can go and see a movie or go and do whatever they want to do. It's not much because the rest of the time is taken up with - we have a hospital situation in people's homes. The hospital bed is there, the hoists are there.

I have to double-up with the carers, so we have to look at our list and go, "Well, I've got to meet this carer at 8 o'clock," and the traffic is tenfold. The rostering people are trying to think, "Well, yes, we can get there, get there, get there," but they lose sight too that we're out there every day. If you travel around to Stafford and all that area where they're doing the tunnels and that airport link, and Kedron and that area, it's stress on driving and stress on the job and your workloads. Your workloads really have tenfolded, even in the community.

As you said, Mr Woods, it's going to get worse and the stats are out there. People want to stop in their homes a lot, lot longer and these older Australians, they deserve the best quality of care. After the world wars they built this country, they built the railways, built the houses, divided the land. You know, they deserve better care and that comes through for more funding so that they can get better training, better quality people out there because the younger generation coming up behind me are just not getting it. It's going to really fall back on the families that, "Oh no, I don't want to look after mum and dad. I want to put them in." You know, they have the right to stop in their home, and that's where the community workers come in.

We deserve that higher rate of pay. We earn every cent that we go out there every day and do what we do, day in and day out, and we do shifts like 6.00 till 2.30, 2.30 to 8 o'clock, and the respite workers might do an overnight shift and, truly, the call-out call is 25 bucks for a personal carer and a registered nurse gets 150. That's

extraordinary and we are just as important out there in the community and in residential, and I can't stress enough that I hope that something comes of this commission today; that someone like Kerri and I have come forward and been able to speak so you can hear from the hard core, you can hear it from people out there who are actually doing what we are doing.

MR WOODS: We're very grateful that you have made the time and the effort to come. Perhaps while we have you, there are a few things we wouldn't mind getting your expert advice on, but just one small matter on the remuneration first. We do understand your situation but, presumably, there are different enterprise agreements with different providers and $17 would be sort of the base pay.

MS JACKSON (UV): It is.

MR WOODS: What would be the top end? Are we talking $21.

MS ANDERSON (UV): No, it's $19 an hour.

MR WOODS: 19 is the top in Queensland?

MR DE BRENNI (UV): Yes.

MR WOODS: Okay. Different states have achieved different outcomes. That's not a very big range.

MR DE BRENNI (UV): I'll just add to that. The agreement under which Kerri and Heather work also provides for an allowance that was devised, called the direct care allowance, which sought to provide some further incentive for retention of staff. The employer wrote to staff and their union late last year and advised that they were unable to meet their commitments in relation to that direct care allowance.

MR WOODS: Roughly what quantum was that, without identifying the employer who's already just been on record?

MR DE BRENNI (UV): The quantum of that exceeded $100 a fortnight. That was promised as an allowance to workers to retain them within the employer, within the sector, but they are unable to meet that.

MR WOODS: Okay, so 17 to 19 is the sort of range.

MR DE BRENNI (UV): Yes.

MR WOODS: The issue of training you've talked about, and the professionalism of your career. What would be your views on the quality of the content of the cert III

and on the delivery of the cert III by various RTOs?

MS ANDERSON (UV): There's definite room for improvement. I think the quality could stand to be quite considerably higher.

MR WOODS: On the content or on the delivery?

MS ANDERSON (UV): A bit of both.

MR WOODS: If we can differentiate the two, if we can deal with content first, is it appropriate? Does it need upgrading? Does it reflect the difference between - - -

MS ANDERSON (UV): It probably could stand upgrading. To be fair, as I said, most of the people that come in, especially residents - and I can only speak for the residential side of it, but by the time people come into residential aged care their needs are much higher and I don't think those kinds of needs are addressed in the current certificate model.

MR WOODS: Is the union movement sort of pushing to get the content changed to reflect the realities? As you said, what used to be a low-care facility is now moving up.

MS JACKSON (UV): Exactly.

MR WOODS: And it will only go up further. The more care you can provide in the community, the higher the acuity of those that you're dealing with.

MS JACKSON (UV): They're leaving their homes at high care and going into extended high care.

MS ANDERSON (UV): Yes. So it is my belief that the union has always pushed for quality training for staff. If we're trying to get professional rates of pay, we want that reflected in the skills that we achieve.

MR DE BRENNI (UV): I think it would bear comment that, again, Kerri and Heather's employer conducts what we would consider to be at the top end of the quality content for that certificate. There are a plethora of providers, registered training organisers, that are predominantly at the low end of the quality of content scale and it would be fair to say that the provision of that training around that qualification is somewhat out of control.

MR WOODS: Again, it's not in your interest to have your members or the workforce generally getting service from a dodgy - to use that technical term - RTO who is, you know, providing the bare minimum of training.

MR DE BRENNI (UV): Absolutely not and, clearly, if the bare minimum is provided, then the bare minimum of quality transfers onto residents and clients. As Kerri and Heather have both mentioned, workers remain in this industry with a view to providing a high level of quality to residents and clients. They don't stay for the money, so clearly do have a view to improving the nature of that content and the way and manner in which it's delivered.

MR WOODS: For community care workers as well, the same views?

MS JACKSON (UV): Yes, absolutely. Older Australians deserve good-quality care and the funding to go into training as well as wages; I can't stress it enough, Mr Woods. Governments need to really look at aged care and put a big bundle in there for aged care, instead of just for allied health.

MR WOODS: Okay. Another area I wouldn't mind your views on, given that you are at the coalface, is the proposals in our draft report to break open the packages. At the moment we have HACC programs, the CACPs and EACH and EACHD as you mentioned, but instead people would get assessed according to their needs and the services would be drawn from a building block approach - so some of this service, some of that service. You wouldn't have to change provider if you had to go from a CACP to an EACH but that provider didn't have EACH packages. You would just extend the intensity or duration or nature of the services. From your perspective as a professional in the area, do you see that that's the right way to go in terms of reforming, particularly on the community care side?

MS JACKSON (UV): I believe it's just one pool where they could go.

MR WOODS: Yes.

MS JACKSON (UV): It's like Centrelink. They go in there - - -

MR WOODS: Yes. They go to the Gateway, they get assessed for their needs.

MS JACKSON (UV): They go to the Gateway and they get assessed. I mean, the better providers out there will always come shining through, so I don't believe that someone or the company, the provider that we work for, will suffer greatly, because they have a great name out there, and the same with three or four other sectors that are out there. Yes, it will certainly give the clients, the clientele, a better overview of what care they would need in that sector.

MR DE BRENNI (UV): It would certainly address a continuity issue. They would have one, or a lower number of carers, providing service to that individual client and, from the anecdotal evidence, the people that Kerri and Heather work with, their

clients, would prefer to have less staff coming into their homes or into their facility in a residential setting, rather than more.

MR WOODS: Yes. We come across constantly situations where an older person will have a provider and they will be coming and doing daily showering and dressing and support in a whole range of areas, but then if the carer needs support for a period, often they won't be able to use the same provider, and so you've got two careworkers coming into the one place and all of that. We've just got to try and wash away those sorts of situations.

MR DE BRENNI (UV): The challenge with going to that scenario of having a broader variety of services delivered by one carer is going to require them to gain more experience and a broader set of skills.

MR WOODS: Absolutely.

MS MACRI: Yes.

MR DE BRENNI (UV): And I think that it's going to be very, very difficult to build that cache of skills and experience with aged care workers that aren't staying in the industry for a long time because the pay is so low. If we're going to increase the level of skills that they have, it's going to be hopefully around quality qualifications, long-term experience within the sector. That's going to rely on fair wages and conditions, and at the moment the evidence that we see is that workers in the marketplace don't consider the current regime, in terms of wages and conditions, to be fair.

MR WOODS: A number of careworkers - putting aside the wages, and I know you don't want to, but just for this bit of discussion - - -

MR DE BRENNI (UV): Sure.

MR WOODS: - - - want to remain in that role, but there are others who look to moving progressively up through a cert IV and becoming an EN or div 2 - however they're described here in Queensland. Do you find much of that migration from one skill base to the next skill base, and is it easy enough for people to do it or are there barriers that should be looked at?

MS ANDERSON (UV): You see that on two levels, I've noticed at work. The young people that we do manage to attract are there just to do their hours until they go through their nursing qualifications and then they leave the PC work. At the other end are people that are getting onto 55, 60, that want to stay within the industry but no longer physically feel that they can continue the job. We're fortunate with Blue Care. They offer scholarships up to that end all the time, to become EENs, but it's

the only way some of the older workers can stay within the industry and keep doing a job that they love but in a different capacity.

MS JACKSON (UV): Yes, we find that in community too. Blue Care have the same - in community, some of the PCs on the road, when they get to that 50, 55 mark, they think, "I can't keep running around in that car any more," with demands on the job of doing at least 10 people a day in an eight-hour day, so they go for the scholarships to go for the EEN, so it just sort of gets that little bit of pressure off them to be off the road a little bit more, because when they do take on that task, they don't do the escorting, they don't do what the PCs do. Their job description is just as important but it's more specified as in like doing needles and things like that.

MR WOODS: Yes, we understand that. Sue.

MS MACRI: I've got a couple of questions. Can I just ask: qualifications with PCs, ENs - - -

MS JACKSON (UV): I'm a personal care worker with a cert III.

MS MACRI: Great.

MS ANDERSON (UV): Same with me.

MS MACRI: And the same with you. I guess this might be for Michael to answer, but it might be comments from both of you as well, just in terms of this workforce and the upskilling and all of that, which is going to be required, there's absolutely no doubt, as the acuity increases. There have been calls from not only other unions but also random submissions that we've received around the licensing and regulation of PCWs and PCAs and AINs and that third-tier workforce. I'd like your thoughts around that and, furthermore, the impact that that could or would have on the workforce going forward.

MR DE BRENNI (UV): I think in two parts I'll answer that question: the first one about increasing the scope and qualifications and the quality that that's able to provide. There's no doubt that, should reform in this sector lead to jobs that require more skills and therefore delivering a higher level of care, if that's able to be linked with appropriate remuneration, the workforce is going to embrace that. New workers to the industry and young workers will embrace the concepts of a well-recognised - and the professional nature of that - workforce because of the wages and conditions that would go with that.

In respect of licensing and regulation, the impacts of that in my view wouldn't lead to changes in and of themselves in the provision of quality care, wouldn't address issues of attraction or retention to the sector without those other

fundamentals being addressed first. So I guess my position is that that's a matter for the second stage when the front-end problems are managed.

MS MACRI: So you look at sort of a framework which is talking about competencies and skills, the correct education and training, remuneration, and then some form of licensing or registration for that tier of work.

MR DE BRENNI (UV): Yes. My union's position is that the most important aspects to sort out are in that first group.

MS MACRI: Yes.

MR DE BRENNI (UV): Licensing and regulation we don't think has much of an impact on the provision of quality, unless those other things are addressed. So at the top of mind for us and the focus of our research and our submissions is around the linking of that quality to those other issues.

MR WOODS: Does that mean if the other issues were addressed properly, to your satisfaction, that you would not be averse to moving to some level of registration? How do I interpret - - -

MR DE BRENNI (UV): In terms of interpreting my comments there, I don't think that we've adequately determined a position on that, in terms of whether or not it would have an impact, whether that impact would be beneficial or not. I think some further consideration would need to be given and I suspect that at some of the further hearings then we would provide some of that information. I think that any reform in this sector needs to be inherently linked to something that has a fundamental impact on the quality of care that's provided to older Australians, and it would be our view that unless we can demonstrate that, then that reform is not worth making.

MS MACRI: Yes. Kerri, can I just ask you: if we talk about quality of care, do you believe the current accreditation process reflects the quality of care that's being given in the residential aged care sector?

MS ANDERSON (UV): I can only speak for my facility, and we have a high standard. We obviously are meeting accreditation - in fact we passed accreditation about eight months ago - but we still could go a way to doing a better job. More staff - we could always do better, I think. I don't know who controls the accreditation. They must have felt that we met all the required standards because we passed.

MS MACRI: Sure, yes.

MS ANDERSON (UV): But I've always felt we can do better.

MR WOODS: Is some of that better organisation and management, or is it just more resources?

MS ANDERSON (UV): More resources.

MR WOODS: That leads me on to the question of management, because your workforce, at the personal care level, are in fact taking on a range of management roles. I suspect, from what you were saying, that you in fact supervise a number of other staff, particularly at that community level, because you are the interface. Is there adequate management training or do you just get put into that role because you've been around, you know how it works, you're trusted, you're a good employee?

MS ANDERSON (UV): No, they do do training - quite well, actually. We're very blessed in the company that we work for. But I can assure you there are other facilities out there that you really do get thrown in with the wolves and they really have no idea. And, yes, I look after several people underneath me in my area, but I'm out there doing the same job as what they do.

MR WOODS: Yes, but you're also supervising where they're at - - -

MS ANDERSON (UV): That's right, yes.

MR WOODS: - - - and what they're doing.

MS ANDERSON (UV): Yes.

MR WOODS: And you're the source of advice and guidance and mentoring and all those extra bits.

MS ANDERSON (UV): Yes.

MR WOODS: But you actually get trained for that to - - -

MS ANDERSON (UV): Yes.

MR WOODS: Whereas, as you say, that is not necessarily always the case.

MS ANDERSON (UV): No, definitely not.

MR WOODS: Quite true. Sue, any other things that - - -

MS MACRI: No, I think we've probably covered - - -

MR WOODS: I mean, I know you've come, and we've heard your particular

views on remuneration and other work and conditions, but it's actually been very valuable to get your feedback and response on the wider structural reforms that we're proposing - - -

MS MACRI: Yes, absolutely.

MR WOODS: - - - because it's good to talk on the record with people who are actually - - -

MS MACRI: Delivering.

MR WOODS: - - - engaged at that level. So we're very grateful that you've made the time and effort to come. Thank you.

MS JACKSON (UV): Thank you very much.

MS ANDERSON (UV): Thank you.

MR WOODS: The Association of Independent Retirees. Could you please each separately for the record state your name, the organisation you are representing and any position you hold.

MR BARTON (AIR): Thank you, Mr Chairman. I represent AIR, the Association of Independent Retirees, in Queensland. There are 14 branches of that and we have made a submission in response to the recommendations.

MR WOODS: Thank you.

MR BARTON (AIR): On my left is Vince Watson.

MR WOODS: If they could separately for the record, please - - -

MR BARTON (AIR): Okay.

MR WATSON (AIR): Vince Watson. I am a member of AIR Brisbane South and chairman of the Pension, Aged Care and Nursing Home Committee.

MR WOODS: Thank you.

MR BARTON (AIR): Brisbane South being, of course, a branch of AIR.

MR WOODS: Yes.

MS MARTIN (AIR): Valerie Martin, Moreton Bay branch of AIR.

MR WOODS: Thank you very much.

MS MARTIN (AIR): I've been associated with Max for a number of years, and we've been doing a report on how it applies to our situation.

MR WOODS: Thank you, and thank you for your submissions. That's very helpful. Please make your presentation.

MR BARTON (AIR): Mr Chairman, there's no doubt that this industry is in crisis. Whether you take it from a user point of view, from a service provider point of view or from an industry worker's point of view, it is in crisis. I've got no doubt in my mind that you have recognised that, otherwise we wouldn't have this 500-page report. Our comments today are going to be in response to your recommendations.

MR WOODS: Thank you.

MR BARTON (AIR): We don't really intend to bring before you any new

evidence, but there may be some matters of fact that we will comment upon in support of what we're talking about. I am going to make a general summary of our in-principle concerns about the content of your report and the recommendations, and then I'll call upon my colleagues to maybe support and illustrate those concerns by actual sort of case study and experience. Both of them have been more involved with the industry than I have, from a personal point of view.

MR WOODS: Thank you.

MR BARTON (AIR): I think the first thing that we want to lay before you, Mr Chairman, is that we've got some general observations that seem to be embedded in the report here. This report is largely descriptive and records those facts - similar to what you have just heard 20 or 30 minutes ago - and it's supported also by selective statistical justification. It's initiated by terms of reference - which I take it were handed to you - and those terms of reference are of concern to AIR because they are accepted as facts by common agreement. For example, in your report you say there are "greater levels of affluence among older people". That's referenced at page (v). There is no statistical backup to that statement; it's just made and it's contained in the terms of reference. It may well be true, but it's taken as a given in your terms of reference, and we find that a little bit disturbing.

There also, throughout the document itself, seems to be an underlying theme where there is acceptance of hearsay and myth reflecting the politics of age. That's where seniors are portrayed as a financial drain on their community and society, and seniors are seen as a group that does not fit comfortably within the society, and that seniors are a dependent group in the society, and seniors, in many instances, are incapable of managing their own economic, health and social needs. Now, I can't point to a specific paragraph for each of those concerns but reading it from a user's point of view, that feeling comes out to me in your report.

MR WOODS: We'll pick that up in debate.

MR BARTON (AIR): Thank you. AIR challenges those sort of fundamental assumptions contained in the report and is concerned with the underlying tenor of the report in that respect.

The next point I want to try and make is this shift to user-pay principles. The whole report is predicated on the basis of separation of costs into major cost components to which you're attaching funding principles. The proposed structure, in itself, is a major shift in funding responsibility and it moves the burden of costs for aged care away from dependency on social welfare to that of a user-pays system.

Now, there's been a system of social welfare available in Australia, provided by the Australian government over many, many years - probably since taxation was first

introduced. Over those years the Commonwealth government has expanded that program to include many middle-class entitlements such as education, such as home owners' grants, such as baby bonuses, such as subsidies for child care. None of these things take into account user pay. User pay seems to be confined to small groups such as what is proposed now with aged care accommodation and, in an education sense, possibly through the HECS scheme.

We're a little concerned at AIR that there seems to be this movement towards user-pay principle away from traditional social welfare benefits by government. So the terms of reference that are used and inspire a movement towards user pay are really determining the outcome here in terms of your recommendations.

The other thing is it's very hard, particularly in a 500-page report, to come to grips with the actual costs that will affect aged care recipients, particularly over different income levels. I would have thought that some examples could have been quoted to quickly round up the impact of what is being proposed here. AIR Queensland would like to see the incorporation of some illustrative examples of how it's going to impact on aged care recipients. I don't think it is but it could well be that there are benefits in there, but they're not apparent on first reading to many of our members.

The next point I want to try and make is that the group we're talking about is a minority group within the seniors age component. In the report you say:

> Only a minority of older Australians are likely to face extended periods of intensive care, and therefore could find themselves liable for very expensive - or catastrophic - costs of care.

Now, it seems to me that we've identified here a small group in a larger age component; that these recommendations superficially seem to discriminate and disadvantage that vulnerable group.

MR WOODS: I think if you read on you'll find that we're actually proposing a solution to that by way of the stop loss so that people don't face it. So although we've identified them, we haven't hung them out to dry. We've said, "Here is a solution for them."

MR BARTON (AIR): Of course the solution deepens when there's no definition of what "stop loss" means.

MR WOODS: It means that is their total lifetime exposure to aged care costs.

MR BARTON (AIR): Yes, but in terms of what? Annually?

MR WOODS: No, no, total.

MR BARTON (AIR): How does it work?

MR WOODS: Total means total.

MS MACRI: Lifetime.

MR WOODS: Lifetime, so that is the full total lifetime cost that they would be exposed to for their co-contribution for aged care.

MR BARTON (AIR): And what is it to be?

MR WOODS: We've recommended in the draft at $60,000 but we've - - - Well, we've proposed as a discussion point in the draft that it be $60,000.

MR BARTON (AIR): That's one point that I was going to bring up a little further on, and you've clarified it, so I won't need to raise it.

MR WOODS: Okay.

MR BARTON (AIR): The alternative cost offset options that might be available; the report says that the fact that unpredictable and potentially very high or catastrophic personal costs are faced by a minority points to the need for a risk-cost pooling or sharing mechanism. I understood that you looked at means-testing for care recipients' co-contributions - that's recommendation 1.9; the setting of lifetime stop loss in 1.10; and the removal of aged care costs from medical expenses on tax offsets, again recommendation 1.10. What wasn't clear to us at AIR was what "stop loss" means, but what was clear was that we were facing the loss of a tax rebate. Again, we would like to have seen some examples that pointed up this distinction and showed how it in fact would work in practice.

If the principle of user pay remains, and in all probability it will, the reform recommendations working towards spreading - and I quote here, "to spread the financial risk of aged care over the widest possible population and over time" - looked at "minimum regulation, allowing competitive free market alternatives and the continuance of taxation incentives and other government" - if the user-pay principle remains, and consistent with alternative cost options available, our people would support the introduction of mechanisms that, for those that wanted it, were able to provide for the event of this particular need arising.

If I can make a fourth point or fifth point, recommendations contained in the report such as improvement to the live-at-home support services, an establishment of a seniors agency, removing the delays and inconsistencies, integrating the various supporting aged care services provided, improving the skills of workers and informal carers, and better oversights of fees, complaints and needs, AIR would support totally those things because we see them as faults in the organisation.

Now, in the matter of accommodation bonds, again it's not clear to me and there were no definitions contained - as far as I could see - in the report as to what a periodic payment was and what period it was referring to, and hence from there what the capping would be on accommodation bonds. So that's something we would seek clarity on before we committed ourselves to a position of support.

MR WOODS: We can deal with that briefly in a minute as well.

MR BARTON (AIR): Thank you. Almost to the end, Mr Chairman, and that deals with transitory provisions. That particular but important consideration is not given a lot of expansion or treatment in the report. It poses as many questions as it answers and probably more, in that, what are the arrangements for existing bonds? What are the arrangements for existing recipients? How is it going to be handled? Is it going to be phased out? How is it going to be phased out? Is it going to be tapered? I think the report is a bit deficient in that regard.

MR WOODS: We'll respond to that in a minute as well.

MR BARTON (AIR): So we request you to re-examine the transitory arrangements and provide more detail for that. The other concerns were, first of all, recommendation 1.3, where you're melding together low care, high care - that type of thing. From our point of view, providing that doesn't lead to an averaging or a diminution in the personal aged care needs, well, that might be a wise move to remove the distinction.

MR WOODS: And it won't affect their care entitlements.

MR BARTON (AIR): Recommendation 12.8 relates to the requirements placed on service providers in reporting missing residents. Now, AIR opposes any loosening of the service provider's duty of care in this respect, and I think you're proposing that they become less stringent. One further matter is the consumer problems associated with the noncompliance of bond refunds within 14 days. In Queensland, AIR is aware of a common practice by service providers to withhold funds pending the granting of estate probate. This currently provides service providers with the opportunity to hold two bonds over the one bed space. That's unreasonable. Hopefully, your establishment of the AACRC will handle these types of situations

and deal with them expeditiously.

MR WOODS: Very good.

MR BARTON (AIR): And we'd be pleased to receive your comments on that as well.

MR WOODS: Thank you.

MR BARTON (AIR): At this stage, Mr Chairman, would you like - - -

MR WOODS: Yes, if each of the others could briefly address their particular situation, because we'd like to answer a couple of issues but we also have a time constraint.

MS MARTIN (AIR): I've dealt with the aged care sector because of my mother being in a high-care situation. She managed at home for quite a number of years with very little care. She actually had some HACC providers come in at one stage. We felt that the amount of care that she received was not enough in the home, considering her level of need. When she was assessed by the aged care - whatever they call themselves.

MR WOODS: Aged Care Assessment Team. The ACAT.

MS MARTIN (AIR): Aged Care Assessment Team, yes. She was actually assessed as needing a low level of care when in fact within a couple of months they reassessed her for a high level of care. There are all sorts of issues here, I think. Because she actually owned a unit, I think there was a requirement for the bond in low care which wasn't in high care and - - -

MR WOODS: Not an unfamiliar story, I have to say.

MS MARTIN (AIR): No, not at all. The level of care she received in a non-government subsidised hostel in a low-care one was very, very good, and I have nothing but praise for them. But eventually she had to move on to a high-care facility and, again, the care was very good. I have nothing but praise for the staff who work there, but I object highly to the way that her income was assessed, and the amount she had to pay for her care left her with actually less than an old age pensioner would have had because of the way it was assessed. An old age pensioner actually had more in the bank at the end of the month than my mother did as a part-pensioner, so I feel that that needs to be sorted out. I mean, if we go into a shop and buy a refrigerator, we all pay the same price that that particular person is asking on that day. Why should some people pay a lot more than others for basically the same care?

MR WOODS: And our report addresses that, but I'll deal with that in a minute.

MS MARTIN (AIR): Right. I do have a question with regard to the 60,000 stop loss. Exactly what does that 60,000 cover?

MR WOODS: Yes. I'll pick that up.

MS MARTIN (AIR): Thank you.

MR WATSON (AIR): I'll make it quick. I've got to appear on my own branch later on. There are three points that I'd just like to quickly go through. Low care and high care: I have a beloved one in high care. I really can't see too much difference. I believe the medical situation is supposed to be the same standard, both in high care extras or high care. I think that they're supposed to have wine with their meals and so on. My wife hasn't drunk at any time in her life so we miss out and they don't give me a bottle. I think it needs to look very closely on that.

The recommendation placed on services reporting missing residents: if I can quickly give an instance that's happened with my wife. It was an unfortunate incident that one of the staff reported another staff member for elder abuse. I was not informed for about three or four days. The police were called in. The doctor was called in. The Department of Ageing was called in. The police never turned up; the doctor never turned up; and it took the Department of Ageing about three weeks before they fronted. Now, please don't make it any easier for those homes. If anything goes wrong, you've got to be sitting right on the problem.

Finally, if I can just say on the bond, waiting for probate and so on, take into consideration that when you put a person in a home - I had to put up a $200,000 bond and it came out of our joint account. As far as I'm concerned, it shouldn't be tied up; perhaps half may be tied up in my wife's estate, but I think you've got to get that sorted out very much - where the money came from. A lot of people are drawing out of their super fund to put up those bonds or selling a house. If the house was held as joint tenants and they didn't have to sell the house, it would automatically pass straightaway to the wife or the husband, probably without going to probate on a lot of occasions. So they're the three little things I'd just like to throw in.

MR WOODS: Thank you. Given the time, rather than ask you questions, perhaps if I respond to some of yours. The first one, the general observations: in fact, what we are trying to do in this report is turn the system around so that it does stress the independence of the older person themselves, so your comments about sort of portraying seniors as a financial drain and not fitting comfortably within the community and the like, if that has come through we will go back through the report, because the whole point of our reforms in fact is to try and assist older people to

remain engaged in their community, to contribute to their community, to be relevant to their community, and so there will be much more emphasis on wellness and independence, care in their own home, whether it's their home of long standing or if they move to a retirement village or an ILU or whatever. So it is certainly not our intention to portray older people in that light and we're happy to go through and see where that perception may have come from. But our reforms are about giving the older people the entitlement; giving them the power to decide who will be the provider of services; and to give them a much greater ability to make choice and decisions themself. So we are at one with you on that, and if some of the language isn't communicating that, we're happy to go back through and look at that. Sue?

MS MACRI: Yes, absolutely. The report is in fact about the reverse of what you're saying, so that obviously - - -

MR BARTON (AIR): Yes, well, my comments probably are coloured too by external comments made, particularly in the political environment, about the future burden of seniors in the community.

MR WOODS: Okay. If there's something in our report that's reinforcing that perception we'll correct it, but the whole thrust of our reforms is not that but, in fact, the reverse. Your point about illustrative examples: yes, we do understand that need, and certainly for the final report we will have little matrixes and calculators and the like. We were reluctant to put in too much of that in the draft until we understood whether people were generally supportive of the architecture of the reforms.

There was no point having detailed debate about somebody on this income and that asset level getting this amount of care until we exposed the draft report, exposed our reforms, and then, having got that reaction, we can now firm up some details. The debate could have endlessly gone on about whether this person should have paid that much. Until we actually understood that there was general support for where our reforms were heading, we were reluctant to tie that down. But, certainly the final report will give you all of those calculators, and you'll be able to look at your situation or your members' situations and say, "Here's where you are. Here's what you would have to pay."

MR BARTON (AIR): Yes. The only point I'd make there is, though, for informed comment on the reforms, you need to see the impact.

MR WOODS: The sum of.

MR BARTON (AIR): And it's hard to see the impact here without some examples - and after all, when your final report comes out it's not getting to get altered; that's going to be it.

MR WOODS: That will be up to government to decide.

MR BARTON (AIR): It will be debated by government, yes.

MS MACRI: Yes.

MR WOODS: Yes, and you will have lots of information where you can contribute to that debate. So there's a balance in there that has to be struck - we understand your point. On the stop loss, if I can just reiterate that in the draft what we are saying is that people would be making co-contributions depending on their capacity to do so. The maximum that's in the draft is 25 per cent of the cost of care for somebody on a high income/high wealth situation. At the moment if you're on a very high intensity package that might be worth, say, 50,000 a year, 25 per cent of that at 12,500 a year, you'd have to be on that for five years before you hit the stop loss, but once you hit that stop loss you don't pay then any more for your aged care services for the rest of your life.

MR BARTON (AIR): So that's just for aged care services?

MR WOODS: That is.

MR BARTON (AIR): It doesn't include the everyday living expenses?

MR WOODS: No, it's for the aged care services.

MR BARTON (AIR): Which are?

MR WOODS: Which are all of the normal services associated with - at the bottom end things like assistance with housekeeping, meals, showering and dressing, wound care, all the way up through intensive nursing and support for aged care.

MR BARTON (AIR): So in terms of your allocation of cost components, that would be generally in the area of personal and health care, but not accommodation charges?

MR WOODS: Yes, exactly right, accommodation is separate. Where people live is a personal decision that they make. As you've done in your community for the rest of your life, you make decisions about where you live and how much you'll spend on your home. If you have very limited assets and income, you get support already from government in the community by way of supported accommodation assistance or public housing or assistance with rental in private housing. So that group of people would continue to get public support for accommodation as they move through and even in residential care - so they would be supported residents in a

residential care facility. The rest of the population currently makes their own decisions about their accommodation, and that would continue right through.

MR WATSON (AIR): In the last five years I've paid $250,000. Would I get a refund?

MR WOODS: For the care component or for the care and accommodation?

MR WATSON (AIR): Care component including the extras.

MR WOODS: Yes, okay. On extras - just briefly, we are running out of time - there wouldn't be this artificial creation of high-care extra service which is a way of getting bonds and things. Every person would have a choice to be able to pay a periodic payment. That could be a daily charge or a weekly rental, but at that level. So that somebody who doesn't want to sell up a home or is uncertain about how long they would be in residential aged care, they can choose to pay a daily charge - and it would be a published daily charge. You wouldn't have the situation any more where the first question they ask you is, "What are your assets?"

The first question you ask them is, "What is the cost of accommodation to be in this facility?" They would have to publish that. So it would be a known published charge, both of the daily rental and of the bond. They would have to publish that. So irrespective of your financial means, you would be able to go to different providers and say, "What is the accommodation cost for your facility?" "I choose to pay it by a weekly rental," or, "I choose to pay it by a bond, because that suits me and I just want to pay a lump sum and not deal with it in the future."

MR BARTON (AIR): It's that quantum of bond that is still mystifying to us. Is that assessed on the daily or weekly or do you pay like a bond for weekly - - -

MS MACRI: No.

MR WOODS: No, there's no bond for your daily or - if you choose a rental option, you just pay daily or weekly as you stay there.

MR BARTON (AIR): So what is the bond period?

MR WOODS: If you pay a bond, it is for your uncertain however long you are in the facility, and then there would be a repayment of that nominal sum at the end. There are no retentions.

MR BARTON (AIR): Who calculates the period? I mean, okay, I go in - - -

MR WOODS: Well, for a bond, you pay at the front end and it lasts - - -

MS MACRI: Till the person - - -

MR WOODS: - - - while you are in the facility.

MS MACRI: Yes.

MR BARTON (AIR): That's fine. I understand that. What I'm sort of coming at is, you go into the institution; you don't know how long you're going to be there. What is the period?

MR WOODS: As I say, if you pay a bond it is until you leave, but if you choose to pay a daily or weekly rental it is for however long you are there. You keep paying that daily charge. For every day that you are there you pay that daily charge.

MR BARTON (AIR): You still haven't established clearly in my mind - and I might be missing something here - is the bond amount set for - if you're going to be in there for 12 months, it's 12 months?

MS MACRI: No.

MR WOODS: No, it's for however long you are there.

MR BARTON (AIR): How do you assess the bond amount?

MS MACRI: The same as currently. There's no time limit on the bond. The time limit on the bond is the time that the person is in the residential aged care facility. When the person departs, for whatever reason, then the remainder of the bond is returned to the family.

MR BARTON (AIR): The remainder of the bond?

MS MACRI: Yes.

MR WOODS: Yes, you get the nominal amount back.

MR BARTON (AIR): Yes.

MS MACRI: Yes.

MR WOODS: We're abolishing retentions.

MR BARTON (AIR): Yes, okay. Now, if I can just then ask the question: the bond amount is then set again by the service provider, is it?

MR WOODS: Yes, and it is published, it is known, and it doesn't ask what your situation is. So at the moment the first question they ask you is, "What is your home worth? How much have you got?"

MR BARTON (AIR): Yes.

MR WOODS: That all goes away.

MS MACRI: Yes.

MR WOODS: They have to publish what the bond is.

MR BARTON (AIR): Yes. So the service provider, you walk into him and he says, "If you want to do it by way of a bond, I want - - -"

MR WOODS: "This is the bond."

MS MACRI: "This is the bond."

MR BARTON (AIR): "- - - $300,000."

MR WOODS: Yes.

MS MACRI: And it's published on their web site, it's in their document, and - - -

MR BARTON (AIR): And that can vary between service providers?

MR WOODS: Yes, absolutely, and by quality of accommodation.

MS MACRI: Yes, on the quality of the accommodation. That's the important thing - , and that comes to your comment around extra service, and at the moment the extra service is approved by the Department of Health and Ageing, if it's a contract and, irrespective of whether you utilise aspects within that - - -

MR WATSON (AIR): $70 a night.

MS MACRI: - - - like, your drink or your cocktail hour and your wife doesn't drink, you won't have your hairdressing because you're not going to have a perm - all of those sorts of things go, and what happens is when you go in and you are paying a bond or a periodical payment or a combination of both, you negotiate with that provider exactly the services that you require and want, so that you're not paying for services that you're not going to use.

MR WATSON (AIR): And how about the five years deduction that's presently on the - - -

MR WOODS: No, that goes.

MS MACRI: No. Yes, that goes.

MR WOODS: There's no need for that.

MS MACRI: The retention goes.

MS MARTIN (AIR): So are you going to keep up with the amount that a resident is required to be left with? I mean the amount of assets - - -

MR WOODS: Yes, there's certainly a minimum - all that stays. So all that minimum protection stays.

MS MARTIN (AIR): A service provider can still ask for a bond as large as he likes, providing he - - -

MR WOODS: Providing you're willing to pay.

MS MACRI: And the accommodation reflects that sort of bond.

MR WOODS: Because otherwise you'll go to a different provider.

MS MACRI: Otherwise you'll go - yes.

MR WOODS: That's right, you'll go to the provider who's providing the accommodation as well as the quality of care that best meets your needs and situation.

MR WATSON (AIR): Could I make a comment that, when I was facing putting my wife in a home, I went to 30 people - 30 homes. Without being rude, I wouldn't have put my pet cat in 25 of them. About three out of the five that I liked, there was a waiting list of about six months, and I managed to get into the one where I got into. I have my doubts whether it's going to be as easy as what you say.

MR WOODS: One of the things that we are doing is not having any limits on the number of residential bed licences. So if it's a good provider and they have a big waiting list, then they can expand their services. There's no constraint on them doing that. So it will open up the market but also we'll be putting a lot more resources into community so that there won't be the pressure that's on residential care at the moment, because to try and get a community aged care package or an EACH

package is very hard for a lot of people; there just aren't enough around. So by putting in more resources at the community level you take some of the pressure off.

MR BARTON (AIR): Mr Chairman, if I could just - - -

MR WOODS: One last one because we are way over time.

MR BARTON (AIR): The service provider holds the bond and collects the interest off it?

MR WOODS: Yes, that's where they generate their funds, but they return the nominal amount of that bond at the end of the - - -

MR BARTON (AIR): Yes, fine. Like you're proposing a system of periodic payment; it could be just a bank debit every month or something like that?

MR WOODS: Yes, exactly - weekly, monthly, whatever.

MR BARTON (AIR): Thank you.

MS MACRI: Just quickly on mandatory reporting: I mean we're not diluting the requirements of mandatory reporting. We are asking for comments back because there are some aspects around mandatory reporting that are causing some problems for the industry. But it's not being diluted, we're asking for comments back, so that's a reassurance for you.

MR BARTON (AIR): Thank you.

MR WOODS: And we have your comments.

MS MACRI: Yes.

MR WOODS: Thank you. We will adjourn briefly, just for 10 minutes, and then call the next participant.

MR WOODS: Could you please for the record state your name and any organisation you may be representing.

PROF BYRNE: Prof Eileen Byrne, Emeritus Professor of Policy Studies at the University of Queensland.

MR WOODS: Thank you very much. Please proceed with your statement.

PROF BYRNE: Thank you, commissioner. The report is a very major step forward, and I think it has been admirably compiled to address some of the very central problems at the moment. However, there are two or three respects in which either your briefing from relevant government authorities or your terms of reference have missed out, I think, two or three problems which I cannot see in the report, which I've gone through very carefully, that aren't going to be solved, despite the fact that I support a number of your recommendations.

MR WOODS: Thank you.

PROF BYRNE: I support, for example, a regulatory commission, in most cases, but there needs to be casework for the remainder. I also support using the family home as part of the contribution to aged care. I have no patience whatever with the assumption that people have the right to an inheritance. I mean, that is just nonsense. We've all made our way in our generation. However, on pricing, there is a serious problem. There is an assumption made by the providers, particularly the not-for-profit providers in Queensland - and notably South East Queensland - two assumptions which are fallacious and which are pricing most of us out of the market. One is that you can use all of the profit from the family home. Wrong. If you're selling, you need about 30,000 at least for the estate agent, the solicitor, other costs, removal costs, and the costs of downsizing from a four or three-bedroom house - you have to sell furniture, buy new furniture and so on.

I want to come to some demographics because I think that's where the weakness of the report is; there are some very funky assumptions which are made by the government on aged care which do not match the demographics. The assumption that people who are currently, for example, between 70 and 85 have any respectable income at all for something like 40 or 50 per cent of the population is fallacious. That age group worked during the 50s, 60s and 70s for the most part. Women didn't have equal pay. There was a marriage bar where women couldn't work at all. I mean, I'm an international researcher, I speak as a very experienced social science researcher, and the social constructions up until the very late 70s and early 80s was that married women should be at home or work part-time. Women don't have superannuation; they don't have savings; they don't have personal income.

Secondly, on that level of demographics, women don't have superannuation. I

am one of the very few fortunate people who was in public - I was a deputy CEO in local government in England before I came here. There isn't much I haven't done, and I went into university here. I have two half-pensions from superannuation. But they are based on my starting salary in 1957 of 500 a year and my deputy CEO salary of between three and five thousand: not 50,000; three and five thousand. It was based on 3 per cent and 5 per cent of the employer's contribution, not 9 or 12. If you do the arithmetic, you will not find that anyone of 65 and over has substantial resources.

If you take all of the cost of the family home and leave them without any capital as a reserve to top up whatever income they've got, no, they're not going to be able to manage. Governments at the moment seem to think that, because in the 80s and 90s salaries went through the roof, that is what the average person has.

Finally, on the financial side of what we have and don't have, if you go through the ABS statistics, when they say that the average family in Australia or the average person has X income, you will find that that has been skewed in the last 10 to 15 years by the rapid rise in millionaires. If you take out the people who have 750,000 and over, or a million and over, you get to a very much lower base figure, and that has not been, I think, factored into the government assumptions about this age group. On the baby boomers, I have a schedule.

MR WOODS: Thank you.

PROF BYRNE: I have a schedule here and I have done a projection of age population of the baby boomers - well, right back to people born in 1926 who are now 85. But the 46 to 66 age group of baby boomers are not going to reach the crucial age for another - well, the 56 people are not going to be aged 85 until 2041; the 66 lot until 2051. The 46, the first lot, when we were all at school, are still not going to hit 85 until 2031. What I have not found in the report - and maybe I have missed it - is the interim for all this block of age group before the baby boomers really hit the expensive age, who have not necessarily a family home which is expensive; again the median.

I have done five years of research into pricing of houses and pricing of retirement villages in South East Queensland, and the median prices of a house on which the providers base some of their pricing for coming in is enormously skewed by the million-dollar properties on the outskirts. Again, if you take the million-dollar properties out, you get back to a much lower figure. So we need a two-phase. Your proposals - tidied up a bit after consultation - will fit those who are hitting the really dependent stage in 2036 to 2051, but I don't see a realistic immediate improvement for those of us who are between 65 and 85 at the moment.

One more thing on demography, because it is important: you know, you would

have done the statistics, that actually if you take any aged care facility, including retirement villages, you will find that it's two-thirds women and one-third men; in fact, it could even be 80:20 or whatever, mostly women. So you need to look at the particular position of women in terms of finance.

MR WOODS: Yes, absolutely.

PROF BYRNE: One more point on demography - I'm sorry, but this is a complicated issue. These issues are all interrelated. Because my generation were brought up that because the taxpayer paid for everything including, in my case, even my PhD from my local authority, we were brought up to pay back into the community, and I've done advocacy ever since I came to Australia in 81. I am sorry and sad to tell you that not only in my own experience and that of my advocacy colleagues in Brisbane but the data shows a massive - well, a massive; I will rephrase that - a disturbingly significant increase in the number of women between 50 and 65 who have been deserted by their husbands for all kinds of different reasons - marriage break-up and so on.

But of all the cases I've had to take through the Family Court or help people through the Family Court or conciliate or whatever, there is not a single one of all the ones I've done since 1981 where the woman did not come off with about a quarter or a third of what the man walks away with for all kinds of complicated reasons. They've been salting it away; they've got the superannuation - you have to fight for that, it is very difficult to get a slice of the man's superannuation. In many, many cases - I can think of 10 cases out of about 22 since 1981 where the woman has been left basically without a home; a 70-year-old who has a mortgage still, and she hasn't got a home to sell because she's got a home that, by the time it's sold, the bank is going to take most of it.

There is, okay, a safety net, and I have read this as carefully as I can in the short time. I deeply regret I couldn't send you a written submission, but I've been dealing with all kinds of other cases which - - -

MR WOODS: You're here today.

PROF BYRNE: One of the things that I think that I have grasped from the quite complicated document is that you have provided safety nets. You may correct me, but if I have understood it correctly, a supported resident is one who is basically getting the age pension; in other words, it's a very low point to qualify as a supported resident. But there is an enormous amount of middle-class poverty, of people who are just a bit too high to qualify for Centrelink.

Some of us actually qualify just for a seniors health card but wouldn't claim a pension, but they have nowhere near the amount of money, and if they don't have a

full house, I do not see where the safety net is for people who are above the - let me rephrase it. The safety net seems to me to be not only too low; it's basically the governmental assumption that you have to be at the poverty line before the government will really plan a policy - not plan a safety net but plan a policy - and I would like to see these proposals spelt out a bit more in a second phase for the people who are all the people in my demography. And I would be happy to spell out a slightly more detailed case of it, if that would be helpful.

MR WOODS: Yes, that would be.

PROF BYRNE: Would that be helpful?

MR WOODS: Thank you.

PROF BYRNE: If I did a document?

MR WOODS: Yes.

PROF BYRNE: I know it's going to be late but - - -

MR WOODS: No. If within a week or so you could - - -

PROF BYRNE: I could do it within a week, yes.

MR WOODS: Thank you.

PROF BYRNE: The copy of the demography - - -

MR WOODS: You have our contact details.

PROF BYRNE: Yes, and I could do that. The next thing again that isn't provided for: I want to come on to retirement villages and for South East Queensland this is really crucial. I can't speak for the other states, but I have done five years' work on the problems with retirement villages in various contexts. At the moment, we drop through the gap. Nobody wants to know that we're aged care. We're told aged care - definition, all the definitions I've found is basically low-care hostels and high-care nursing homes.

MR WOODS: And community care.

PROF BYRNE: But in terms of where people are in organisations, and community care where you're living in a street as it were. You're living at home. The assumption is that people who live in independent units in retirement villages are just like living at home. You know, we're just the same.

MR WOODS: Yes.

PROF BYRNE: Wrong. I can't speak for the other states, but for South East Queensland, wrong. And it is getting to crisis point. Again, I can only speak for my state, but there has been almost no policy development of residential places for so long that the waiting lists are unreal. It is simply not true to say that we can choose where we go. Whether it's a retirement village or whatever, we can't choose for the most part. What is now sitting in the retirement village is mostly the not-for-profit because they're prepared to take more than the commercial villages.

We have got dementia cases. They shouldn't be in the village. They're not coping. We have actual dementia cases. One has had to be removed in a very sad crisis situation recently. We have cases where the wife or husband has dementia, and I mean really serious. The other partner, the spouse, started off by being highly intelligent and able to do all kinds of things, and we've watched for two years in two or three retirement villages while they are now almost at the dementia level because they are dealing every day - dealing with a dementia case is quite complicated, it needs quite a skill, and they don't have it, so they end up yelling at their wife or husband all day, which is not good for either of them.

We have one case where there is a blind 90-year-old. He's almost totally blind. His wife has dementia. He's in a retirement village. Okay, HACC et cetera has got only - I apologise to you, chairman. You are obviously the 5 per cent exception, but I've worked with men all my life because I was the only woman at my level, and only a male government could possibly think that one hour a week of a home help is adequate for somebody who is, quote, "living at home", and particularly somebody with dementia.

This particular case is appalling. She no longer can go to the lavatory. There are faeces over the floor. He can't even see his medication and so on. And everyone is saying, "But they're in a retirement village." There is no regulation; there is no supervision; there is no social work visit. The person who is reporting all this is the home help who does one hour a week - a very caring home help, who arrives at the next place she goes to so distressed that she has to have coffee before we can actually settle her down to get her working.

I have got about 16 cases like that that have been reported to me since I have been really inquiring about this. This is not unusual. I'll come back to the question of choice in a moment - you know, "They choose to live there" - but we have got a number of other cases in retirement villages where there are people who are either very partially sighted and frail and 87 or who have cancer and they're struggling and coping. They've got as much backup as anyone can provide them with, but it's not adequate.

What have they been told, commissioner? The 87-year-old blind resident, who is very frail - she's as sharp as a tack, I have to say, but she's very frail and she's not coping; she's had falls. And she's tired. She's tired of actually struggling to cope. She has twice been told that she doesn't qualify to go even on the waiting list for residential care because she can still shower herself.

There is a second case of an 85-year-old who we've been trying to get into another village - an 85-year-old who has a weak heart and very high blood pressure to the danger level. Her place is now so dirty that none of us will actually have a cup of coffee when we go there. We make all kinds of excuses and say, "No," and so on. Her son has come up from Melbourne several times.

The families do their best, but the assumption that there are families is another assumption that government is making. A number of us have no families. The families often are in Melbourne, Perth or even Singapore, the UK or America. The assumption also on the part of policy-makers that families are supportive is naive. Some families walk the extra mile over and over again and you admire them. They've got kids and grandkids and they still do everything. Other families - and there may be good reasons for it - simply do not support. You cannot make an assumption that families any longer have the social and moral commitment that families in the past used to do.

Many of these people who have dementia, they're frail, they have chronic illnesses, they are losing it. There's another that I know who doesn't know the day of the week. She can't handle money: she regularly gives her home help $50 or $100, and it's an honest home help and she says, "You've already paid me." She can't cope with shopping any longer. We're now trying to get her shopping.

The complications of attempting to get backup: what is in the retirement villages is now what used to be in the low-care hostels. If you look at my data - and I will spell out in the document I will send you the relationship, and the age groups, of what's going to hit where. If you look at the relationship of those, you will find that on my figures, I think, we are going to have to face 15 years until we've made a dent on residential places sufficient to alter the demography of the retirement villages. They've got to go somewhere.

Another thing, which even Blue Care will agree, and even the other not-for-profit providers - they have conceded, with some difficulty, that what is now coming into the retirement villages is much older. People used to come in at 65 and play tennis and bowls and all the rest of it. Well, people forget that you don't go on playing tennis and bowls; you get sick. But what is coming now into the retirement villages is coming in at 80 and so on. They're not coming in young. They're coming in sick. They're coming in frail.

That has two other implications: (1) we have to have an acceptance that you have an extra stage. You do not have: you live in a street or you're in a low-care hostel. We've come into retirement villages because we couldn't cope. I do hope that it is evident to the commissioners that I don't have Alzheimer's or dementia, but I had to move into my retirement village urgently. I have a very bad spinal injury from an accident in Brussels when I was working for the EEC. It's not age, it's disability. I couldn't cope, and I'm a coper in life. I'm a survivor. I could not cope, and even my doctor and my surgeon said, "You need to move urgently," and I had to move in. You move into a retirement village because you are not coping at home. So to make the assumption that we are the same as 23 Lentara Street is a wrong assumption. We need greater backup.

One of the benefits of the retirement villages which is underestimated is that when I was living in a street, my neighbours, who were nice people - they were not difficult neighbours, but they didn't help. They didn't put my dustbin out. They always forgot. If I rang saying, "Could you come in and put in a light bulb?" they'd say, "Yes, of course, we'll send David around," but they didn't, and it's humiliating to have to ask for help. So what you do is you move into a retirement village, because you're not coping in all kinds of ways.

The benefit is that in a retirement village - well, in most of them, and certainly in the not-for-profit ones which are run by the churches - there is an ethos, so that we all drop in on people and we notice, we will do things for people and so on, and that is a benefit. But there are four retirement villages, two of which are not-for-profit and two of which are commercial, where there is nobody now competent to organise social events. We used to have all kinds of things organised for residents. That's gone. That is going, because what's coming in is sick and elderly. The people who used to do it are now sick and elderly. The younger people coming in, they're either still working at 70 - I mean, this is going to be a new pattern. People are going to go on working, particularly after the financial crisis. There are people who are working who never thought that they would have to work after 65.

Also, they are coming in with a different - and no disrespect to them; this is entirely a matter of their choice. But the people coming in aren't coming in with the expectation of community work in the same way. Blue Care, Baptist Care, Aveo will provide and do provide activities officers for residential care and nursing homes. They think it's important and they make great play of it. Nobody is providing any staff for the retirement villages.

Moreover, the not-for-profit providers are in financial straits, which needs I think some kind of separate investigation. We are constantly told in a number of villages that there isn't money for this and there isn't money for that, and that's why the staff are being cut.

The staff in some villages in two not-for-profit providers in South East Queensland - I can't speak for the north. In South East Queensland one organisation has completely sacked almost all of its middle management staff in a reorganisation. They have moved all the functions to head office and they have doubled the workload of the liaison people who used to visit residents, who did a kind of almost social work, you know, and noticed that somebody needed HACC assessment or whatever. They have now been put in charge of minor works, paying bills and so on, because there's no middle management to do it any longer, with the result that they're no longer available for residents and we're told, "We can't afford to employ people."

There is already difficulty in recruiting staff for all three sectors - retirement villages, residential and so on - partly because they're underpaid, and that is a difficulty, but there is another factor which has been inadequately recognised, which is that there has been a steady diminution of staff, a steady pruning of staff because of their financial difficulties. The whole question of funding needs a look. Now, I have handled budgets all my life. I don't know whether you watch Yes, Minister but - - -

MR WOODS: I remember it well. I and my minister laughed at the different bits.

PROF BYRNE: Well, I spent 20 years in English local government negotiating with Sir Humphrey and Bernard, only mine was called Sir John, and I recognise from my own experience that simply because somebody says, "We're short of money and we're underfunded," it is not necessarily true. You need to peel aside a good deal. You need to find whether they've got too many chiefs and not enough Indians, which is the case at the moment of the providers - well, two providers at least in South East Queensland. You need to find whether they're actually using the money efficiently and so on, and they're not. It's been quite obvious with a number of the complaint issues in one or two tribunal cases that - I've been through all the tribunal cases under the Retirement Villages Act recently and it's quite obvious that some of the problem is lack of supervision. One provider was actually told, "I'm sorry, but if that's the problem, then you employ more supervisors."

I'm also saying that the question of the efficiency of the providers needs a shrewd hard look. I don't just believe that "they need more money". I do think, and I would suggest, that if you have any kind of further inquiry will you please involve some of us as residents - those of us who don't have Alzheimer's. I think that the inquiry needs a continuing dialogue with residents.

MR WOODS: You are here today.

PROF BYRNE: Precisely, but I said continuing. I used the adjective

"continuing".

MR WOODS: Yes, I did note it.

PROF BYRNE: Now, regulation: I support a regulatory body. I do not support your recommendation in the report that retirement villages do not form part of the regulation for aged care. We are aged care. What did we do that somebody says we're not aged and we don't need care in the retirement villages? I can't understand why retirement villages have been so separated out. I am saying that all the evidence that I've had over the last five years and the advocacy that I've had to indulge in - and we've conciliated before two tribunal cases but a couple of cases that we started to prepare - shows that there needs to be regulation.

I support your recommendation that the retirement villages acts need harmonising across the states, but please would you not do what you've done on disabled passes, and that's harmonise at the lowest level. Recently the ministers have reached some kind of agreement - they didn't ask us, of course - about disabled parking passes, which are crucial to us. I'm now told that I can't use my Queensland pass in New South Wales, so am I less disabled in Newcastle or Sydney? That's been the result of the ministers getting together and harmonising. Please don't do that on the Retirement Villages Act.

Now, the Queensland act, which I know backwards - boring it is but you have to. I know it backwards. The complaint mechanism means that you have to go to a tribunal but you can only go to the tribunal on something that is an actual breach of the act, as it were. There are whole ranges of complaints that we ought to be able to raise that you can't really take to a tribunal because where in the act does it say that you're in breach of your duty of care because you haven't provided safety rails or whatever? Blue Care has recently alleged to me in a five-hour meeting that it doesn't have any fiduciary care. I have gone back and I think we're going to fight that one out. But if it is true that they don't have any fiduciary care on either pricing or other things, then we do need a revision in the act.

The complaint mechanism is cumbersome. Secondly, given what I have said about the demography of the retirement villages - they're much older, they're sicker, et cetera, and that you get somebody like me sitting in one is an accident - nobody can go to a tribunal. They can't afford lawyers. They haven't got the background and the training to prepare a tribunal case. It takes forever. I mean I'm not criticising the tribunals, they do their best, but it is a cumbersome process. By that time the complaints - I mean you're into disaster. There needs to be some kind of much more manageable complaints mechanism, not only for low care and high care, which is very proper, but for retirement villages because that's where you've got the current low-care people.

That's where we have one provider who has created some quite dangerous situations on one particular old site because they're not upgrading the old villages and, again, they haven't got the funds. So what's happening is Blue Care in particular - I refer to Blue Care because it's the massive big provider. It provides a massive amount of the stuff in Queensland. They're now building a multimillion dollar Azure Blue at Redlands and it's going to have a gymnasium and spa and cafes et cetera. For the last five years all of their head office impetus has been towards big glossy integrated stuff.

Commercially, I have no problem with that. I have no problem with if you've got wealthy people coming up and they want all this, by all means have a lot of provision and choice. I don't have a problem with that. I have a problem with a not-for-profit provider concentrating on the wealthy. I cannot see why the majority of retirement villages need a whole range of expensive facilities when we haven't got the basics. In other words, if we were to build glossy schools with planetaria at the stage at which you hadn't even got a science laboratory and the rest, somebody would say we weren't doing our duty. If we built a technical college without any engineering laboratories because we provided five swimming pools and an Olympic pool in another one, you would tell us that we weren't doing our duty.

Why is the government giving money to organisations like Blue Care - and there's been another case in New South Wales, I think - for glossy projects of that kind which take consultancy, millions of dollars of consultancy, all the effort of planning and so on, at a stage at which the older villages have stood still for nearly 10 years. This is why - - -

MR WOODS: I'm not sure to what degree that's actually government-funded.

MS MACRI: No, it's not. Retirement villages don't receive any Commonwealth funding at all.

PROF BYRNE: But that is the criticism. What I'm saying is that that is not excuse for regulation. There is an ombudsman in Canberra for ageing. There's an ombudsman for aged care, but when I went into the Internet and I typed in, I discovered he's only the ombudsman for what is government-funded. Why don't the rest of us deserve an ombudsman?

MR WOODS: There is a general ombudsman available to all people for services and they don't discriminate on what your - - -

PROF BYRNE: No, but what I'm saying is why - if there is either injustice or mismanagement or inappropriate management or complaints in retirement villages which now have the clientele that ought to be in low-care residential care, why is there no - I mean why is the duty of care and the duty of responsibility and the duty

of proper provision limited to what government funds?

MR WOODS: Well, if it is in relation to government-provided care in a retirement village, then the aged care commissioner does have a role, but otherwise, living in a retirement village is seen as the equivalent - in terms of the accommodation side, not the care side - of living in any accommodation of your choice, whether it's - - -

PROF BYRNE: Which is the point that I started by making, that it's not appropriate, because it is no longer the case.

MR WOODS: I understand your premise, yes.

PROF BYRNE: I think it is really important that this extra wedge of stages of aged care gets written in and gets recognised and then gets keyed into the rights. I cannot understand how government can say that someone in a retirement village that has a very serious complaint - for example, lack of provision of safety; there have been one or two very disturbing cases where the provider has not provided a safe environment. Simply because it's not government-funded, why is that not something that inspection, for example, should cover? Doesn't it matter if I have an accident? I mean, it matters if somebody in a home has an accident, but it doesn't matter if I have an accident in something which is run by a not-for-profit provider?

MR WOODS: If there is a failure of care or creating a hazard, then I'm sure that there are processes that can deal with that.

PROF BYRNE: Okay. So what I'm saying is that the current Retirement Villages Act does not adequately provide for that.

MR WOODS: Okay.

PROF BYRNE: It is weak. For example, the penalties: I went through the act and when I found the penalty in each case it said, "You lose a certain number of points." Points for what? Now, okay, failure to provide safety of care, $5000, $10,000 on-the-spot fine, that is going to register or whatever, or the chief executive officer will be held legally responsible. You have to have a penalty that is realistic. The Queensland act is laughable in that regard. I don't know what the other acts do. Well, I've looked at the New South Wales act; I can't speak for the others.

MR WOODS: I bow to your superior knowledge on the Queensland act. I'm sure you know it infinitely better than - - -

PROF BYRNE: The duty of care, I think, is an important issue and I cannot understand why we have no redress on the duty of care. The provider is able to

ignore for years complaints or whatever because there is no redress. Unless you can actually prove a complicated case to the tribunal, there's no redress there, and that's mostly financial. Most of the tribunal cases are where we have argued that, you know, we've paid maintenance to the reserve fund and they haven't delivered the service or something. But the fundamental issue of running the village and so on, there is nowhere we can go, apart from, I suppose, the general ombudsman.

MR WOODS: Reluctantly, I have to draw attention to the time.

PROF BYRNE: Yes, I know.

MR WOODS: If you have a final point that you wish to make - - -

PROF BYRNE: Two quick ones - one on pricing: I've dealt with the question that you can't make an assumption that all the family home stuff is available.

MR WOODS: And we know.

PROF BYRNE: However, there is again no control of pricing. I have done an analysis of the pricing of retirement villages, the entry bond for retirement villages, from 2005 to 2010. In the case of two providers, it has all the sophistication of an out-of-control yoyo. There is no apparent relationship with market prices. I mean, the allegation is that the bond that you pay in - 300,000 for what you're getting - is in relation to comparable things in the market. That's the allegation. Wrong. The 10-year trends, for example, for the western suburbs, the group of five suburbs in the west of Brisbane - unlike Sydney, that's good middle-class here, I should explain; different from Sydney.

MR WOODS: Yes.

PROF BYRNE: The trend is that the prices went dramatically down to 2005 and then they started creeping up again rather slowly to 2010. That's across the five suburbs. But the prices in two of the retirement villages rocketed up in 2005 and they were charging something like 100,000 more than you could actually sell your home for, and they then went down and up, and if you look at the actual relationship between, for example, an 85-square-metre two-bedroom unit - which is a reasonable comparable thing for a unit in a retirement village, and if you look at the comparability - in many cases they're charging 60 to 100 thousand more that the comparable price in the suburb at the time. There is absolutely no control of pricing. And, again, I say that listening to people constantly saying that we have choice, that people go where they choose: no, they don't. We don't have choice. Even with superannuation, and I've worked all my life, there were only two villages where I could afford a one-bedroomed unit, not even a two-bedroomed unit, and I had to

move quickly. You don't have choice.

But many people have been unable to go - and this is for them serious - into the suburb where they've lived all their life. In order to get somewhere at 250 or 300 thousand instead of 500 thousand - I mean, half a million for a two-bedroom unit? They've had to move suburbs and for somebody of 75 or 80 to go into somewhere which is a strange suburb and they don't know the chemist and they've got to move doctors and all the rest of it, that is bad. There should be some kind of external moderation of the prices of retirement villages as well as the price of the bond going into the residential area, because they are part of the pattern and because that's where people are going to have to stay for 15 years.

Regulating: I agree with your regulation overall. I'm happy to put a little more in writing at some stage for what is nevertheless, I would like to say, overall a major step forward as a report. I would just like to ask one final wish for you: the Australian government in the 30 years I have been here has acted very differently from the British, Danish and German governments. We are never given enough time. The government, generally speaking, moves very quickly and I'm accustomed to three months at every stage. I mean, it's a long-time problem; it's been around for a long time. Nobody has done anything for ages. I plead with you not to let the next stage be so rushed that we haven't got time for detailed discussions on sub bits of it to get it right. Please don't let the government rush you. I do urge you: it is important that you listen to residents and consumers, and we are grateful to you for coming to Brisbane to listen to us.

MS MACRI: Thank you.

MR WOODS: Thank you very much.

MR WOODS: Can we ask Queensland Aged and Disability Advocacy to come forward, please. Thank you very much. Could each of you separately identify yourselves and the organisation you represent and any position you may hold.

MS DEANE (QADA): Margaret Deane. I'm the chief executive officer of Queensland Aged and Disability Advocacy.

MS KOK (QADA): And I'm Rebecca Kok and I'm the manager of advocacy services for QADA.

MR WOODS: Thank you. Thank you for your written contribution that was placed on the record; some very useful thoughts that we have tried to reflect on. But today is an opportunity for you to draw our attention to your key points. Thanks.

MS DEANE (QADA): Thank you very much, and thank you for the opportunity. Our approach, if it's acceptable by you, is that we will sort of do it jointly.

MR WOODS: Yes, absolutely.

MS DEANE (QADA): And that enables us to, I suppose, show the areas of expertise and the more detailed knowledge, although Rebecca probably knows as much if not more than me. QADA is, I suppose - we see ourselves as the voice of consumers as an advocacy agency and, like our counterparts in each of the states or the territories, we've been in the system for over 20 years and have operated as independent and confidential client-directed advocacy services.

Our reach in one year - and particularly, I suppose, in more recent years our reach would be over 20,000 people in any one year through our information and education activities, as well as our direct client representation and, more recently, consumer consultation processes which we've been independently funded for. I think the key message that we really wanted to put forward was that we believe that advocacy for older people needs to be independent and part of any direct aged care system, and I suppose we don't see ourselves in the role of a peak, which has quite specific representational issues either for a client group or on a specific issue. We do not represent any particular issues. We actually represent the issues of older people across the board.

That said, we don't disregard or denigrate the actual role of advocacy at different levels - advocacy by service providers in relation particularly to, say, clinical issues and those sorts of things. We're not saying that isn't an important role but we think in terms of representing around people's rights and responsibilities that it's very important to have that independence and I think that is really what we have worked on to develop quite professional advocacy frameworks that cover legal advocacy, particularly around and linked to guardianship and administration, which

is really I think a significant issue for a lot of older people, as well as the frameworks that actually cover people from different cultural backgrounds, Indigenous people, people from Aboriginal and Torres Strait backgrounds, Australian South Sea Islanders, and then some of the other more special needs in particularly gender-specific groups and the differences and how you can assist, and awareness of their issues.

Really, one of the things that we want to say is that we have had a lot of experience and it has been funded and it's really fantastic to see that the Productivity Commission has, I suppose, recognised the need for funded advocacy services across the board, and I think that whole idea of the current services not having a conflict of interest is a significant component of that type of advocacy. The other important part is that there are differences in the states, and Queensland for one, and there are a number of other states that have got - that we have different levels of funding but in Queensland and some of the states we can actually represent the client from when they enter the aged care system, right through; passing through each of the different stages. So we see that that's a significant advantage.

I think, too, that we can't emphasise enough the vulnerability of a lot of the clients that we represent and particularly those that are reluctant to raise issues because they don't want to be labelled as complainers. That word "complaint" has a very negative connotation for them - and that whole issue of fear of retribution. I think that our models are really looking at not being non-adversarial, working in partnership so the clients feel comfortable in pursuing the issues and that services can recognise, I suppose, some of the quality improvements that can be made.

The models I suppose - and I'll let Rebecca talk about those. I think the model actually has a whole - there are a number of components. It's not just about representation, and I think I might just hand over to you there.

MS KOK (QADA): So going on from what Margaret was talking about, in terms of education that's a very large component of what we do as an organisation, and in terms of advocacy representation to our consumers to ensure that they are understanding of areas within the aged care system and to assist them in navigating services and access to services, as well as - when they're actually receiving services - what their rights and responsibilities are, and in terms of actually assisting them to be informed about what their entitlements are. As Margaret pointed out, they're a very vulnerable group so they need that independent information and support to understand what it is that they actually may be able to receive in terms of their options and what they're entitled to and their rights around that.

We would do that through self-advocating as well, and I guess we really support that framework of self-advocacy so that the consumers are actually empowered to take on that role of raising issues themselves or understanding what

their rights are.

MS MACRI: Sorry, can I just ask you, just to get my head around the service, would you equate to TARS in New South Wales?

MS DEANE (QADA): Yes, exactly.

MS MACRI: Okay, and Elder Rights Advocacy in Victoria.

MS DEANE (QADA): Yes, Tasmania and South Australia; all states.

MS MACRI: All states and territories.

MS KOK (QADA): Yes, all states and territories. South Australia has us and, although it's actually similar to ours, they may receive slightly different funding for other programs.

MS MACRI: Yes, and provide slightly different services. From what I can gather, that's quite often from state to state.

MS DEANE (QADA): Yes, I think TARS for one is tight because they have a very strong focus on retirement villages and that part. That, out of all of us, is the one state that has significant funding for that component of their service, and then on the other side they do not have funding through the HACC, the Home and Community Care Program, which we do and which some of the other states do.

MS MACRI: Great, yes.

MS KOK (QADA): I guess I could see potential where there could be that consistency throughout the services that are already established to provide an advocacy service to cover the entire range of aged care.

MS MACRI: Yes, okay. Sorry to interrupt.

MS KOK (QADA): No, that's all right.

MS MACRI: I just wanted to - - -

MR WOODS: Giving a locus.

MS MACRI: Just getting a local flavour but the bigger picture.

MS KOK (QADA): Yes, that's right. So obviously also we do provide specific representation to our client group through individual advocacy and supporting

individuals with the issue that they might have in relation to HACC services, aged care services and, as Margaret already suggested, it is really around a collaborative framework because the clients are vulnerable and they have to continue receiving that service after we've gone, so it's important that they have that established communication pattern and relationship with their providers as well. So that's an important part of our framework.

MS DEANE (QADA): And I would have to say that I know that our colleagues follow a similar approach

MS KOK (QADA): Yes, that's right. In terms of systemic advocacy, which again is a very vital part of our role, we really have the opportunity through our consumer consultation work - we're actually talking with consumers on the ground level - and through our casework to be able to influence change at a higher level for the future, and that is something we've currently been successful in doing as well, particularly with the HACC Program, so we're able to do that also. That sort of summarises it.

MS DEANE (QADA): So I guess in terms of a nationally-funded advocacy infrastructure I think that would bring that capacity to bring about reform and long-term sustainable change management strategies and implementation across the aged care system. Obviously, it's important for us all to plug the fact that recognition needs to be given to those - that there are established services and infrastructures in place that have evolved over a period of time. The services are respected and recognised within those jurisdictions, which I think is an important part. I guess what we see as funded independent advocacy, being seen as an integral part of aged care services, is a really positive part of the report.

I think that really, most importantly, a national advocacy system enables government to meet its obligations under various international, national and state conventions and legislation. Our national aged care advocacy program operates under the legislation, as we do in terms of HACC under the Home and Community Care legislation. I think that that is quite a significant thing for consideration in having a national advocacy system.

I think that the other thing is that, to ensure that older people's needs are met, the advocacy services need to be resourced well. In a country like Australia there are a number of different factors that impact on the ability to do that, and what we've found has been a very successful model is having regional representation, and I don't think that that just applies here. It has been recognised in other reform areas for other services, in terms of the healthcare system and things like that. From our perspective we have a track record now of having regional offices, and we have more people contacting us because they have people there that know the local nuances and they know what people want and need. Certainly our work has increased in each of the areas where we've had that regional presence.

MS MACRI: Because Queensland is virtually two states, isn't it?

MS DEANE (QADA): You could say more than that, really.

MS MACRI: But there is a huge divide in Queensland.

MS DEANE (QADA): There is a huge divide, yes.

MS MACRI: The Far North and the South East.

MS DEANE (QADA): Exactly, and I know that similarly in Western Australia and in the Northern Territory we've actually developed an advocacy framework to work with clients from Aboriginal and Torres Strait Islander communities as well as Australian and South Sea Islander. That is a very different model and it's very much a hands-on, face-to-face model that gets the results, and so I think that those are really significant components of it. I've probably talked enough about that, so we might just move to some of the other recommendations in the report.

MR WOODS: Please, yes.

MS DEANE (QADA): Unless you have any specific questions about advocacy.

MR WOODS: No, we understood that side of it.

MS DEANE (QADA): We'll probably just do a little sum-up at the end, or you can ask a question. We saw that the integrated care system - and the importance of a single-funded system. It needs to have the capacity to respond to the differences in each state and territory, particularly the geographic ones that we just alluded to in terms of our own service, and that ability to respond to the different needs and what level of service people require, and also to assist the delivery of that whole continuum of care. Having that all coming from one funding source we see can have its advantages.

We strongly support the establishment of an independent single entry point through the proposed Gateway and that will go a long way to addressing some of the gaps, particularly to provide consistent information, assessment and care coordination, as well as referral services. I think that that concept is really important. That I think would go a long way, and certainly from the consumer consultations that we have conducted in Queensland over the last five years, those are all issues that keep coming and it comes up in our casework. But that consistent information is the one thing. It's there all the time and it's come up each year.

MS KOK (QADA): Following on from that, whilst having that single entry point is

really important, the fact that you've also said that there would be multiple ways of people - - -

MR WOODS: Ways of accessing. Absolutely.

MS KOK (QADA): I think that is really key because, as we've talked about having a regional presence and all those sorts of things, it's so important for people to be able to access that sort of service, otherwise they just won't do it. So that's really important. Also, being able to assess and provide assessments, and also linking into those financial assessments from an independent point of view, is really important as well for our clients, who are often afraid to ask questions and aren't understanding the information they're being given, particularly if it's the care provider and they're thinking, "Well, I'm going to end up with this provider who's going to be providing the care," so they may be reluctant to speak up about certain things. So I think having an independent body to do that is very important; and also in terms of understanding what their options are and where they can actually go, because we get a lot of calls around people thinking that they aren't paying the right amount of money in terms of aged care facilities, and also in the community, and they don't understand maybe where the finances are actually going to. So that transparency around those issues is vital.

MR WOODS: Absolutely important.

MS KOK (QADA): Yes. I know in the model it talks about the fact that you would have perhaps that over-the-phone assessment initially and then face-to-face for a more complex assessment.

MS MACRI: No.

MS KOK (QADA): No?

MS MACRI: No. Basic.

MS KOK (QADA): Basic, sorry. Yes.

MS MACRI: Yes. So it's equating to your HACC-type services.

MS KOK (QADA): What we have seen from clients is that even that very basic assessment level needs to be done face-to-face, because you have to see the environment that they're living in. Often people aren't - I wouldn't say "honest" but they don't give out all the correct information over the phone; whether they just don't understand maybe what they're being asked or for fear of wanting to not basically give their circumstances away.

MR WOODS: Sure.

MS KOK (QADA): So we would really strongly advocate that there is a need for that face-to-face assessment. We've seen lots of occasions where people's care is inappropriate, basically.

MS MACRI: I guess what we were trying to do was to not overcomplicate that.

MS DEANE (QADA): It's a really fine line. It comes around to that whole level of functionality. You know, it's really hard to say that you're not functioning well. So that's one of the areas. That basic level of support is to maintain functionality and I guess that's where we see some of the issues.

MS KOK (QADA): People don't necessarily want to even ask for help or recognise that they need it, so even getting to that stage can be quite difficult. That's what we've seen, anyway, with our clients. Also, I do think that level of care coordination that possibly could be there - whilst I know it's talked about, the service provider taking on a more extensive role and I think that that's important, I think care coordination in terms of making sure the person ends up receiving a service is really important, as our current system doesn't always link them in and people can be left after having the assessment and not actually being linked into a service.

MR WOODS: Yes, we agree with that.

MS KOK (QADA): Yes. We do have a role in that as well and I see that we could potentially have a larger role in assisting with access at that level. We're not funded to be able to provide, obviously, the extensive work that would be required at the moment, but that could be a potential for us as an advocacy service that's independent, trying to link people into services. I think it's dangerous when it comes from the service provider because obviously they have other maybe agendas and - - -

MR WOODS: Other agendas.

MS KOK (QADA): Yes.

MR WOODS: That's why we saw the Gateway as having that follow-up role: "Have you got a service provider? Do you need help with identifying an appropriate provider?"

MS DEANE (QADA): And in that Gateway it was mentioned about advocacy, so we see that we could play a complementary role.

MR WOODS: Yes, absolutely.

MS KOK (QADA): Yes, for sure. Also I guess an area that we have seen as well - and whether this would fit in there or not - is the issue of reassessment. Often, when people are maybe at risk of maybe service withdrawal or a reduction in service, having an independent assessor would be really important in that sort of situation. Often when we get called in is when it's at the point where they're about to lose their service - and so obviously having advocacy assist in that process. But often the client is concerned that perhaps they're not being assessed as well as they could be because it's the service provider that's conducting that assessment, so perhaps there is a place for the Gateway system to also be able to do those reassessments.

MR WOODS: Yes. Where there's any doubt or dispute - - -

MS KOK (QADA): Yes, exactly.

MR WOODS: - - - then the Gateway would organise for a third party process.

MS KOK (QADA): Great. I think that's a really important aspect of it. That's probably most of the Gateway that I wanted to talk about.

MR WOODS: Yes.

MS KOK (QADA): In relation to the consumer-directed care component, again we would agree very strongly that that's really important and you've highlighted that considerably throughout the report. I think it is important that that is balanced and acknowledged in terms of the vulnerability that the client group does have and in terms of being able to understand what their options are and where people can go needing that support, possibly through that process, because whilst choice is really important, a lot of people don't necessarily want to take on the responsibility of having to coordinate their own care.

MR WOODS: No. So they could go to a single provider that they're happy with and say, "Here's my bundle of entitlements. Here are the payments I'll give you my co-contribution. I'll sign over the subsidy. You look after me."

MS KOK(QADA): Yes.

MR WOODS: If they don't like that, then either they do a dispute resolution mechanism or go somewhere else. But they don't have to try and put things together.

MS KOK (QADA): Yes, so just making sure that they have that support and understanding of what their rights are around those areas so they don't get lost in the system as well, I think is important. Some of the issues we have come across are around particularly packaged care, so having a single focus would be really important because with packaged care often it can be that - - -

MS MACRI: You fit in this box and, if you don't, too bad.

MS KOK (QADA): Yes. Again, people don't understand what they should be getting.

MR WOODS: Yes.

MS KOK (QADA): How many hours it is, all this confusion, because there isn't transparency around those, around how the services are delivered.

MR WOODS: And having to change provider if your intensity changes.

MS KOK (QADA): Yes.

MS DEANE (QADA): And that becomes a major issue, I think.

MR WOODS: Yes.

MS KOK (QADA): And I think, too, being on a waiting list for a package and not getting any service because, well, you don't fit into this category or this category.

MR WOODS: Yes, we'll do away with all that.

MS KOK (QADA): Yes. So I think that's really important.

MR WOODS: Fees?

MS DEANE (QADA): Fees has always been an issue, and in this state it becomes - because there isn't consistency, so I think having a national fee structure with inbuilt flexibility - and that's again to take note and take into account individual differences and needs and the capacity to pay.

MR WOODS: Sure. But some clarity so people understand, "These are the arrangements. They fit into this bit. That's what the arrangement is." But there's all the hardship stuff at the bottom and stuff that will all carry on as currently.

MS DEANE (QADA): Yes, exactly.

MS KOK (QADA): Yes.

MS DEANE (QADA): And I think that the other issue, and the one that we come across, is that at the moment HACC - and it does differ in each state - a lot of those services there isn't a fee or a contribution, and so people are reluctant to move to

packaged care but yet they need it, and they refuse it.

MR WOODS: I know.

MS DEANE (QADA): I think that has got to be addressed.

MR WOODS: That's why there would be a more progressive - so the higher the intensity of service, the appropriate - - -

MS KOK (QADA): And I think that's the thing people don't understand: "Why is it that now I have to pay the fee?" because we've actually seen cases where people's services have been reduced but then their costs aren't reduced and it's, "Well, why?" There's no consistency there and it doesn't make sense why.

MS MACRI: And the other thing is, too, quite often people might have services and then they could be reduced but they don't reduce them because they're concerned about if they do, they won't get back in.

MS DEANE (QADA): Get them back, yes. That's exactly right.

MS MACRI: That's the other issue around that.

MS KOK (QADA): Yes, for sure. We've seen that as well, yes. So in terms of fees I think definitely there needs to be that transparency. The inequality is there at the moment, so trying to address that, and also looking at some of the other issues we've come across; thinking about remote locations. We've seen with packaged care and other services, because of the distances carers are travelling, that gets absorbed into the package as well, and so people like me and my service - - -

MR WOODS: It means reduced hours.

MS KOK (QADA): Yes, exactly right. So I think that recognising that - - -

MS DEANE (QADA): Yes. It's almost like there's got to be some adjustment, a top-up, to take account of that, so that the client actually gets the level of service and care that they need and - - -

MS KOK (QADA): So while there's - - -

MS DEANE (QADA): - - - there's no - - -

MS KOK (QADA): There's still flexibility - sorry - for those areas or issues that fall outside.

MR WOODS: That are one-off, yes.

MS KOK (QADA): Yes.

MR WOODS: Workforce?

MS DEANE (QADA): Can I just say, too, in relation to - I don't know that I've totally understood in terms of the payment - - -

MS KOK (QADA): Co-contribution.

MR WOODS: Okay.

MS DEANE (QADA): And the co-contributions. And then the other issue is a level of concern around where - if providers are able to set charges for care and accommodation based on the market forces - - -

MR WOODS: No, not for care.

MS DEANE (QADA): Not for care? Okay.

MR WOODS: Care: you come out of the Gateway with an entitlement.

MS DEANE (QADA): Okay.

MR WOODS: That has a price attached to it. Your co-contribution, part of that price is set according to your circumstances, but the overall price to providers doesn't change; just the difference between your payment and the subsidy changes within that price. And so providers won't be competing on price; they are given a standard fee. But on the accommodation side, if you're not a supported resident, then providers providing residential care can choose whatever level of accommodation they want to offer and the price for it, as long as it's a published price and includes a daily or weekly rental, as well as a bond.

MS DEANE (QADA): Okay. Thank you. That I feel allays concerns up to a point. I guess from our perspective - and I think this is going to become more apparent as the client group age, particularly when they've been in long-term care, and if their financial situation and their investments, for whatever reason, change and they're not worth what they thought they would be; I guess highlighting the emotional stress that that will place on someone, particularly your 85-plus people, at the thought of, "Well, do I have to move? Am I going to have to move? Am I going to be out of here?" and those sorts of things.

MR WOODS: No.

MS DEANE (QADA): So I guess that was one of the concerns based on some of the casework that we've had to date. And there are going to be more of those people and we realise, particularly now, that people's capacity and their investments over many years are not going to be the same. So that was just a concern.

Workforce: that is one we come across, in terms of the differences in each state in qualifications and the status of those qualifications, where something that someone may gain in New South Wales may have a higher status or a higher level of training than a similar one in another state. So the need for national consistency is really important. One of the biggest issues that we come across through our client work is the impact of agency staff on clients. I don't think that that's not an unknown fact, but we just wanted to mention that.

MR WOODS: Yes, we're aware of that.

MS KOK (QADA): I think also the whole Quality Framework, whilst there are certain standards that, for example, aged care facilities have to meet and that sort of thing, I would say from our experience as an advocacy service some are very open to that whole Quality Framework and including advocacy and their clients, really wanting to understand what their clients' needs are. But then there are others that maybe aren't, to the point that they may not even allow us as an advocacy service to come in and talk with them. So perhaps having some sort of - - -

MS DEANE (QADA): I know it's complicated.

MS MACRI: I know the accreditation agency is in the process of looking at consumer involvement within the - you know, which is obviously advocacy involvement or consumer involvement in the accreditation process.

MS DEANE (QADA): And it's not the accreditation agency that has the issues. It's the services that - - -

MS MACRI: But if it becomes encased within the standards or the process - - -

MS DEANE (QADA): I think that's what we were asking: that it is part of it, and it is there in the HACC standards and it's coming in and continuing with the common community care centres, so I think across the board it would make a difference.

MS KOK (QADA): It would make a big difference.

MS DEANE (QADA): But I guess in terms of regulation we fully support the separation of those aspects, both the quality and the complaints investigation mechanisms. They're separate from, and they're in an independent statutory role.

MS KOK (QADA): I guess just summing up, we've talked about the fact that we see advocacy as playing an integral role in the new aged care system and that the one system is very important, but also recognise the vulnerability of the clients that we're working with and that they need to understand and be educated around how to navigate the system as well, and a lot of people may not have supports to do that, so just recognising that and thinking about how that can happen for people, because we definitely support the need for choice and I guess competition in the marketplace will produce that, but at the end of the day recognising how that can best service the clients and consumers.

MS DEANE (QADA): And having the support, I suppose, to exercise that choice.

MR WOODS: Absolutely.

MS MACRI: Absolutely, yes.

MS DEANE (QADA): And I think that the advocacy services that exist - we do have longstanding relationships with key industry providers and government, so I think that is something that should be retained.

MS MACRI: Absolutely.

MR WOODS: Excellent. Thank you. It's been a very helpful discussion and what I liked was not only your discussion about the advocacy services themselves but your perspectives on all the other reforms. It's nice to get your interpretation of where there are strengths and weaknesses in the proposals.

MS DEANE (QADA): And thank you for clarifying that, because I think we were struggling a bit on that and I kept thinking, "We can't go back and read it again."

MR WOODS: I feel the same way sometimes.

MS MACRI: Yes, it's a very long document.

MS KOK (QADA): Thank you for the opportunity.

MR WOODS: Thank you. That was very good; appreciate that.

MR WOODS: Your turn, Vince. This is your second go.

MR WATSON (AIRBS): I'll make it short and sweet.

MR WOODS: We have your written document, so you won't need to read it all out, but if you want to just draw attention to a couple of points when you find your glasses.

MR WATSON (AIRBS): First of all, I'd like to thank you.

MR WOODS: If you can just give your name and who you're representing this time.

MR WATSON (AIRBS): My name is Vince Watson. I'm a member of the Association of Independent Retirees, Brisbane South branch, and I am the chairman of the Aged Nursing Home Committee.

MR WOODS: Thank you.

MR WATSON (AIRBS): First of all, I've got an ear infection and I can't hear too well, so if you can bear with me.

MR WOODS: That's fine.

MR WATSON (AIRBS): Without getting into too many ifs and buts, I've listed about four or five things and I'd just like to talk on those. First of all, I've interviewed in confidence several staff members with some 10 years each of service. They are adamant that they do not have sufficient trained staff and hours are being cut at all times. It's extremely strange that at the time of certification - a nursing home has to get certified every so often - at certification inspection by the relevant department, staff numbers are usually doubled for the show. I think that's something that needs to be looked into because they're painting the place up, which is not in reality.

MR WOODS: We've heard that from others as well, so thank you for that.

MR WATSON (AIRBS): I'd like to make two comments there. One of the major problems in nursing homes that I've been associated with is the lack of the staff of their ability to talk English, and this is something that is very difficult for the old people. I would like to suggest that perhaps the government bring in some type of a nursing home diploma where they could encourage people to come along and train for nursing homes with a diploma. I've seen staff there, very good staff, go and get fully qualified as nurses and that's the end that you see them. I think you've got to lower your horizon and get somebody that's going to stick with you and give them

the rudiments of what it's all about.

MS MACRI: Okay. Accommodation bonds?

MR WATSON (AIRBS): I'd like to move on to accommodation bonds. Presently nursing home providers are allowed to charge a bond on low-care and high-care extras. A bond cannot be demanded by the provider of high care unless both parties agree. Differing from charges, the current system is negotiated between the provider and the proposed resident or their family. Charges are virtually looked at by the Department of Aged Care.

As reported in the Australian newspaper, the proposed resident or their family are babes in the woods compared with many current nursing home providers. The system is being abused, where proposed residents are selling their homes for, say, $1 million and the provider is taking the majority of the sale price which then is not accountable for Centrelink purposes. The resident then receives a full pension and has no assets or income and pays very little for the - - -

MS MACRI: Can I just say, I think we went through this pretty thoroughly with your other colleagues and I think the draft recommendations now really are there just to prevent exactly that.

MR WATSON (AIRBS): All that I'd like to add would be that I would be very careful of how you do it, because I believe there are unscrupulous providers out there that have put it over families for a long time.

MS MACRI: They wouldn't be able to if the recommendations that are in the draft report are carried through and the government implements them.

MR WATSON (AIRBS): Okay. The next is taxation rebate for medical and nursing home expenses. In AIR at our branch about 55 per cent are part-pensioners and about 60 per cent do not have allocated pensions and that poses severe problems that I'm going to talk about. Rather than take away any taxation benefits by way of tax rebate of 20 per cent after the first $1500 to increase to $2000, seniors health cards are based on the taxable income.

As many self-funded retirees are paying more than 55,000 per annum nursing home fees plus medical and personal taxes, those who are not fortunate to have their affairs set up in the allocated pensions are forced to sell capital items such as property or shares. Once their taxable income goes over 50,000 single and 80,000 couples - and there is 100,000 for somebody that's in a home - they've got to sell assets and they're losing their seniors health card. Many are on 10 scripts a month and are forced to pay $33.50 for each script. This does cut out after five months. Surely these people who have worked hard, saved their money to provide for their

old age and paid their taxes all their lives, and paying their way in the nursing home at little or no expense to the government, deserve better.

I have been advised by the shadow minister for the aged that less than 1 per cent of our population are presently in nursing homes. I believe it's the figure of 170,000 and we've got a population of 22 million, so we're not talking a hell of a lot of people. Noel Whittaker, a well-known financial writer and adviser of Queensland, has published a very interesting article in the Courier Mail that the average person in a nursing home pays more, in the last two to three years of their life, in medical and nursing home expenses than the whole of the rest of their life. I think some serious consideration should be looking to those, especially those that haven't got an allocated pension. We've got an allocated pension; we've got our seniors health card. The lady in the next room hasn't. She's lost hers.

MS MACRI: Yes, okay.

MR WATSON (AIRBS): And it's unfair.

MS MACRI: All right, we'll take notice of that one. And if we move on to user pays.

MR WATSON (AIRBS): Okay, user pays. Published Australian figures - increases of 20 per cent each 10 years for people over 80 years up to 2050. Some of these people will still have 25 to 30 years of working life before they require nursing home care. If it's going to be user pays, perhaps a scheme could be considered to collect from these potential users on the way in, rather than hit those who have already paid their taxes and have no further means. I believe there has to be a preparation.

Finally, the luck of the draw. As previously stated, only less than 1 per cent of the population will go into a nursing home. The worry to the now residents of nursing homes, who have provided to look after their old age, when they see their nest egg disappearing is enormous. They will die from financial worries rather than old age. It would appear that it would be like winning the Lotto to fall off your perch at home rather than be faced with these expenses at the end of your life. Surely the proposed scheme is (indistinct 4:51:09) towards a few unfortunates who are faced with the end of their lives in the nursing home system.

MS MACRI: Okay, thank you.

MR WOODS: Thank you very much, and we have the document as well as your statement on the record, and transcript will be available. Thank you for spending most of the day with us.

MR WATSON (AIRBS): That's all right.

MR WOODS: We apologise for the various noise and - - -

MR WATSON (AIRBS): I just wanted to give you the - I visit the nursing home six days a week, I know what goes on in there, and the other side of the story from a husband who looks after his wife.

MR WOODS: That's very good of you.

MS MACRI: And that's valuable for us.

MR WOODS: So thank you for spending your time and putting this together.

MR WOODS: That concludes our scheduled participants. Is there anyone who wishes to make an unscheduled statement?

MS GALLEN: If I could, please.

MR WOODS: Can you please come forward?

MS GALLEN: Yes.

MR WOODS: Perhaps if you use the last remaining microphone.

MS GALLEN: Thank you, Professor Woods. Robin Gallen, the Crestmead 40+ Club. I wasn't aware that I could speak today, so thank you very much for the opportunity. One of the things that I'd like to say, that I spoke to the professor about, if she'd include it: there's nothing about the amount of women who are now being coerced by their families to sell the home and to go in with the family, only to find in the shortest time that the younger members of the family, including grandchildren and other members of the family, make their life a living hell and there's just no way for them out. Many of them have gone onto acreage and there isn't any transport. Once the family leave the home they've got no way to get to anything that's social. We've looked at it in Logan through LANDS but the LANDS only have a restricted area where they can travel to and we're finding this a growing problem.

I myself am a victim of elder abuse and you couldn't think that anyone would be abusing me, but I have a 45-year-old mental son who - and it's probably drug-induced psychosis - is just making our life and our family very difficult - financial burden. It's always a crisis. I'm just one of thousands now of older people faced with people making their life a misery and there just doesn't seem to be any way out. I've spoken to the Elder Abuse line and they understand it but there really is no way of addressing the family members that are now moving in on the elderly because of broken marriages, et cetera, who are really causing havoc for the elderly. I expect to live many more years and I just hope there's a solution to this problem. Thank you.

MR WOODS: It is a genuine issue. So what support networks do you call on? You mentioned that you'd been in contact with Elder Abuse and that they're understanding.

MS GALLEN: They're understanding but that could often mean nothing, you know. I can call the police if there's a crisis. I waited two days for the police to come. My son has been admitted to Logan Hospital numerous times. One night he spent the whole night in hospital and they didn't even look at his medication or what's happening with his medication, and he said to them he was going to jump under the train at Kingston station. I pleaded with them to do something and they

just let him walk out the door.

MS MACRI: So it's that real interface of the mental health system and - - -

MS GALLEN: The mental health system. There's so much money going into systems. I've got to tell you I know in our Logan area we're so fortunate with the systems that we have but I don't know where the money is going in mental health. I can talk to 100 people who say that they've got the same problem that I've got with younger people with these mental health issues.

MS MACRI: Yes, okay.

MR WOODS: Are there other avenues that you've found have been more helpful? Is there any little sort of area of - - -

MS GALLEN: A window?

MR WOODS: Yes, a window.

MS GALLEN: Well, I say it's like a deck of cards, okay. My son has got this deck of cards and every time there's a window of opportunity, like some safe housing, then somebody shuffles the cards and says in three weeks' time there's going to be a house available, and then they tell us, "Oh no, that place was vandalised so that's not available." Then you need five more support letters because your situation has changed because you've gone from living on one person's couch to another and you've changed houses. "So now you've changed houses we've got to get a whole lot more information." We just go round in circles. I've just been able to come today - I had a crisis this morning which my elder son is now taking care of for me today, but I'll go home to the same problem.

In order for my son to see his two children, who are not quite eight and 10, then I'm the supervisor for the visits, which means he can't have any alcohol. He can't have any alcohol during the visit. I have to do all the driving, I have to do all the supervision and make a report, but it's so important that these children are kept in the loop. So you could say, "Look, just back away and just leave him be. Just let him - whatever he's going to do," but now we've got the grandchildren and this is so important for them now, that at least some of the time they're seeing a stable father, even with the burden on me to make him stable for that six-hour period once a week. And every Saturday I've got to spend - the preparation getting ready for Saturday, so it was like half past 2 this morning when I couldn't sleep any more, so it's like Thursday night, Friday the preparation, Saturday the long visit and Sunday trying to recover, waiting for the week to go around before I've got to do it again - and the financial burden of all of that as well.

MR WOODS: Thank you.

MS GALLEN: That's one issue.

MS MACRI: Yes.

MS GALLEN: And I look like a strong person, don't I? I mean, I really am feisty.

MR WOODS: You certainly do.

MS GALLEN: But the system is letting me down terribly. The house for him - the apartment was supposed to become available in November. We've just couch-surfed for months and nobody has got an answer. Without the house he can't have the children. He can't have the children because he hasn't got the house. That's it.

MS MACRI: Look, I think we just need to note the report is about caring for older Australians. Elder abuse in itself has come up, you know, from time to time.

MS GALLEN: Yes.

MS MACRI: But it's also this interface with the mental health. It's the older person with a younger person with a disability, which is either mental health or whatever, and I guess it's about how we slot that into the report.

MS GALLEN: I'm actually 72.

MS MACRI: Well, I tell you what, you're fantastic.

MS GALLEN: Thank you so much.

MR WOODS: Thank you very much.

MS GALLEN: Thank you so much.

MS MACRI: And thank you for sitting here all day.

MR WOODS: Does anyone else wish to make an unscheduled statement? That being the case, I conclude this session of the Brisbane hearings and the inquiry hearings will resume in Sydney on Monday. Thank you very much.

AT 4.59 PM THE INQUIRY WAS ADJOURNED UNTIL
MONDAY, 28 MARCH 2011