S&C

SPARK AND CANNON

Telephone:

Adelaide	(08) 8110 8999
Hobart	(03) 6220 3000
Melbourne	(03) 9248 5678
Perth	(08) 6210 9999
Sydney	(02) 9217 0999

TRANSCRIPT
OF PROCEEDINGS

PRODUCTIVITY COMMISSION

INQUIRY INTO CARING FOR OLDER AUSTRALIANS

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

TRANSCRIPT OF PROCEEDINGS

AT SYDNEY ON MONDAY, 28 MARCH 2011, AT 8.38 AM

Continued from 25/3/11 in Brisbane

INDEX

MR WOODS: Ladies and gentlemen, welcome to the Sydney public hearings for the Productivity Commission inquiry into Caring for Older Australians. I'm Mike Woods and I'm the presiding commissioner for this inquiry. I'm assisted by Commissioner Robert Fitzgerald and Associate Commissioner Sue Macri.

The commission has been requested to undertake a broad-ranging inquiry into the aged care system with the aim of developing detailed options for a redesign which will ensure that the current weaknesses are overcome and that 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 and 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.

I would like to welcome our first participant to the hearing. Could you please provide your name, the organisation you represent and the position you hold?

DR PESCE (AMA): Dr Andrew Pesce, president of the Australian Medical Association.

MR WOODS: Welcome, thank you, and thank you for your contributions to date, both your submission but also the round table that we had earlier which was very, very helpful to us. So thank you for all of that. Please proceed.

DR PESCE (AMA): Thank you for the opportunity to appear before you today. Elderly people in Australia deserve a right to medical care regardless of whether they're in their own home or in an aged care facility. Access to medical care is a critical consideration in caring for older people and medical practitioners are an integral part of that aged care workforce, particularly in residential aged care.

The AMA appreciated the commission speaking directly with geriatricians, old age psychiatrists, general practitioners and rehabilitation and palliative care specialists to better hear about their first-hand experiences. We were excited that the commission's inquiry would identify meaningful changes to overcome some of the difficulties faced by doctors caring for older Australians and the difficulties that those older Australians themselves face because of that.

I'm afraid we are a bit disappointed that the draft report makes almost no reference to the provision of clinical care to older Australians generally and access to medical care specifically and that there are no specific recommendations for the government to consider. There is no doubt the medical workforce and the entire health workforce will be challenged in providing care to an ageing population, and we need to start planning for that now. We need to set up the funding structure so that doctors can be more mobile and attend to aged care residents and so that doctors can involve other carers as a part of the team to provide management that they coordinate of the patients. We need to set up an environment that is attractive for young doctors to consider incorporating aged care medical practice in their career plans.

There is a clear imperative for the Australian government to develop a sustainable service delivery framework to provide access to medical services for older people, guided by the outcomes of your inquiry. I stress they do need some consideration and some considered input. I believe the Productivity Commission is very well placed to provide that. I would be happy to take your questions.

MR WOODS: You've raised, both in your submission and in your discussion points this morning, issues relating to the delivery of clinical care to people. Now, for people living in their own homes, whether that's current home, independent living unit, retirement village, whatever, wherever people choose to live, that's the very strong interface with the primary care system. The issue then is for those people - putting aside residential care for the moment, if we can separate out the two - what specifically additional would you be considering is necessary for us to recommend in relation to delivering primary care to people who have frailty or other aged-related clinical needs compared to the general population? Why does that need special attention and not just attention in the broader primary care context?

DR PESCE (AMA): Well, in answer to the part about providing primary care to aged people in their homes and if they're frail and less able to move, it would be a great advantage for that to be provided in their homes.

MR WOODS: True.

DR PESCE (AMA): There are significant opportunity costs which are generated to provide care in people's homes. Obviously when you aggregate demand and aggregate output you can provide it, and possibly the current MBS rebates might go close. They probably don't even do that in practice and surgeries, but at least it forms a basis for a business model whereas, to leave the surgery for half an hour to make one visit in a person's home, there is not adequate attention in the current MBS fee structure to provide that care. When we move then to aged care facilities it becomes

even more problematic, in that often those residents are receiving some care from the nursing staff employed by the aged care facility; there is not a good process to facilitate a communication with the treating doctor; there are often inadequate facilities when there should be able to be provided good facilities for doctors to come.

MR WOODS: Yes, if I can explore the residential care in a minute, but just continuing the focus on the nonresidential care, so issue 1 for you is the insufficient remuneration to encourage a GP to leave their surgery, attend a visit, and return to the surgery. So you're saying the total elapsed time for that function isn't sufficient to provide adequate clinical support or to encourage - - -

DR PESCE (AMA): Yes, it becomes increasingly difficult for a whole lot of reasons.

MR WOODS: But again, that's not just a feature of aged care; attendance at a person's home can be related to a whole range of issues. Presumably these are matters that have been raised in the context of primary care generally and there are negotiations or representations or significant debates over a period of time about whether the schedule is sufficient or not?

DR PESCE (AMA): The difference is, of course, that for aged care health consumers, even routine care probably needs to be best delivered in their homes, whereas for younger people, except for people with significant disabilities which affect their mobility, most people can attend a doctor's surgery. Instead of it being just a small part of practice for mainstream primary-care home visits, for aged care for people living at home it would be a large part; if they have mobility problems, it would be the routine part of medical practice.

MS MACRI: Just again coming back and, with that, you talk around practice nurses and community nursing services, and it's about that whole care and the whole approach to care. I was just a little bit surprised around the lack of those sorts of community nursing services, especially in metropolitan regions. You talk about having good models in urban, rural, and metropolitan, so where do you see that link between the GP and their home visits, community nursing services, which there are very good ones. Then of course people on CACPs, EACH, and EACHD, at the moment, are visited pretty regularly through the case manager and the provider, so I'm just wondering how you see the GP working in that whole team approach?

DR PESCE (AMA): I suppose one of the focuses of this inquiry that I pick up is that you want to maximise people's choice about a whole range of things and I would have thought that should include a choice of model of medical care that they'd want to deliver. There will be some people who'll be very happy to accept care provided

by an organisation that does it on behalf; there'll be those who do actually want to see their doctor. I think it is a two-way thing: I think doctors have to want to do it, but I believe the majority do. The need to make sure that we don't fragment, so a doctor doesn't come and think that this is the care that has been provided and then someone else comes in. So there has to be a whole-of-system approach to that. Currently, for various reasons there is a bit of fragmentation and the very most extreme example of that is the fact that, if there's a problem, a patient gets shunted off to a hospital for assessment rather than a doctor assessing them in a primary care setting, which would normally be what happens.

MR WOODS: We certainly do want to avoid unnecessary travel and use of the hospital environment, wherever that's possible. We're supportive in that sense and we certainly do want to encourage people having the ability to remain outside of residential care for as long as they choose. Where they choose to live is a matter that we also hope to free up, but, yes, we do need to encourage deliver of clinical and broader nursing care into the home environment. So apart from the incentive on the scheduled benefits side, are there other particular issues in relation to community care that you would want to raise before we move onto residential care?

DR PESCE (AMA): It would be very helpful to have an augmentation of the current trend; that is, to have funding for practice nurses and nurses who work with the medical team who could be delegated. They could be the real primary carers; they could go out and see the patients and then report back to the doctor who coordinates the care and comes to see the patient when that is actually required, whereas a lot of the routine care might be provided by nurses. But the current business models don't allow for that very well. There isn't adequate funding, especially in metropolitan areas, for funding for practice nurses employed in general practice. There have been some improvements lately, but they are still short of really allowing GP practices to employ sufficient numbers of nursing staff to really help them provide higher volumes of care at a more efficient level of care than currently is provided.

MS MACRI: So the only thing that's limiting practice nurses at the moment is funding; there's no other regulatory issue?

DR PESCE (AMA): I suspect there're workforce issues as well. There's not enough doctors and not enough nurses at this stage. Nurses will tend to stay employed in the hospital systems, because there is more of a career path there. So I think workforce is another issue. Funding, workforce, I think they would be the two main obstacles.

MR WOODS: Given that your point there was about practice nurses - and of course they operate under the direct delegation and supervision of the particular GP,

but there is also a broader care network, and we're looking to expand the amount of care and nursing delivered in the home environment. Is there insufficient relationship between the treating GP and the broader nursing and care workforce that is working with older people? We have anecdotal statements made to us during our various visits, particularly where we go to rural and remote areas where there seems to be a reasonable amount of integration of knowledge, coordination, and cooperation between the community nurses, the nursing staff in the local base hospital, et cetera. But, to be honest, they say to us, "But it's very difficult to get the GP to be part of that team environment." I'm saying that's only anecdotal; I don't have any hard quantitative data, but it's not an infrequent statement. Is there something that's preventing a fuller cooperation between the local GPs and the broader health infrastructure, particularly in country areas?

DR PESCE (AMA): I suspect that in country areas it might be better because there are smaller numbers of people involved and personal and professional relationships occur more easily if you don't get turnover and you're not speaking to someone new each time there's a phone call. If there is a barrier to GPs becoming more involved, I think it would be the perception that their value is less than they'd like it to be in the care team; that they're just being used to plug the gaps when the team that's actually managing the patient can't cope any more, "So, by the way, can you come in and fix up the problem now," rather than being incorporated into the whole management plan of whatever the care is being delivered.

In my experience and as an AMA president I find that there are certain things which bring the best out of the medical profession and there are certain things which bring the worst out of the medical profession. Often the implication or the impression that they're not being valued, that they're not being taken seriously, their input isn't highly valued, will tend to marginalise them and they will be less active members of what should be a good, coordinated multidisciplinary team.

MR WOODS: That's sort of behavioural, which gets a little bit hard to actually form a recommendation around, other than, "People should be nice to each other and cooperate."

DR PESCE (AMA): No, with respect, I think that when the services are being planned, the GP should be involved at that point rather than being a passive bystander, and saying, "Well, this is what we can do and, when we can't do it any more, we expect you to come in and plug the gaps." With respect, I think there could be more mention of incorporating GPs locally at every level of service planning, not just at the end when the wheels fall off.

MR WOODS: We're certainly happy to explore it, because whatever is likely to work is worth pursuing. We have, as I say, a strong interest in getting a

multidisciplinary cooperative arrangement between all the various health providers, and especially so in rural areas.

DR PESCE (AMA): I have to tell you, coming mainly from the public hospital system, that's what has caused disengagement of public hospital specialists; when they're not included in decision making, they walk. If there's a private hospital across the road, they'll walk to the private hospital and not put in the hard yards in the public hospital.

MR WOODS: Anything else you want to pick up on community?

MS MACRI: No.

MR WOODS: Let's then look at residential aged care, and from time to time you and your organisation have made a number of valid points about: when you come in and there are agency staff who don't know the patients, or even trying to find who's the responsible RN at the time, lack of consulting rooms, lack of IT infrastructure and the like. We're conscious of those, but what particular priorities would you focus on; where would you direct our attention specifically?

DR PESCE (AMA): You've mentioned them all. We would like you to consider that, in the same as there are a number of functions of aged care facilities which are subject to accreditation, the provision of adequate infrastructure for practice should be one of those. That obviously has implications in retrofitting existing facilities, but certainly moving forward it should be a requirement.

When I was a junior specialists, I'd just finished my training as a gynaecologist, I was asked to go from the public hospital to a nearby aged care facility to see an 85-year-old woman with postmenopausal bleeding, which is not uncommon. I was the most junior consultant so of course I was the one who went. I turned up and here was a woman in a four-bedded room with very little privacy. I had to do a gynaecological examination to do my job properly. There wasn't a light, there wasn't a speculum, there was nothing. I said, "From now on, you've got to bring the patient into my clinic. I can't review patients in these" - it wasn't even an examination room. That's just at the very, very most basic level of the barriers to anyone feeling good about when they get a phone call saying, "We'd like you to come and see a aged care resident for a problem."

Since you've asked me, we'd very much like you to consider recommendations about accreditation for provision of clinical services in aged care facilities, I think also, from our point of view as the AMA, incorporating access to medical care as well as other nonmedical clinical care, and we would like that to be something which you would consider making a recommendation about.

MR WOODS: Progressing to potential new models, I noticed in your submission you had drawn on an extensive survey of the intentions and actual activities of a number of GPs. If my memory serves me, it was an average of four to five residents per visit; on average, clinical interface time, a bit over three minutes; nonclinical, writing out prescriptions, writing up the case notes, organising whatever, about 13 minutes. So there is a trend of activity occurring, but also less and less GPs willing to take on that load. As you point out, a number of the older GPs, over the next 10 to 15 years, won't be there in the future. Again, we've had the experience of a number of very well-managed aged care facilities saying, "We have a relationship with three GPs, two of which are in this centre and there's another one over there. They all know each other and work together and, if one's on leave, the others take over." Clearly it's still a right of every patient to have the GP of their choice, but in those situations there seems to be trend that, over time, the residents migrate to the three or four. Is that a trend that you see developing more and more of as you talk to your colleagues?

DR PESCE (AMA): Yes, there's no doubt that the colleagues of mine who're telling me, "By the way, I do go to aged care facilities," they tend to be older rather than younger, and I think there is a cohort that basically take on that responsibility. I guess in general practice there is a willingness to stream into various subspecialties of the specialty of general practice; melanoma clinics, skin cancer, and aged care as well. I think that's quite good that people choose the path that they are most enthusiastic about, willing to do what's necessary, and have that extraprofessional goodwill. I think that's probably happening and I guess the problem is if the cohort who want to do it is so small it means a lot of people are actually missing out.

MR WOODS: So what do we do to encourage that, if it is a useful way to go, whilst still ensuring that every resident has the right to choose their GP? Is having some residential aged care facilities becoming teaching facilities, are there any other initiatives that could be put in place that would support this development?

DR PESCE (AMA): I think in certain instances that would be very good, because then you've got the people who are training there doing a lot of the routine work and the GP or the people who are coordinating it are the consultants; I suppose in the same way a consultant in a hospital doesn't do all of the work and deliver all the care. That would be good where it could be delivered, but I don't think that can happen at every facility.

MR WOODS: No.

DR PESCE (AMA): I think there are other ways you could creatively support a better business model for GPs in private practice to deliver care. It comes back to the

aggregation principle. If you were able to identify GPs who are interested, recognise that they're underpinned by Medical Benefit Schedule payments, but say, "We also need to pay you a retainer for you to express an interest in covering the facility, agreeing to be part of the team of GPs that is on call when necessary, et cetera," then that gives you an up-front incentive to say, "All right. This is already covering my background practice costs" - let's just say - "while I'm away, and so, when I do go, what I'll be earning will be income."

There are a whole lot of ways of creatively doing this. I've had a lot of quite creative suggestions which end up providing access at the equivalent of what we would consider AMA rates, to pay doctors for not very much extra investment, when you combine the various MBS, Safety Net, and the concept of an up-front retainer. So it's not as expensive as a whole lot of people throw up their hands and say, "This is going to be hugely expensive." One of my colleagues who has an interest in this says if the retainer reflected a $2 per day per resident retainer to general practitioners you could get general practitioners attending patients in aged care facilities being remunerated at AMA rates, which are substantially above the MBS bulk-billing rate.

MR WOODS: Now, from the operator's perspective they'd say that the fee that they get paid by taxpayers plus co-contributions doesn't have a component for that and that therefore this is over and above, and where are they meant to get it from. Now, different operators seem to have different capacities to manage it in the budget and different GPs have different appetites for needing retainers, so presumably there's some - give and take can happen in that context. But it's certainly a model that we are becoming more aware of and are interested to pursue that.

DR PESCE (AMA): Look, that was just one suggestion.

MR WOODS: Yes.

DR PESCE (AMA): I guess there are a whole lot of - - -

MS MACRI: It is the US model; in a lot of the states in the US.

MR WOODS: Yes.

MS MACRI: Yes.

DR PESCE (AMA): But, you know, the way - I guess one of the frustrations we see in the health system overall is the sort of cost shifting that occurs: to save a bit of money here we impose huge costs there. This is an example where if there was a single funder, a true single funder, that was funding care and it wasn't being shifted between Commonwealth responsibility for primary care and what is still major state

responsibility for hospital services - of course, sure, just send them to the emergency department for assessment.

MS MACRI: I mean the other frustration we get again, and anecdotally from the other side, is the frustration of often dealing with the fact that under user rights people have the medical practitioner of choice. Sometimes it's a medical practitioner who is reluctant but continues because of that relationship, is possibly not as up to date in terms of their medical practice in relation to some of the more specialised areas around dementia, Alzheimer's, those sorts of things. Then they have the frustration of some places, 40 residents with 15 different GPs that they're trying to meet the needs of a number of different GPs with different requirements and expectations.

DR PESCE (AMA): Yes, look, I can see that that certainly is an issue that could develop. I think the answer to that is good communication sort of for people who do want to provide a service to attend multi-disciplinary meetings; recognise that there will be some people in that facility who will need higher speciality level treatment on occasions for various things. It will help keep the GPs updated. I think the answer to that is - you know, within the medical model is multi-disciplinary meetings to make sure that the GPs who are providing services are communicating with all of the other providers at the facility and being involved in that loop.

MR WOODS: If there is anything further in that particular space - I mean we're very conscious of all your other issues, and we can rattle them off quite clearly and give them appropriate consideration. But there does seem to be an opportunity in this space that we haven't explored yet as fully as may be available, so if, on reflection, any of your colleagues can put together some further thoughts on that in that space, that would be helpful.

DR PESCE (AMA): Thank you.

MR WOODS: Anything else, Sue, while I'm - - -

MS MACRI: No, not really. I think we've got all the other - - -

MR WOODS: Yes, I think we're very familiar with your proposals and again though, genuinely thank you - and a number of your members have turned up either in a personal capacity but as supporting a similar line. So thanks for your cooperation.

DR PESCE (AMA): Thank you.

MR WOODS: Thank you.

MR WOODS: Could I invite Combined Pensioners and Superannuants Association to come forward, please.

MS CROWE (CPSA): Thank you.

MR WOODS: Thank you very much. Please, for the record, could you state your name, the organisation you are representing and the position that you hold?

MS CROWE (CPSA): No problem. My name is Charmaine Crowe. I'm the policy coordinator at Combined Pensioners and Superannuants Association of New South Wales. Combined Pensioners or CPSA represents pensioners, superannuants and low-income retirees. We have a combined membership of just over 31,000 people across New South Wales.

MR WOODS: Thank you. Thank you for your initial submission and your supplementary submission and the meetings, consultations that you've been involved in. So we're very grateful for your contribution to this inquiry to date and no doubt you will keep an eye on where we are heading. Please, I invite you to make a statement.

MS CROWE (CPSA): Thank you. Look, we appreciate the opportunity to comment on the draft report. While we welcome some recommendations made by the commission, in particular the recommendation to have an independent body to assess the cost of care we are deeply concerned about other recommendations that have been made, especially with respect to broadening the funding base. The commission's report focuses on broadening the funding base for aged care in order to meet the increasing cost of aged care due to an ageing population. The commission therefore focuses on quantity of care to the exclusion of quality of care and any improvements that may be needed to improve quality and therefore additional funding required.

This, in effect, means that the commission is prepared to countenance the government reducing its aged care expenditure in real terms while seeking ways to make care recipients' housing pay for overall costs increases. It seems that the main driver of the commission's reforms is to find ways to increase aged care funding without raising taxes. This is perhaps also why quality of care has largely been ignored. It is disappointing to see the commission note that the current accreditation and compliance monitoring systems are perhaps not all that good but fail to propose that funding arrangements only be altered once there are adequate accreditation and compliance monitoring systems in place.

We are very concerned about the proposal to effectively extend the user-pay

system in aged care. Perhaps one of the greatest problems with the user-pay system for an essential service like aged care is that it penalise those who are unfortunate enough to need the service. In CPSA's experience older people are dismayed at the cost of care, especially those who pay a bond, but also full-rate pensioners living in residential aged care where they have to pay 84 per cent of their basic rate of pension in their daily care fee, leaving very little or an insufficient amount to cover the cost of health services, pharmaceuticals, clothing et cetera.

Expanding the user-pays system will discourage people from getting care services they need, especially those least able to afford it, but also those who baulk at having to either sell or mortgage their home to pay for it. This will inevitably lead to aged care becoming a last resort rather than essential service initially accessed in the home. Consequently, many will be subject to avoidable medical interventions because of falls, poor nutrition or a lack of primary health care. Following the 1997 reforms it is clear that a two-tiered system has been installed in the aged care sector, where those with a capacity to pay are able to access better facilities, while those without the capacity to pay must try to secure whatever they can get. CPSA does not believe that this will dramatically change under the commission's reforms.

With respect to bonds, CPSA is strongly apposed to bonds. The current average bond is $233,000, which equates to a resident paying approximately $461 per week to live in an aged care facility. In CPSA's experience, older people pay large bonds not because a bond is excluded from the pensions means test, but because they are required to pay a large bond to secure a bed and also because bonds are very attractive to providers, so this leave the perspective resident with very little choice but to hand over a large bond. It is perplexing that the commission have stated their opposition to bonds publicly but then proposed that bonds be extended to high care. CPSA understands that to do this is to remove the artificial distinction between low and high care, but in that case CPSA would consider it more appropriate to remove bonds from the system altogether.

With respect to the market setting the price of accommodation and therefore the size of bonds as recommended by the commission, CPSA is not convinced that price gouging could not occur, even if the Aged Care Regulation Commission, which has been recommended by the commission to be the independent price setter and monitor of compliance, et cetera, is to monitor the sector to ensure that price gouging does not occur. CPSA asks, how would price gouging be defined; how would it be monitored; how would the quality of accommodation be assessed in terms of assessing whether or not price gouging is taking place; and how would prices be regulated if price gouging was found to have occurred.

This leads me to reverse mortgages, which has been peddled as a way to ensure that people won't have to sell the home to access aged care. Australia has a very

small reverse mortgage market, with currently about 38,000 loans with an average worth of 70 to 80 thousand dollars each. If the commission's recommendation regarding reverse mortgages was to be installed the reverse mortgage market would have to expand considerably. The commission identifies the New Zealand government's residential loan scheme as a possible model which Australia could emulate to fund aged care recipients' private contributions.

The scheme in New Zealand plays a very small role in funding aged care. CPSA's analysis shows that it contributes just 8 per cent of total industry earnings within an industry of 34,000 beds, and the industry generates approximately $170 million each year in earnings. The loan scheme in New Zealand also has an income and asset test that effectively limits the scheme to those with expensive owner-occupied housing, for these reasons a similar scheme in the Australian context is very unlikely to be feasible, especially in the short term.

Australia's aged care industry is 215,000 residential care beds, 70,000 community care packages, and 600,000 people under HACC. If the government were to adopt the proposal to back reverse mortgages to fund care and accommodation contributions, the government would need to rely on the existing reverse mortgage market and rely on it expanding rapidly. The sector would also need to cater for very different needs. Currently most people take out a reverse mortgage to fund home maintenance; this would change to fund aged care.

Reverse mortgages are also very complicated, expensive, and carry a lot of risk. The commission fails to quantify the risk associated with reverse mortgages, which the government would be expected to cover. If they did, they may well find that using commercial reverse mortgages to fund aged care is more expensive than increasing aged care funding directly, without the middle man of the reverse mortgage industry. Despite reverse mortgages being peddled as a way for paying for aged care without needing to sell the home, this is of course not true; the home would have to be sold eventually.

It is unclear what would happen under the commission's recommendations where a spouse continued to reside in the former home of the care recipient who had taken out a reverse mortgage to pay for their care. If the spouse eventually needed care themselves they would have little choice but to sell the home to pay back the reverse mortgage debt, as it is unlikely that a lender would allow them to take out another reverse mortgage. Similarly, if a dependent or a child with a disability resided in the home of the care recipient, the home would eventually need to be sold, leaving the child or dependant without a home.

At the moment reverse mortgage lenders typically stipulate that informal carers move out when the person they care for dies. This means that anyone being cared for

by an in-house informal carer would have to live with the knowledge that, to receive aged care, the informal carer would become homeless on their death. Older people in low-wealth areas or those, for instance, aged under 70 would be constrained in unlocking equity in their home because of their circumstances. They may well be left with no choice but to sell their home to fund aged care.

With respect to care costs, CPSA is deeply disturbed by the recommendation to include housing wealth in the determination of care cost contributions for community care. Someone requiring help around the home a couple of days a week will undoubtedly reject taking out a reverse mortgage and therefore accessing community care because of its cost. Full-rate aged pensioners will be particular disadvantaged by this recommendation as they are required to contribute up to 25 per cent of their care costs and would therefore have little choice but to take out a reverse mortgage to fund it or indeed sell the home and downsize.

CPSA calls for publicly-funded aged care insurance to meet funding shortfalls. Insurance would avoid penalising those requiring care, remove barriers to access because of cost, ensure an even spread of funding, and safeguard adequacy of funding over time. It would effectively be a user-pay system that would see wealthier people paying more for their care through the taxation system, while provisions could be made for low-income earners through a tax offset, if it was seen to be required. It's important to note that the commission has failed to identify how government subsidies would be increased to better fund concessional places. Although an independent price setter would be used to assess what subsidies should be, there is nothing other than public scrutiny to force the government to comply

Moving on to accreditation, CPSA is disappointed that more was not identified by the commission to improve accreditation. CPSA sees a number of areas where accreditation fails to properly monitor compliance or ensure compliance in residential aged care. CPSA strongly opposes any reduction in unannounced visits by the accreditation agency or aged care centres and accreditation agency. Indeed CPSA calls for these visits to take place outside for business hours, as visits by the agency are restricted to. We think that more unannounced visits should take place at night time and also on weekends.

With respect to mandatory reporting of abuse, CPSA calls for this regulation to stay and indeed extend it to resident-on-resident abuse. Currently it is not mandated that providers report alleged abuse where has been carried out by a resident on another resident. We think that, at the very least, if resident-on-resident abuse was reported, we would be able to gain an accurate indication of how widespread the problem is. We also don't consider the 24-hour reporting period burdensome. Indeed we would think or imagine that aged care management would want to deal with the problem as soon as possible where there were suspected cases of physical or

sexual abuse of residents to ensure that residents in the facility were protected.

With respect to the entry point for aged care, we would call for advanced care planning to be made part of the entry process into aged care, where it was possible. We would also call for an independent financial advice service to be provided to older people and their families or representatives to assist them in making the right financial decision in terms of accessing aged care. This would be particularly important if the sector is further opened up to the market.

Finally, CPSA supports mandatory staff-to-resident ratios, with the appropriate skill mix, in order to address understaffing of facilities, which often leads to poor standards of care. If staff are time poor and there is inadequate skill mix or both, from our point of view quality of care is often undermined. So happy to take some questions.

MR WOODS: Thank you. Clearly you've been through the report in some detail. That's appreciated, but having done so I'm puzzled by some of the conclusions you draw, which I don't know where they come from but not from the report. If I can just illustrate with a few things.

You talk about the virtual exclusion of dealing with the quality of care and yet the single most important recommendation is that care be delivered to people according to their need, not according to whether they fit packages and the like. So we're actually focusing on delivering care more to people in their homes, because that's where they want the care delivered - that doesn't seem to get your support, for some reason - that we break open the packages so that we actually tailor care to the individual needs of people; but that, for some reason doesn't seem to be getting your support either. I'm not sure why.

The call on the taxpayer, given that the taxpayer on the care side would be paying between 75 and 95 per cent of the cost of care seems to be a significant and important call upon the taxpayer to fund care. Care will be equivalent in quality and quantity for all people irrespective of their financial situation, and their co-contribution will be matched according to their capacity to pay, but there is no variation in the quality of care or the quantity of care that people would receive from their entitlement that's delivered by the gateway.

You raise bonds, but in fact we're making it mandatory that there be a published periodic charge, a daily charge or a weekly rental, for all people entering residential care; but that didn't seem to get a mention, but I would have thought that that then overcomes a lot of the concerns about bonds, that there is a published daily or weekly rental charge and that all people are entitled to sign up to that if they prefer that, rather than bonds. So I'm just not quite sure. There seems to be disconnect

between the draft report and your opening statement. If you could help explain that to me?

MS CROWE (CPSA): Yes, sure. You might have to jog my memory all the points that you raise that we have issue with. With respect to quality of care, I appreciate what you're saying that everyone should be entitled to an adequate standard of care. We don't see anywhere in the report - what we would like to see is funding somehow tied to that. That's certainly not part of the report.

MR WOODS: Well, it is, in the sense that - well, it is, not in the sense of, it is. People go to the gateway, they get assessed for their needs, their needs would be tailored to their actual circumstances, so they would get an entitlement to care. There would be a price determined for that care and that one price would be offered to all providers. There is no variation in the price of the care, and that would be transparently recommended by the pricing authority.

MS CROWE (CPSA): I understand what you're saying. I guess our issues with respect to quality of care arise in the actual care that's delivered to the individual. So yes, they may be assessed in terms of their care needs and that may be met by funding. Let's imagine that takes place. We're more so interested in whether or not that care achieves - - -

MR WOODS: So are we.

MS CROWE (CPSA): Yes, I think everyone is. Also the monitoring to ensure that that care is carried out from - actually. So that's what we're concerned about, and it's why we make comments about the current accreditation system and we've made comments about the accreditation system in other inquiries and also the complaints scheme designed to deal with poor standards of care that arise.

MR WOODS: Okay.

MR FITZGERALD: Can I just clarify? Your bottom line is, however, that the government should be the sole funder or not? I mean at the end of the day we've got a scheme, as Michael has indicated, that on community care the government funds between 75 and 95. By 2050, including all of the accommodation charges, everything, government's contribution will have risen from 0.8 per cent of GDP to 1.9 per cent of GDP and it will be the contributor of at least two out of every three dollars, at least two-thirds. That includes all costs. We would have thought that that's very reasonable. The government is by far the dominant contributor, remains the dominant contributor, it's appropriate they should be. But what percentage do you think the government should contribute vis-a-vis the private sector? It can't be zero, surely - it can't be, sorry, 100 per cent with zero private contribution.

MS CROWE (CPSA): Well, I think from our point of view Australia, compared with other countries in the OECD, spends relatively little. Indeed, we're sitting fourth from the bottom, at 0.8 per cent, and even by 2050 if we were to be spending 1.9 per cent - this is the Australian government - it would still be spending slightly over half of what Sweden currently spends on their aged care; you know, it's fully funded by the Swedish government.

In terms of user co-contributions, our greatest concern is basing people wealth on their housing assets. So if you've got a system where - and correct me if I'm wrong, which is what the commission has recommended, that the individual's housing wealth be factored into an assets test for both community care and residential aged care - you're inevitably going to find that those with the least capacity to pay or those people with the least level of income are the worst affected in terms of access. So if someone is entitled to receive a community package but they're told they're going to have to contribute let's say 10, 15 per cent of the community package's cost in terms of a user co-contribution, if they're on a full-rate aged pension they well find that they have little choice but to take out a reverse mortgage to fund that.

MR WOODS: If they have minimum wealth and income they're only going to be paying 5 per cent.

MS CROWE (CPSA): If their house is valued over the threshold - - -

MR WOODS: Yes, if they have significant wealth then that would get drawn on.

MS CROWE (CPSA): Well, our issue with that is that you're going to be perhaps penalising people who have purchased a house say 30, 50 years ago in an area that now has increased substantially in value. It's the family home. They are going to have to take out a reverse mortgage to take out that extra cost if they don't have adequate resources from their rate of income, which is highly unlikely, because if they're on a full-rate aged pension - - -

MR WOODS: Yes. If they have significant wealth, that may need to be drawn on in part, but with also a stop-loss total lifetime limit.

MS CROWE (CPSA): Sure, but I guess the damage is already done in taking out the reverse mortgage. I mean I must say that reverse mortgages are a very expensive way of funding aged care costs. Reverse mortgages incur compound interest and depending on the lifetime of the reverse mortgage - I mean if someone has to take out a reverse mortgage at the age of 70 to pay for care in the home, they may well live - it's possible they will live to another 20 years. That debt is going to grow over

that time in line with compound interest and the possibility they should pay it back.

MS MACRI: Well, there is a stop-loss, as we said.

MS CROWE (CPSA): The issue is that the reverse mortgage - it's not necessarily going to pay care costs, it's going to the lender, the financial institution that has lended the money in the first place, and they are going to be charging interest on top of the amount taken out.

MR WOODS: Given the time - I mean you've set out your views, and we are grateful that you have set them out in detail. I'm not sure what further we can pursue today. Is there a particular - - -

MR FITZGERALD: No, that's fine.

MR WOODS: So I think at this point, given that we do have other participants who are scheduled to appear five minutes ago, perhaps if we draw this session to a close. But if in relation to - - -

MR FITZGERALD: There should be one or two comments, if I could just clarify for the record. You've indicated the situation of a spouse or a partner in a home; they will not be required to sell the home. I think I made that clear in the conversations we had privately. But we have a very strong view, and it will be articulated more clearly in the final, that should a spouse be required to go into residential care and there is a reverse mortgage in place, the house does not become forced to be sold or what have you until that other partner either dies or the house is actually sold at that stage. There will be no case where a partner who has a legal entitlement to that house would be required to sell the house or leave the house. I just want to make that clear on the record and we will make it abundantly clear in the final document.

MR WOODS: I thought it was sufficiently evident in the draft, but, if not, that will - - -

MR FITZGERALD: We will make that clear.

MS CROWE (CPSA): We think that there needs to be a greater exploration of how reverse mortgages actually work.

MR FITZGERALD: Sure. We've taken that on board and it certainly will be in the final, so we thank you for that. We will do that.

MR WOODS: If following today's session there are some useful ways forward that you can see, that meet your needs, that would be a helpful additional contribution.

MS CROWE (CPSA): Thank you.

MR FITZGERALD: Thanks.

MR WOODS: Thank you for your time.

MR WOODS: Can I call forward the Ethnic Communities' Council of New South Wales, please? I've just been advised that the ABC want to come and just take filming, they won't be doing audio. But if there is any person present who doesn't wish to be filmed, if I can invite you to leave temporarily, just while the cameras are rolling. I don't have much to do on either count. Please, could you, for the record, state your names, separately, and the organisation that you are representing, and any position you hold.

MS ROMEO (ECC): My name is Caroline Romeo. I am the statewide Home and Community Care Multicultural Access Program officer with the Ethnic Communities' Council.

MS VAN AKKEREN (ECC): I am Joyce van Akkeren. I am the Home and Community Care Multicultural Access officer of Bankstown, Fairfield, and Liverpool of the Bankstown Area Multicultural Network.

MR WOODS: Thank you. Thank you for your original submission and for your supplementary contribution to this inquiry. We are grateful for your on-going participation and welcome you today. Please, do you have a statement you wish to make?

MS ROMEO (ECC): I would just like to give some preliminary background. Our roles are similar, but they're also different, so we're going to bring a statewide and a local focus to today's hearing, reflecting our diverse knowledge and roles. The Ethnic Communities' Council and Bankstown Area Multicultural Network are very strong advocates for multicultural communities.

We particularly examined chapter 9 of the report as it focuses on cultural diversity and thank the commission for identifying some key aspects of service provision for people from CALD backgrounds, like recognition of the costs of interpreters and translations, languages resources, as well as the need for partnerships, and the principles that will guide delivery of care for special needs groups. On the whole the report offers a new framework for aged care and the possibilities of increased engagement with multicultural and ethno-specific organisations. However, we feel it could be strengthened in line with the new multicultural policy and further discussions with organisations that represent multicultural interests like FECA.

We have three key points we'd like to address today. One is the Australian Seniors Gateway, the second is Mainstream Accord, and the Workforce. These points are interrelated and critical to meeting the needs and preferences of older people from CALD backgrounds, particularly when we think of the accepted

framework of care that embraces person centred, culturally appropriate, and the enabling approach.

We just need to make a preliminary point on chapter 9, and that refers to the description of non-Anglo Australians as people from non-English speaking backgrounds, a term that is contentious but valid when advocating for a subset of people who are described as speaking a language other than English and who come from non-English speaking countries. For the purpose of this hearing today we are going to use the more accepted term, CALD, which is Culturally and Linguistically Diverse, which recognises people who speak English but are diverse in terms of their religion, culture, migration experience, as well as those whose first language is not English. So we're onto our first point, which is about the Australian Seniors Gateway.

MS VAN AKKEREN (ECC): That is my point to start with. There's merit in a decentralised system such as the Australian Seniors Gateway, which has a role in community information, referral coordination, and assessment, particularly in areas which appear to be less developed for a multicultural and ethno-specific perspective, and we feel that it seems to be drawn particularly on the residential care in terms of end-of-life palliative care, complex and dementia care, and complex care at home.

We don't know the shape of the Gateway. However, we do need to raise some issues to consider to this gateway. The Gateway assumes that older Australians will access regional and local hubs for information and assessment. This may be true for a proportion of the culturally and linguistically diverse population, but does not address the access for many in the culturally and linguistically diverse community, such as those who are more isolated - and we are talking about, in particular, people who have not strong community networks; who are from small and emerging communities; or who are Aboriginal or of Aboriginal-like background; but those that are also isolated who have illiteracy, lower literacy, and have mental illness or are homeless. For some people from CALD backgrounds, their history of migration is so traumatic that government agencies are viewed with suspicion, and we think we need to point that out.

Then there's a group of people from culturally and linguistically diverse backgrounds who have never been consulted or have never had an opportunity to verbalise their needs; what we may term as an expressed need. For example, in 2007 the aged care needs of all the Khmer and Assyrians living in the south-west Sydney region were captured in response of community concerns about their ageing population, and this enabled actual community development workers and development ethnic organisations to respond to those needs. Through the consultations in south-west Sydney with carers and consumers, we've also gathered sufficient evidence to indicate that people access services at crisis point, either

because they did not have knowledge or understanding of the service system or have actually insufficient access to the system, which has under-met needs. Under-met needs are not uncommon in CALD communities as they are unlikely to advocate for more respite or transport, for example, as they just want to get on with the business of caring.

The above, what we just talked about, suggests that community development workers, ethnic organisations, ethno-specific services and GP social hubs are essentials as information advisory advocacy agents for older people from culturally and linguistically diverse backgrounds, including the powerful word-of-mouth recommendation. This was reiterated by the Fairfield SLA in their settlement needs plan with DIAC - Department of Immigration and Ethnic Affairs. Use of interpreters does not go far enough to ensure equal access and quality outcomes for some groups of people. A single point of access to information negates the role of the plethora of multicultural, ethno-specific community agencies and community development workers as dissemination points of information.

Some community workers work tirelessly within the migrant community, even as volunteers, to get the message out about services and to improve access for all, in particular those that most need support. Reducing or eliminating the role of ethno-specific agencies would reduce community capacity building and participation in the social inclusion agenda. Loss of community workers is a loss for the community and its diverse members. We often see that in our sector. We believe there is a role for the Australian Seniors Gateway and for multicultural, ethno-specific organisations as partners, as there should be no wrong door into the aged care system.

Another point is about Centrelink. The commission refers to Centrelink as the proposed information access point. In our experience TIS, which is the Translating and Interpreting Service, or multilingual services are good value for generic needs but aren't able to effectively interpret health and community concept of service. New South Wales Health does fund a health care interpreting service, which is the HCIS, currently available to Health clients as well as HACC services. We believe that the aged care framework could be strengthened if it is built on a skilled health and community interpreting network with specialised knowledge of health and aged care terminology so that they're effective in delivering information about care for people from CALD backgrounds.

We agree that central assessment must be embedded in the design of the gateway to reduce the burden on providers and consumers. However, that assessment must include more than just telephone assessment; importantly, a face to face option - home or central point - and one that supports family and friends as central to the assessment, particularly for those with less formal relationships

including people from CALD, GLBTI community who may be supported by families of choice to provide care and support.

We would also recommend that the commission recognise the need for culture-appropriate assessment tools and training for workers performing assessment. Examples are the RUDAS, the multicultural cognitive assessment scale, and the Culturally Sensitive Assessment Guide and Handbook for aged care assessment teams in use in Sydney and south of Sydney local health networks. as it is now.

The commission is only too aware that people in rural and regional areas are at greatest risk when they cannot access timely and relevant services, as are those who are disadvantaged through their special needs status. We'd like them to choose an option that works well currently and which could be strengthened and which has the brokerage options. They give clients more diversity of choice and are flexible enough to meet complex client needs. Mainstream and multicultural organisations would benefit from access to skilled bilingual, bicultural workforce usually located in ethno-specific and multicultural organisations.

MS ROMEO (ECC): I'll go on to our second point, which is about whether it's mainstream or CALD. The responsibility for care of CALD populations or special needs group has historically been the domain of ethno-specific or multicultural agencies. What we need is a service system where diversity is embedded as core business in the aged care sector, be it partnerships or brokerage or other models of service. Ethnic organisations have spent many years providing culturally appropriate services to its community, including services for older people. But many ethno-specific organisations were funded for settlement needs. Some receive short-term funding for residential access, which is the CPP program, and some receive no funding at all to support their population between the settlement and their residential care stage. Services, if any, come from small adult grants. For such groups we need assisted support through a model that facilitates advocacy, counselling, support referral and information.

We have an example. In south-west Sydney the above model is provided by the Cambodian-Australian Welfare Council brokered through Home Care. The model builds capacity within the community, increases their knowledge and provides culturally-appropriate care services. We support the reform in part as it identifies opportunities for partnerships. Many ethno-specific and multicultural community organisations are heavily dependent on volunteers and lack the skills and resources of some mainstream organisations. Recently, a large mainstream organisation was awarded a grant to deliver information sessions for an ethno-specific community using the languages and networks of one partner combined with the skills and resources of another. This suggests that ethno-specific and multicultural not-for-profits have a strong role to play in the reform of the aged care sector both in

community and residential care, whether in information or service delivery but more importantly, as cultural brokers.

Our third point is about the workforce. The New South Wales HACC sector has an interesting workforce subset, bilingual and bicultural workers, which we'd like to stress who have a important role in reaching out to communities and communicating information about aged and community care in relevant community languages. A recent project that was funded by ADEC is, "Get to know the aged care system," using bilingual community educators. These workers are well respected in their communities and are integral to delivery of face-to-face information in migration communities. Quite separate from other states New South Wales HACC also has a well-connected network of HACC multicultural access program workers of which we are two. The network works at grass routes with migrant communities, HACC providers and support ADEC regional and central staff in planning.

The network has developed several innovative resources to address service responsiveness. We encourage the commission to consider the role of community development workers in building the capacity of the sector, facilitating, advocating and improving care for old Australian from multicultural backgrounds. The lack of a sufficient call to workforce is of great concern to us, not because there is no interest but that qualified students are unable to connect with employment organisations or lack knowledge of the pathways into care work when that passion and skill, not only language, can be matched with the individual and community's needs.

For example, we were recently contacted by Asian Women at Work who support their members to access employment. They contacted us to find a pathway into aged care but they weren't able to get work despite having a basic qualification which is a cert III. We encourage the commission to realise the potential of multicultural and ethno-specific organisations and community workers to be a part of the solution to develop culturally-appropriate care through industry specific recruiters similar to the job network, apprenticeships, mentoring, intensive training and employment support, solutions beyond that available today.

We also recognise that the commission raised the notion of cultural awareness as a way to mitigate cultural differences but we would recommend that cultural awareness and cultural competence training be considered as mandatory and an ongoing competency for the care force and management so that we have a whole of organisation approach to service delivery. Two minor points: we support policy and research but also draw attention to local research that identifies local needs and creates better local inclusion outcomes. The report should also qualify the description of older Australians to include the diversity of older Australians, including those from diverse cultural and linguistic communities or similar.

We welcome any questions and if we can't answer any of them, we'd like to address them in writing but particularly we would like to thank you for giving community development workers an opportunity to give evidence at this hearing.

MR WOODS: It has been a pleasure to have you here as well your submissions. I was particularly grateful for the way, in your response to our draft, that you focused very clearly on which chapters and which parts of which chapters so that I could see the connection between what we had written and what your response was and also the inclusion of a number of case studies gave life and relevance to that. So whoever put the submission together, thank you very much, it is an excellent piece of work.

A couple of things from me and then my colleagues. One is with our proposal to open up the supply side so that good providers of either community and/or residential care can expand if people are choosing their services so that the choice goes back where it belongs to the older person and they get the entitlement and then they can approach a range of providers and there are no constraints on providers in quantity; obviously quality and accreditation and all of that does remain. But do you see that as being helpful to the CALD community in terms of providers who have particular skills in these spaces would then not be constrained by not having packages or not having bed licence et cetera where that limits them at the moment, that this would provide greater opportunity for them to expand and develop and meet the community needs.

MS ROMEO (ECC): I think I will give that to Joyce because Joyce is a local worker.

MS VAN AKKEREN (ECC): So you're talking really about a workforce - - -

MR WOODS: I'm talking about the providers of services who currently may not be granted sufficient packages or may not be granted sufficient HACC budget and not being able to therefore meet the needs of the community, even though those members of the community would prefer to get services from somebody who particularly understands and appreciates their needs. By making the reforms that we're proposing, will that help those providers and therefore help the community?

MS VAN AKKEREN (ECC): It seems to be that the packages do appear very favourable in the community and, in particular, if the provider has - we have got one big provider in south-west Sydney who has a significant bilingual workforce and that has been very appreciated by the community. That seems to really quite work in the sector; that if you do provide bilingual workforce, it is very much appreciated. You can see that then also the other services are increased that that particular mainstream service does.

MR WOODS: One other: you mentioned the inability of some workers from particular cultural or language communities who have their cert III, they're not being able to obtain employment. Can you expand on that a little and is there anything that the commission could usefully recommend in that space that would get over whatever that issue is?

MS ROMEO (ECC): Yes, I actually have that experience, I actually went to Granville TAFE and I addressed a whole room full of students who were doing diploma of community services. I was quite saddened in fact that they could not see the pathways. It was like they would have to complete the course and then they would have to find work, and I'm thinking, "Here is a whole room full of students who should be picked up by the sector." There seems to be a lack of connection and integration between employing organisations and the TAFEs or the RTOs.

I think it's really critical for people from CALD backgrounds to have access; for employing organisations to go directly to the pool of workers and absorb them, whether it's through apprenticeships or mentoring them into the sector. I think that's really important for those communities, otherwise we're not going to have a culturally responsive workforce. I think even within south-west Sydney, for example, I think the Bankstown Council and with other community organisations have started a workforce development project to increase the number of people from CALD backgrounds, because they recognise that those people are getting older, they are also becoming more diverse, and we need to respond. There are local initiatives, but the recommendation I'd like to make is that employing organisations should partner with RTOs. I don't know at what level, but I think it should be mandatory.

MS VAN AKKEREN (ECC): The other part is that you've mentioned the apprenticeship system is possibly a pathway into this sector. What workers will say is, they do not have the experience and knowledge. So they do not know where to go, which service they could seek a job from. But if there is an apprenticeship system happening, the mentoring and the training in-house would assist them into the sector.

MS MACRI: Again we would welcome some more information. We are getting, right across Australia, varying comments about the value of some of the RTOs. Certainly the information we're getting, that the students that have gone through TAFE are far superior, in terms of the outcomes of their education, in both the cert III and the cert IV aged care worker, and there're a number of RTOs that are three weekends and you've got your cert III, and people are very poorly prepared. I would think that this would be doubly if you are then coming from a CALD background. I just wonder if you know how many people are really coming through the TAFE program as opposed to some of the RTOs that are less than desirable in the

outcomes of the education?

MS ROMEO (ECC): I actually asked the woman who was delivering the training at TAFE Granville, did she know how many people were going through the sector; we don't know that. I think we're losing people who are, what I would call, qualified students, because they are unable to negotiate that pathways; they are not supported enough. I went in there to recruit volunteers for my project as a volunteer in the south Asian community, and I'm going to have to support those four students that are volunteering with me, to make sure that there are people who are skilled and need to be educated about the sector, but it's on an individual basis and we need it to happen at an organisational level. Because, as we said, there's a very high engagement by community development workers on a voluntary basis with their communities. I do it, I'm sure other people do it. We need something else that makes that work.

MR FITZGERALD: Just on the same issue, the providers have said to us that they in fact are quite willing to employ CALD workers but that the English proficiency is now a significant problem. I'm just wanting your take on that. We heard, for example, somewhere, that in fact the government had reduced the level of English training or English teaching for non-English speaking background people, at the very same time as we want more of them engaged in the workforce, so we do seem to have a problem. Our initial indications are that there are lots of people doing the cert IIIs, but there's not that many people being employed after they've done the cert IIIs. Yet we know that needing a bilingual workforce is going to become much greater as the ageing of the population predominantly occurs in non-English speaking groups into the future. What's your take on what's happening with English proficiency within the TAFE and the sector generally?

MS ROMEO (ECC): I think it varies, because the group of people I spoke - it's not specific to that one. There are a group of them that are good English speakers even though they're from diverse backgrounds, and I'm actually supporting somebody from an Eritrean background, so a strong refugee background. There are those that don't have the language proficiency. Just like when the people receive it in the first five years when they come to Australia, I think there is a place to allow intensive English skilling that complements whatever courses they're doing. I think it's not that difficult, because TAFE offers it. I think there is a place for that, so that they have English skilling at a competency.

MS MACRI: Can I just quickly ask you one other question; it was around relevant tools for assessment and you named a couple of tools. Are those tools uniformly used in HACC or through ACATs that you're aware of?

MS VAN AKKEREN (ECC): I only know that is happening in south-west Sydney

with the ACAT team, but, no, I can't answer that question. Sorry.

MR WOODS: I suspect we're not very far apart and we're certainly very grateful for your added insights, which we will take on board. Thank you very much.

MS ROMEO (ECC): Thank you very much for the opportunity.

MR WOODS: We will adjourn until 25 past 10. Thank you.

MR FITZGERALD: Thanks.

MR WOODS: Okay, thanks, Presbyterian Aged Care. Could you give your names and organisation and position you hold in that organisation, that would be terrific.

MR SADLER (PAC): It's Paul Sadler, the chief executive officer with Presbyterian Aged Care NSW and ACT and - - -

MR WOODS: And you are - if you can just give - - -

MR SKELTON (PAC): Yes, my name is Greg Skelton. I'm the CEO of PresCare in Queensland.

MR WOODS: Great.

MR SADLER (PAC): Together we're representing the national Presbyterian Aged Care network.

MR WOODS: Good. Please, just an opening statement, then we'll have some time for questions.

MR SADLER (PAC): Okay, thank you, Robert. I guess what we'd like to say on behalf of our national colleagues is how much we're impressed by the work that has happened to date with the inquiry, and that we strongly support the directions that are set out in the draft inquiry report. We've obviously got some specific comments to raise with you which we'll move to, but we did really want to stress at a starting point that from our point of view the direction that the commission has set out is one that we believe should occur. It's really a matter about how we get there that is the issue and some of the detail, not the direction that you've set out in the report, which we fully support. I'm going to touch on a couple of issues then Greg is going to touch on a couple and then we're obviously happy to get questions and answers.

Firstly, in terms of residential aged care, I think we would feel that the commission's report has headed in the right direction but there are some questions that we have about how things will operate in practice. In particular, we believe that it's important that there be some financial modelling done in this next phase of the work, and I am aware that through the Campaign for Care of Older Australians there's some discussions going on with the commission about exactly this area. I'm also aware that ACSA and ACAR are looking at some financial modelling about the impact and sharing that with the commission.

We do believe that's really important, because from our point of view there does appear to be an impact of a shift to a greater reliance on periodic payments versus lump sum payments that is inherent in the structure of the report, with the

opportunity for the pensioner bond scheme, equity release schemes interacting with the way you're describing the accommodation payment system operating. We believe that that's at least partly a transition issue but also partly an issue for organisations like our own in terms of the sorts of debt levels that we may carry into the future.

Historically churches have been pretty reluctant about having big debts with banks, and we haven't historically had that to any great extent. Yet we can foresee in the future with the commission's approach in the draft inquiry report that indeed we may have to carry high debt levels for longer. That has some significant implications for the trust organisations that own often the aged care operations, they certainly do in our - background then for the Presbyterian Church. It also has the possibility of a greater risk and a greater perception of risk from the banks who might be lending to us. I think understanding what that level of risk might be with a greater reliance on periodic payment rather than lump sum payments in the capital area is something that I guess we're really keen to see explored in the final report.

I note that Mike has made comments about the recommendation of two bedrooms for concessional residents, and we would share those concerns. I guess we've written in our submission that we really feel that it's the clinical needs of the residents that need to be the driver here. We're very conscious that for people with dementia with challenging behaviours, people in palliative phases, that really single rooms are definitely the preferred clinical model. While we recognise there's a tension between a funding model on the one hand and how you deliver the clinical outcomes on the other, it really is important for all people, irrespective of their capacity to pay, to actually have the type of residential aged care that they need when they need it. So setting up a system that could potentially result in shared rooms for assisted residents we don't think would be a good outcome. I'm conscious that I don't think that's what the commission intended either, but we certainly would encourage you in your new thinking on that point.

The other area I want to briefly mention, and then I'll hand over to Greg, is the area of the regulatory burden on aged care providers. It is an area that's acknowledged substantially in the report. One particular area you asked for feedback from us on was the issue of abuse reporting. It's an area I've done quite a bit of work historically and I did my masters thesis in the area of abuse of older people and I undertook on behalf of Aged and Community Services Australia a national survey of their members on the issue of the mandatory reporting that was brought in in 2007.

I won't speak to the detail of it because it's outlined in our submission and also in ACSA's submission, I understand, but certainly the view I think we would all share from the Presbyterian Aged Care network's point of view is that it is overdue for a review of that legislation. We are dubious whether it serves the interests of

older people, in that their right to choose what happens to them when an assault might be alleged to have occurred is taken away; because the reporting legislation basically mandates an approach, which if you're the victim of an assault in the community you have a choice about what involvement the police have and whether charges get pursued et cetera. That right appears to be taken away by the current legislation.

We believe that the current legislation has had a detrimental effect on staffing in aged care because it's clear that there's a perception of an enhanced workload for little apparent outcome in terms of actually improved conviction rates or anything else. It's an area where we're starved a bit for information. The Department of Health and Ageing really hasn't released a lot of detail about the reports that they've received. It does make the information that we're operating on somewhat difficult to know what the outcomes of this piece of legislation have actually been. Greg.

MR SKELTON (PAC): Thank you. I'll attempt to be brief. A couple of things that I just wanted to raise, particularly in relation to block funding and day therapy centres. These services are absolutely essential and I think they have to continue to be part of an integrated aged care system. In some cases they're the only access to services that elderly people have. A lot of those services provide physio and podiatry, but there's a lot of group work going in relation to things like falls prevention and balancing. They're absolutely essential going forward. They are a great integrative tool and they're at a low cost. So that was one of the things I wanted to raise.

The other thing that I wanted to raise was particularly access to labour. Now, I know there's great problems in Western Australia, but certainly in regional areas of Queensland the problems that we face is that if the average aged care worker is 45 in the CBD areas, they're 55 in places like Rockhampton and those regional towns. It's extremely difficult to get labour, let alone replace labour. I don't want to open up the migration debate but I just want the commission to be conscious of the fact that perhaps in the future we need to consider skilled and unskilled migration as part of the solution, because otherwise there is not going to be anybody to actually care for these people in regional towns.

What I'm really passionate about is maintaining the FBT concessions for not-for-profits. I was involved with lobbying the government over 11 years ago for that heavily. Organisations like church-based groups who don't return capital to shareholders who are delivering residential services for 1 or 2 per cent margins need to be able to attract and retain labour. These concessions are heavily utilised in all levels of the organisation, not only from a carer's level where there may be some comment about increasing wages at that level. They're utilised throughout the organisations and I think it's important to recognise that people in a missional-driven

based business don't simply work for remuneration but it is actually important, particularly in this tight labour market particularly in Queensland, as well that those concessions are retained.

The other thing I just wanted to mention is that low-cost housing, the NRES model seems to be working and a lot of organisations are particularly - we are looking at the moment about integrating the low-cost housing model with our nursing home facilities and there is a huge need - and it's supported heavily by local councils - for the continuation of an integrated low-cost model throughout the country. So it is really important that that access to that sort of capital and system be maintained.

MR FITZGERALD: Good, thank you.

MR WOODS: Thank you and it was very helpful the way you tied your comments on our draft to the individual recommendations so that we could see what specifically you were addressing. You made mention of the issue of cost of supply but presumably through the consultation process you now have some greater clarity. If not, just briefly for non-supported residents it's a matter for the provider to determine what is the price that they will charge for the accommodation component, putting aside all the issues of care, and as long as you have, as part of that, a periodic charge, whether it is a daily or weekly rental and as long as you publish both that and the bond, then you set your price according to what happens in your local marketplace. If you set it too high, you have vacancies and if you set it at an appropriate price, people would be willing to purchase for the accommodation standard that you're offering, just like they choose accommodation standards throughout the rest of their life.

So the reference to cost of supply was purely as - that's where you start from in your pricing model but what price you determine will be dictated by what people are prepared to pay for what you're offering by way of quality.

MR SADLER (PAC): In the draft report, Mike, it wasn't quite clear to us whether there was somebody who was going to check on the calculation methodology - - -

MR WOODS: No, there won't be.

MR SADLER (PAC): - - - that providers applied because there was a kind of implication that you need to start from that periodic basis, lump sums get derived from following that. We were quite sure how the monitoring of that would occur.

MR WOODS: We would suggest that the authorities would monitor behaviour during these initial years and only very reluctantly would impose some form of

regulatory intervention if providers were attempting something and had market power to do so. But also within our proposal by not having artificial constraints on supply by way of bed licences or care packages and the like if one provider in an area is attempting to price higher than the underlying quality dictates, then other providers will, I'm sure, take advantage of that situation and come in and offer something that the market is much more willing to adopt. So that is how we envisage that unfolding.

Yes, there will be a transition process to the extent that people may choose to pay a daily or weekly rental or some other periodic charge or some blend of bond and charge. That is for them to decide. In a lot of cases where there is uncertainty about how long they may require the care in a residential facility or whether they hope that with some rehabilitation and restoration they can return to their community abode or don't want to go through the situation of drawing on their current housing asset, then sure people will have that option. To the extent that then leads to a write-down in bond volumes, we're happy to discuss what transition issues are involved in that. It has to be in an orderly manner. It's not in the interests of the community to have the industry overall go through an adjustment that leads to unnecessary disruption. Individual providers we're not there to protect but the industry as a whole has to be able to have an orderly transition.

MR SKELTON (PAC): Commissioner, do you think that the Australian banking system understands the potential changes that are coming because I certainly don't get the feel on the ground that that is something they have got their heads around just yet.

MR WOODS: We have certainly had representations from the banking sector and we have in fact noticed various bankers in our audiences sitting through the hearings. So we're confident that they are very interested in the topic and are putting their minds to the consequences of it. For most of the economy they are actually used to the concept of people coming with bankable propositions and expected cash flows and levels of debt. That is not an unusual form of financing in industry - like, about 90 per cent of the economy - so they will get used to the idea for this sector as well.

MS MACRI: We have got some further meetings coming up with the banks on a one-on-one well just to keep educating them and keeping them in the loop.

MR SKELTON (PAC): It's just the change in the risk proposition. I think they have actually seen aged care as being quite a safe and bankable area for quite a long time.

MR WOODS: Yes. As have providers, as have a whole range of people and that is probably part of the problem, not part of the solution.

MR SADLER (PAC): It may well be but as you rightly pointed out one of the concerns from our point of view, and I suspect others in the industry, is we already know through the aged care approvals there is an underinvestment, particularly in high-care residential care. Uncertainty in the transition period could see that extend for a period of time, so it is in all our interests to actually have the transition process quite clear so that there is not a continued underinvestment in those sorts of areas.

MR WOODS: But I would remind you also that the daily charge for supported residents for high care under our recommendations would actually be based on the cost of delivering that care, not the $28.72 that you currently get for new investment, so that would be a positive. The second is that without having this artificial creation of high care and low care and extra service that it's an accommodation proposition that you're offering so that also, I would have thought, is a strong positive for the industry.

MR SADLER (PAC): I think we feel on balance where we would end up is much better than where we are now.

MR WOODS: It's how to get there.

MR SADLER (PAC): It's how to get there I think is our major concern at the moment.

MR WOODS: We agree with that. One other thing that I would like to comment on is the question of reassessments once people are - so they would go to the gateway, through various mechanisms, through various outlets but end up with an entitlement based on their assessed needs that reflects their actual needs and with a clear statement of what their care co-contribution would be. In terms of then a change in the circumstance we're certainly happy to talk with providers and have been about the role that they would play. We certainly don't want to create an additional bureaucratic layer unnecessarily and so good providers would no doubt have the trust and faith of the gateway established over a track record and just make the changes and notify the gateway who has to, of course, the additional expenditure or reduced expenditure, depending on the circumstances.

But then there would be normal risk audits and the like that would go in and just ensure that what was being done was being done properly. If it is a provider with a less trusted track record, then they would expect closer questioning of the change in circumstances.

MR FITZGERALD: I think we're looking potentially at two different approaches in relation to residential and community care and this is obviously part of the

post-draft consultations which we are going into. One is a view that once a person enters residential care perhaps the need to go back to the gateway is significantly lessened and we rely on validation processes. In relation to the community care, perhaps coming back to the gateway becomes more important. So we welcome the industry's views about how to deal with that and I think we are open to the view that the way in which you would deal with residential care and the way you deal with community care might end up differently.

Can I just make a couple of comments. One is in relation to the co-contributions for care, largely in relation to community care. On the diagram or the table on page 3 you indicate that your view is that the government is largely responsible for care. But then you also say, "However, if not, if there are going to be co-contributions that they are affordable." We agree. Given that we have put out in the draft the 5 to 25 per cent co-contributions, do you have a particular view about that proposal as to whether it meets your test for affordability or do you have some reservations about that?

MR SADLER (PAC): I think we're probably comfortable with that kind of range. You indicate in the draft report that there is more testing to be done about where those thresholds should be placed and I think we would agree with that because clearly many, particularly pensioners, are on a very tight income and so any co-contributions that they are expected to make have a significant impact on their disposable income for other costs. We know that costs like electricity and various other things are going up substantially. So we do have a concern that whatever we end up with as a co-contribution regime in the community and in residential aged care leaves people with enough disposable income to actually meet other costs in their lives. But I think as a starting point the sort of range you have indicate we would feel is a reasonable starting point.

MR FITZGERALD: The second one is a more complex one and that is in relation to your issue that you have raised in your paper about services in rural areas. You are a provider of services in both metropolitan and rural, what do you think the approach should be in relation to smaller regional and rural communities? Again, I just qualify that. A lot of areas have moved to the multipurpose models where there are integrated health age care models and there is a lot of favour for some of those models. So what is your approach?

MR SKELTON (PAC): I think the difficulty in rural and remote areas, for example, is access to services and in an inner city area you can route plan and you can do what you need to get around very efficiently. But when you're travelling 70 K's to the client and you're paying mileage rates at ATO rates, it becomes a lot more expensive to provide that service. So the question whatever - there has to be a social justice argument about what that client can afford to pay. During the recent

Queensland floods we couldn't access our clients. There are major problems with getting to these people and providing the basic needs. So the co-contribution has to be equitable.

I guess the other area is that we feel that access to allowing people to have some home modifications to keep them in the home. For example, in Mackay with one client we couldn't even get into the stairs because we had a workplace health and safety issue about it before we could even get to the client. So you have to build a $20,000 ramp just to get access to the client. So there are different issues and I don't think there is one simple answer. But I think we just need to be cognisant that particularly in remote areas it's difficult to actually get to the client.

MR SADLER (PAC): I know - and this came up in the session I attended with Robert and Mike and Armadale - that the issues I think often for small country towns are around needing the infrastructure to be guaranteed to be there and payment systems that are client or resident based versus block funding, depending on the side of the town and the need to actually maintain an infrastructure. I think this applies in both community programs and in residential aged care sometimes mitigating the fact - and that is covered, I think, in your draft inquiry report that there is a case in some instances to block fund, particularly in remote and very small tows.

MR WOODS: At least to ensure the presence of what is a variable component.

MR SADLER (PAC): Exactly.

MR SKELTON (PAC): Make the safety net is in place.

MS MACRI: Just Paul around the elder abuse and compulsory reporting. One of the things I guess for us that is important and I see in your submission that it's your view that consideration should be given to complete repeal of the legislation. One of the issues for us and why we asked for some more information around this - that issue of repealing would be an interesting one and I would suggest a fairly brave person to do that. However, it would be really helpful for us in terms of where we have asked for more information on this where the current legislation or regulatory requirement is absolutely overburdensome and I think you make a really good point about that choice of pursuing or not pursuing and perhaps where it could be probably expressed or written in a way that is better for both providers or consumers.

We would, I would suggest, a little bit more other than what we're getting at the moment around either repeal or review. It would be helpful for us to have some specific areas that are a bit onerous.

MR SADLER (PAC): Certainly. I am happy to give you a few comments on that.

In terms of, I guess, the genesis of the legislation it was from media reports of some fairly graphic and very unfortunate incidents that had occurred in Victoria and then that led to more reports from across the country coming to light. It's interesting, in the ACSA survey when we actually looked at how many of the cases that were being reported to the department then led on to any media covered, it was a total of four out of over 600. It is a very small proportion that lead to that outcome, yet it seems to me that the legislation was about a response to media coverage and it required the government of the day to be seen to be doing something.

So that is my first comment because I think if you don't understand that context, you don't understand why the legislation, in my view, isn't working. I think there are a number of things that you could do to the legislation that are short of complete repeal because I agree with you, having put it in it will be very difficult for any government to completely go back on it. I think for a start you could ask the question about why reporting mandatorily resident-to-resident abuse is actually a requirement. It's part of the legislation at the moment yet it would seem to me that that can be dealt with between the families involved, the residents and, if need be, the police, depending on the seriousness of the incident.

I think there is certainly a case for extending the time frame for reports to the department if there is going to continue to be a reporting requirement. There is a substantial proportion of the cases, about half in the ACSA survey, that were found to be either outright vexatious or unsubstantiated and it would allow more time for the police investigation and the provider to investigate the case before a requirement to report to the department actually came into being. I think there are some other significant issues, there is a whistleblower component to the legislation which protects - and I think rightly so - one of the good pieces of the legislation. Somebody, if they make a report about a concern, there is no action that can be taken against them, either by the approved provider or other people.

But I think there is a conflict between that whistleblower protection legislation and industrial relations rights whereby if you're taking some form of disciplinary action against someone, they have actually got a right to know what the concern is. So there is some inherent conflicts between aspects of current legislation which I don't think have been resolved with the current legislation. Also a possible alternative approach would be to, rather than having any reports to the department, actually include a standard on the issue of protection of older people into the aged care standards and actually use that as the testing mechanism, rather than having individual report mechanisms at all. It is interesting to note that in the disability services field, particularly in New South Wales, there is such a standard about protection from abuse that is part of the disability standards in New South Wales. It is not actually a national standard, it is an extra one they have added in in the New South Wales context. But it is certainly something that could be looked at as an

alternative approach to the whole mandatory reporting approach.

MR WOODS: On workforce issues and you briefly mentioned the potential of the 457s and other vehicles for supplementing the domestic workforce, in terms of the workforce that is already in country, what's your view on the quality of training that is available to them. How do you ensure that those who you are recruiting - and let's take the majority of the workforce, the PCAs, the PCWs level - how do you gain some understanding of those who have a cert III but not a lot of experience but that that will have been a quality cert III and what do you then do by way of employment possibilities and career pathways to offer training into cert IV levels and ENs and move up?

MR SKELTON (PAC): Look, generally speaking I think the cert III level entry isn't too bad. I think we find different issues in different parts of the country. Certainly in the city of Brisbane there is a huge number of cert III people coming out without a lot of experience and we generally find they're overseas workers or they've gone into it for a particular reason. I think the skill level still requires extensive amounts of on-the-job training and I think our organisation is certainly putting a lot of investment into leadership and beyond just the mandatory training that is required of a PCA or a PCW. Generally speaking those people want to be in that industry and they enjoy the work that they're trying to provide.

The concern I have is that the turnover rates in that particular area are still significantly high. In our organisation the turnover of that part of the organisation is about 35 per cent per annum so it is extremely high whereas in the RN levels and above it is a lot lower than that. We have made comment that finding labour is particularly difficult but in regional areas I guess the issue for us is actually finding new people to bring into the organisation. Most of our people have 20 or 25 years' experience in those towns and they're hitting an age where we can't actually replace, particularly in places like Rockhampton.

MR WOODS: You made mention of NRAS. How would you more closely integrate what it's doing and where we're trying to head in aged care?

MR SKELTON (PAC): Certainly my organisation has made application to current NRAS round to integrate continual care on a site. We have large blocks of land. We're not typically looking for a return-on-investment type model but certainly that integrated aged care community where we can provide capped EACHDs plus have a nursing facility on the facility as well as provide good quality low-cost housing in maybe quad blocks or duplexes or that sort of nature is really important for us because in places like Rockhampton where we have actually made application the council is desperately crying out for low-cost housing. So our approach would be to utilise the assets and resources we have to actually reduce some of that need.

MR SADLER (PAC): The other comment I would make about NRAS is I think there is a need to look at the existing stock of independent living units that were built back in the 50s through to 80s. We've certainly got a substantial number of those and while there is some capacity under NRAS to apply the test is that you're providing new housing stock and, of course, that's difficult to show when you're actually trying to do up an old place and I think there is increasing evidence that that stock of independent living units is being lost to low-cost housing and that is gradually eroding over time. We certainly had to close some units because there simply wasn't an alternative and the buildings were become unsafe.

MR SKELTON (PAC): Can I just add that we have recently costed this in terms of a quad block. It's about $70,000 for a two-bedroom on the ground sort of quadplex. In a lot of cases our stuff in the 50s and 60s you're talking bathroom modifications of 10 or 15 thousand and kitchen modifications of similar levels. In a lot of cases it is better and easier to start again than it is to - yes.

MR FITZGERALD: Thanks.

MR WOODS: Thank you very much.

MR SADLER (PAC): Thank you.

MR WOODS: We appreciate your ongoing participation in this inquiry and for your attendance at various workshops et cetera. Thank you.

MR SADLER (PAC): Thank you very much.

MR WOODS: Are the Public Interest Advocacy Centre available? Thank you very much. Could you please, for the record, state your name, the organisation you are representing and any position you may hold.

MR DODD (PIAC): Thank you. My name is Peter Dodd. My full title is solicitor health policy and advocacy with the Public Interest Advocacy Centre from Sydney. Do you want me to continue?

MR WOODS: Please.

MR DODD (PIAC): Thank you very much.

MR WOODS: Thank you for your earlier sub. That's very helpful.

MR DODD (PIAC): Yes, we put that sub in earlier. Today I just want to concentrate on one particular area, this is the area that - PIAC's main focus is in the consumer area and I just want to talk to you today about the complaints, complaints management and a little bit about complaints management and advocacy. Just a little bit of background PIAC. PIAC is an independent non-profit law and policy centre. We concentrate on public-interest issues by both litigation and policy work. PIAC has been around for 27 years and we have a long history in terms of issues about patients' rights and health rights. A lot of this work is focused on patient safety and complaints issues.

We were very prominent in the lobbying that led to the Australian Charter of Healthcare Rights that finally happened a couple of years ago but we were also involved in both legal representation and policy lobbying in terms of the Chelmsford Royal Commission which people in New South Wales will remember - a lot of people remember that - which led to the Health Care Complaints Commission in New South Wales which is an independent complaints body. So that is the background in terms of what PIAC is about, especially in relation to this inquiry.

As was indicated, we put in a submission in July 2010 and made some broad observations and we still, of course, rely on those. But today I just want to go through a couple of propositions, I think, which we have put out. I guess the first thing is that we do support - and I think everyone would be aware when I talk about the Walton Report. We support the need for an independent authority to deal with assessment, investigation in aged care complaints and resolution. It's just an essential thing and we refer to the Health Care Complaints Commission in New South Wales and I think that is a good model.

I have just got to start by saying complaints shouldn't be see as a regulatory

burden. Complaints are a positive thing. The public benefits from the complaints system, not just the individuals. The public benefits because it clearly adds to their safety and quality of health care and aged care. So that is the proposition I think the commission should be starting with and we certainly start with.

Independence means lots of things. I think people are saying it should be independent but I think it means lots of things. But what we are talking about is the decisions of a CIS or any other complaints body can't be overturned by either bureaucracy and government. Unfortunately, that's the situation we have at the moment and PIAC would say that that is an untenable situation and I think Prof Walton has pointed that out in the report, that leads to a lack of confidence both by consumers and providers in terms of the system for resolution of aged care complaints.

I think the Walton report sets out very well the reasons for an independent complaints body. The department's focus is very different to a complaints body's focus so that is one reason for independence. A complaints body must be seen as neutral operating - and I love expression - "without fear or favour". I think that is really important. I don't think that is seen now, it can't be. The department can overturn the decision of the complaints investigation and resolution body. I don't think anyone really suggests in the past that there has been political interference but I think it's important that the complaints body can't be seen as something that can be interfered with by a politician or a minister.

Transparency is certainly very important and that's why there should be independence. That is why the second proposition that we have put to you and we will develop later in a submission is that the authority that assesses, investigates and manages aged care complaints should be directly responsible to the minister for aged care but that authority should be autonomous in the decision-making in the same way that the Health Care Complaints Commission can't overrule care assessment and investment functions. We have referred to section 81 of the Health Care Complaints Act which is, I think, relevant here. We're not saying that a complaints body shouldn't be accountable. That accountability can come in lots of ways. You have referred yourself to oversight by the ombudsman, certainly Prof Walton did, there can be an rigorous internal appeals system which we totally support and there could also be parliamentary oversight. In New South Wales the Health Care Complaints Commission has - there is a joint parliamentary committee that oversees the HCCC and all those add to the accountability of the HCCC in New South Wales.

It is worth just having a look at section 81 of the Health Care Complaints Act. Section 81 says that, "The Commission is subject to the control and direction of the minister, except in respect of the following: the assessment of a complaint; the investigation of a complaint; the prosecution of disciplinary action against a person"

- that is probably not something relevant to aged care complaints; "the terms of any recommendation of the commission" - and again that is relevant because the aged care resolution should be able to make recommendations - and also talks about "the contents of a report of the commission, including the annual report." These are the things that should be independent. So it's not saying there shouldn't be any ministerial oversight, it's saying that those are the things that should be independent.

We give qualified support in terms of the recommendations for the Productivity Commission for an Australian Aged Care Regulation Commission, AACRC. That's going to be difficult for all of us to say.

MR FITZGERALD: We may change the name.

MR DODD (PIAC): The only comment I make there and PIAC would make is that whatever the structure there should be a body which has dedicated officers that look at the assessment of complaints, that investigate complaints, that resolve complaints. Even internally those three are different functions that are obviously related but there must be dedicated people properly trained and that is the key. I think there is going to be a lot of discussion about the structure - Prof Walton recommended a different structure - but I think that is the important thing that it is independent and that there are dedicated officers.

We note that the commission has stated that they support an independent body dealing with complaints. We agree that there should be an arm's length appeals process where appeals are heard by the AAT. But we also support a provision that there should be internal firewalls in any internal review structure between the original assessment investigation decisions and those that undertake the internal reviews. I think that Prof Walton also made that recommendation. It is just speculation but it is interesting to contemplate if there is a larger body that does provide the opportunity to actually have a clearly separated internal merits review section, that is separate from the complaints investigation body still with people that understand how that system works. If is a larger body that would be provide the opportunity for those Chinese walls to be created in the organisation.

Finally, we do support the recommendation from the Walton review that there should be a wide of rage of ADR options available and we note that the government has already put out a discussion paper canvassing some of those options and PIAC has responded to that. But the final thing that I want to put to you is to think about what sort of models we can adopt and what we suggest is that we certainly support a wide base of alternative dispute resolution models and I think that that is another thing that has clearly been lacking. I know they have been in the system but there should be some more formality in terms of that.

But it is important that if you do have those models then you must have - and this is really essential - an independency advocacy service that can assist complainants in terms of dealing with the providers in the situations where you do have those ADR models. It is not a level playing field. The providers have all the resources, they have dedicated people that deal with complaints. They hold all the records, they hold all the information that goes into a resolution of a complaint. What PIAC suggests is that the Australian government should look at the New Zealand model where there is a New Zealand Health and Disability Advocacy Service. That was established in 1996 after the Cartwright inquiry which was a similar sort of inquiry that occurred in New Zealand similar to - different issue but the same sort of thing that came out of outrages that were seen in the health system and the need for an independent investigation body. But also the Cartwright inquiry said that there should be an independent advocacy service.

The advocacy service in New Zealand is a free service available to any one person who has a concern about a health or disability service. I certainly think that that could also fit into aged care complaints. It deals with people who come off the street, it deals with complaints that are referred to them by the Health and Disability Commissioner. They are empowerment advocates. They assist and act on behalf of the consumer and this assessment is a direct approach to assist the consumer to resolve their complaints. Importantly they are independent. I won't go into the funding. It's a different system but they are a independently funded and that is, I think, the key. These are not legal advocates, they're lay advocates but they're not inexperienced advocates, social workers, health professionals in the system. But it provides a very good model, I think, to look at the sort of system that could be used. We wouldn't be saying it just should be aged care complaints, I think this sort of model should be adopted in relation to health and aged care complaints in Australia.

I think I must emphasise that - and I note the agreement of the commission - this cannot work, especially alternative dispute resolutions, unless there is that independent, well funded, properly funded advocacy service. I will end my remarks there.

MR WOODS: Thank you. Hopefully in our draft report our emphasis on that meets with your support. In your initial submission you also raised a few matters relating to the exercise of choice and by freeing up the supply side of the market. Now, having put out our draft and attempted to address the full range of consequences of that for the older person who requires services, do you still hold concerns with our proposed model or is that something you'd like to reflect on?

MR DODD (PIAC): I think we would like to reflect on that and we may comment on that. I would have to put that on notice but the general comments would still apply. As I said, our focus is mainly on the complaints resolution scheme.

MR WOODS: It was useful that you did have a range of other - - -

MR DODD (PIAC): Yes.

MR WOODS: - - - issues in your first submission but I don't know if you were intending - I've been on the road for the last few days so I'm not sure if you've put in a final submission.

MR DODD (PIAC): No, we haven't.

MR WOODS: That's what we understood.

MR DODD (PIAC): Yes, we'll do that, sir.

MR FITZGERALD: Just a couple of things. In relation to the complaint handling body, whether it sits independently within the regulation of the commission, a question is as to what should its powers be. As you know, most ombudsmen around Australia only have the ability to make recommendations. So in this case they could make recommendations to the regulator, to the gateway, to the minister or to the department. Some people feel that falls well short. So the question I've got for you is do you see it as a body with a determinative power which requires action, or like most statutory ombudsman in Australia simply able to investigate, try to get a resolution but in the absence of resolution can make recommendations?

MR DODD (PIAC): I think in practical terms there has to be that element that it can only be recommendations because, I guess, a complaints body is not an enforcement body in that sense. The problem is that the perception now is even those recommendations can be overturned and I think that is the problem. The HCCC in New South Wales is a good model. I mean, it makes recommendations to health bodies. Is there anything that says, is there any penalty that a health body doesn't follow the recommendations of the HCCC? There isn't. Do they ever not? Well, they may not but they certainly wouldn't be admitting it. They certainly try to all extents follow the recommendations of the HCCC. I think that's all you can do in practical terms.

I'd love to think that there might be a model that would go further than that, but I'm not sure whether I can envisage one that would take away from the powers of the government to make decisions and the powers of the accreditation agencies, for example, to make decisions. It's the problem that the HCCC has with a big hospital as against a health professional. They can sanction a health professional for lack of standards or misconduct. Nobody wants hospitals closed or facilities closed because there's been abuse in those facilities, for example. There needs to be other forms of

resolution. That always must mean recommendations must follow.

I think the important thing about those recommendations too is that there has to be appropriate follow-up. There has to be appropriate mechanisms to make sure that those recommendations are followed and they're not just followed in some sort of perfunctory way and then hopefully everyone will go away. There are mechanisms that can be set up to ensure that that happens.

MR FITZGERALD: My last one is just in relation to the advocacy service. In the draft report we've acknowledged the need to increase advocacy. We've had presentations, particularly in Melbourne, from the Elders Rights Advocacy Group which is part of the National Aged Care Advocacy Program. My understanding is that there are eight bodies as part of that program and it's funded to the tune of something like $2.5 million by the Commonwealth government. Given we support increased advocacy, and given your view that there needs to be a service, do you have a view as to whether or not the increased support of funding for that type of advocacy network is the appropriate way, or do you think that a separate - as you've indicated in the New Zealand experience - health and disability sort of advocacy body is necessary? Now, I don't know whether you've given thought to that but if you're going forward do you build on the current base or are you suggesting there needs to be something in addition or alternative to that?

MR DODD (PIAC): I think that there are two different things. I think there is a need for a general advocacy service that doesn't require lawyers. It doesn't require necessarily that level of legal intervention. There also is need for a body that provides legal advice, and advice across a wide range of things, to people who are residents of those care facilities and I think that's a very separate function. There is certainly a need for the aged care advisory service - and New South Wales to provide that function. PIAC thinks that the New Zealand model is a better model in terms of assisted resolution in the complaints system.

Someone may go to an agency or a rights service, get advice about their rights and then referred to the advocacy body, "These are the people that will help take you through your complaint."

MS MACRI: Just two things: in relation to again complaints and community care and how you see better access from people in the community through to these complaints resolution or advocacy bodies - because quite often people are a little more isolated out in the community; and the other question is just around, I guess, the interrelationship between complaints and quality of care and accreditation. Your comments around those two issues.

MR DODD (PIAC): Well, the first one: it's always a problem for complaints

bodies to get their message out to people in the community about the service they provide. It's interesting - I didn't mention it - but that advocacy service in New Zealand has an education function as well. It's out in the community. It's got the ability to go out to community groups and talk about the service it provides. I think that's important. But there's a whole range of strategies I think that should be used by complaints bodies to let people know that the service is available. I think again none of this comes cheap but it's really important because it's no good having a service if people don't know it's there.

I think there is a concern in the community and there's a concern of people who complain that they might be victimised, their relatives might be victimised, so it's really important to emphasise that it's an independent service and it does act without fear and favour, and protects them in terms of their complaint. The second point that you make I think is the point that I started with, that the complaints process shouldn't be seen as a regulatory burden, it should be seen as a positive thing that aids the safety of aged care and general health care in Australia. If you don't have a complaints system then how do people find out about abuse? There could be mandatory reporting but our system works on a complaints system which leads to systemic change, which leads to better care.

We talked about the Cartwright inquiry in New Zealand, the Chelmsford Royal Commission. All of those changes have come because there have been situations where there has been not a proper complaints system and there has been, unfortunately, bad standards of care, and often criminal treatment of patients.

MR WOODS: Thank you very much. We appreciate your presentation, and if you were in the next few days able to get - - -

MR DODD (PIAC): Yes, we have an undertaking to do that, sir. Thank you very much.

MR WOODS: Care Innovations to come forward, please.

DR MARGELIS (IGECI): Good afternoon.

MR WOODS: Thank you for coming. Could you please, for the record, state your name, the organisation you represent and the position that you hold.

DR MARGELIS (IGECI): My name is Dr George Margelis. I'm the general meeting for Intel-GE Care Innovations. It's a new joint venture for Intel and GE, specifically in health care technology.

MR WOODS: Do you have a statement you wish to make?

DR MARGELIS (IGECI): Yes. First let me commend the Productivity Commission's review of aged care services in a wide-ranging review. The intergenerational report showed us the issues we are facing with a large and rapid increased in the aged population, and as someone at the tail-end of the baby boomer generation I think it is important to recognised that this ageing tsunami, as some people have called it, is not necessarily a bad thing.

The alternative to ageing is far less palatable to those of us entering that phase of our lives. It demonstrates that the various health and social policies of the past decades have to a large degree had their desired effect of improving the health and wellbeing of the population. The consequence is the population is getting older and, human physiology being what it is, it requires aid.

Some of you may have recently seen that Time magazine had an article about a gentleman called Ray Kurzweil. Ray Kurzweil is a science fiction author initially in the US who has taken up a very active role talking about the interplay between physiology and technology. He's made a prediction that in the next 20 or 30 years that interplay will lead to a concept he calls a singularity where this confluence of technology and physiology will lead to immortality. I'm not a huge believer in that. I do believe that we will have an increase in longevity as we go forward, but I think the dream of immortality is still a while away.

So to introduce myself, my background in health care, I have been involved in the health care profession since 1979 when I first enrolled in university. My initial qualifications were as an optometrist. I went back and received qualifications in medicine. Even before that time I spent quite a significant part of my time involved in aged care, having been a member of an ethnic community which at that stage was first generation, and many of my parents' generation were bringing their elderly parents out to Australia. So we were seeing first-hand the need for aged care

services.

Having spent about 20 years in clinical practice, the last 10 years I've spent looking at how technology can take a role in health care and in aged care. For the first five of those I worked in a local company to develop health care solutions. For the last five I worked for a company called Intel which is the world's largest microprocessor company, but I was working specifically within our health care group which has one of the largest research groups specifically looking at how technology affects individuals. That group was specifically looking at how technology affected ageing in home and health care.

Much of what I will be talking about today has been plagiarised from one of my colleagues, Eric Dishman, who many of you may have heard of. Eric is the head of our research division and also the chair of the Centre for Aged Services Technologies in the US. Recently, Eric submitted to the US Senate on meaningful use of IT in real lives of patients and families.

Before I start I have two basic assumptions on which this is based upon. Firstly, aged care and health care are very closely linked. That's demonstrated by the correlation between the age and use of health care services. When cannot separate health care from the provision of services to the aged, and good health care is a prerequisite for good aged care. Secondly, our goal is to provide to older Australians the ability to live with maximum independence in an environment of their choosing, and they have told us in our research that they prefer, where possible, to live in their own homes and communities. But we need to do this safely and with as high a quality of life as possible.

Based on those assumptions I believe that one shortcoming of the draft report of the Productivity Commission was the omission of a detailed examination of the role technology will play in the short to medium term in enabling us to deliver better quality care to ageing individuals, as well as providing opportunities for enhancing their independence and quality of life.

Many of you may be aware that the Australian government is in the process of implementing a relatively comprehensive e-health policy which includes modernisation of information delivery in our primary and hospital sector. Initiatives like the upcoming MBS items for telemedicine services; the personally controlled electronic health record; the implementation of electronic health records in our hospitals, and standardisation around the data sets that need to be transferred between providers is important. I'm sure that's been covered by my colleagues working more deeply in that space.

My area of interest over the last few years has been how technologies in the

home can enable people with the vagaries of ageing to stay in their home safely and for longer, plus also alleviate the stress of caregivers, in particular the informal care provided by family and friends. The importance of the informal care providers cannot be forgotten as we face a major challenge to our health provider workforce. Over the last decade, my colleagues at Intel have been doing active research for how these technologies can be used in the home environment. This involved actually testing technologies, often in prototype, in the actual homes of people and receiving not only their feedback but observing their usage and documenting it.

A few things stood out from this. Firstly, despite everyone's perception, the adoption of technology for the aged was not an issue if the technology was designed for their situation. Just dropping a personal computer in their lap was not a successful way of doing this, but developing the devices that serve a specific purpose, and were easy to use with interfaces that took into account the visual and tactile capabilities, were taken up quite easily. We often found satisfaction scores in the 90th percentile. The beauty is that with currently available technologies these are not hard to make.

Secondly, where there was a benefit to the individual or their families, a large majority of the elderly were willing to accept some potential loss of privacy and confidentiality to enable them to receive better care and services. I remember a quote provided to one of our researchers by a frail, elderly man who lived in a nursing home. His quote is:

> I'm at the point of my life where someone has to help me get dressed and go to the bathroom. So do you really think I'm worried about someone discovering whether or not I have taken my medications on time. If your technology could help me get back some independence it's a risk I would be willing to take.

There are numerous examples of how technologies can assist the elderly in maintaining their independence. I'm happy to table some reports from our research if that's required. We found that there were some fundamental capabilities that the use of technology in the homes of aged care provided. Firstly, it empowered individuals with tools to help them make sense of and do their own care; secondly, it allowed them to collect real time biological and behavioural data and trends in the home with alerts for out of normal situations; thirdly, it facilitated virtual visits with health care providers when appropriate by a range of media; fourthly, it enabled social networking awareness and care support for family and friends when nearby or distant; fifth, it allowed personalising care plans and educational content for each individual based on their needs, preferences, data and capabilities and, sixth, it allowed the triaging of precious medical resources to enable the right amount of care to occur in the right place and time.

To accomplish this, I believe we have to change some of the ways we think about providing care. Whilst in an ideal world all these services will be provided by a smiling, caring human being in person, supply and demand situations tells us that's not possible. So we need to look at how we utilise technology to scale out the limited workforce effectively whilst maintaining high quality care. Effectiveness and efficiency are the two buzz words. In a pilot study we did last year with Hunter Nursing Agency up in the Hunter region, we showed that using technology in the homes of patients with advanced chronic disease, we were able to significantly improve the efficiency of the home nursing workforce, and also provide as good if not better care into the homes of these patients.

The greatest challenge we faced in that project was not patient or clinician adoption, it was the availability of reliable data connections. So I would commend to the Productivity Commission that probably one of the greatest enablers of this solution is the government's national broadband network initiative to ensure equity of access to these technologies to all Australians. Selecting those who will most benefit from such interventions is the key to delivering this service effectively. Each individual has their own unique needs, however, if we can provide technology that is flexible and that can scale up or down the services it provides, dependent on the needs of the individual, I believe we can provide this personalisation.

I suggest the best way to do this is not to rely on proprietary single purpose devices, such as those used in the past; rather use technology based on the same principles as the personal computer that can be adapted to people's needs. When the PC first came out in the early 80s it was designed as a business - - -

MR WOODS: Can I just draw your attention to the time, if you could leave a couple of minutes to - - -

DR MARGELIS (IGECI): Yes, of course.

MR WOODS: Thank you.

DR MARGELIS (IGECI): However, because of the way it was designed, new software could provide new solutions to different people. Today the same hardware can be used by a scientist, a doctor, an accountant and a game-playing six-year-old. That flexibility comes from not designing proprietary devices that can only perform one task. They may be cheaper in the short term but they lock you into a very limited future. I commend to the commission that they look at the Continua Alliance, an international collaborative of over 230 organisations whose focus is providing useable standards for new technology.

Recognising unique needs: chronic disease is an issue that's facing a large part of the population. It's been proven that using technology in that space has made a huge difference. Medication management is also a major issue and again there's a demonstration of technology making a difference there. Socialisation is a major problem. We can actually provide tools nowadays that enable them to see and speak to their families remotely and allowing social networking amongst their peers. The ability for the aged to use tools similar to Facebook but with interfaces designed for their own flexibility are key. What we need to do to support this is to make sure these implementations can be rolled out. Today we face a number of small-scale pilots around the country of these technologies. What we need is large-scale rollout so that people can actually get their hands dirty.

So to summarise, I'll paraphrase my colleague's recommendations to the US Senate. Firstly, get connected. All providers - and that includes families, friends and individuals themselves need to be able to electronically share information. This is facilitated by the NBN and the personally controlled electronic health records currently under way in Australia. Secondly, get decisive. Provide tools that enable providers and individuals to make informed decisions based on best practice and on available information. We need to be able to flag variations, breakdowns and areas for improvement. Thirdly, get coordinated. All members of the care group, formal and informal need to be able to know what the other is doing as it relates to the individual who is ultimately in control of that information flow. Fourthly, get personal. A proactive prevention-oriented system of care that personalises care plans based on an individual's requirement, based on their health status, preferences and resources, that shifts care and responsibility to the individual and their family, with the appropriate tools, and to the home where appropriate.

Technology is not a magic bullet for all of aged cares issues, but its judicious use, based on common goals of providing individuals with the highest possible quality of life and delivering an efficient and equitable care system, will be beneficial for all involved.

MR WOODS: Thank you very much. Sue.

MS MACRI: I guess the only thing I would say at the moment - I mean, this is a broad vision out there and just even in our consultations so far it's been amazing the number of consumers and carers particularly that don't have access and don't have the skills. You talk about "get connected, be decisive, have the tools" but I would have to suggest there would need to be a huge education program out there. There are still a lot of older people particularly in the community and their carers that are very reticent about IT. In your model of all of this I would suggest there probably should have been a fifth dot point of "get educated".

DR MARGELIS (IGECI): The Aged Care IT Council is doing a very strong job at the moment to develop that education in the aged care sector. As far as education for the user, one of the big issues we still face in Australia is health literacy is generally very low. But, again, it comes down to developing tools that are easy to use. A classic example I always like to use: when the iPhone came out the training required for most people to take that up was minimal. Before I was actively involved in aged care my big involvement was in technology in hospitals and we used to always hear the common complaint that, "Doctors won't use technology," and yet today you go to most hospitals and 95 per cent of them have an iPhone in the pocket and use it regularly. If the technology provides benefit, there is usually a very straightforward path to learning how to use it and again designing technology to be easy to use is critical.

MR FITZGERALD: My question is about public policy. We acknowledge that we didn't do a lot in the report about technology and I think there will be a bit more of that in the final. But even after your presentation I'm left with this issue as to what do you think the public policy response should be. So largely is it a matter of trying to ensure that providers - including the government as a provider - embrace the new technologies in their delivery of services or do you have a specific set of recommendations that directly relate to the government's role in this? Clearly at the moment we can't quite see what the government's role would be other than to facilitate it, acknowledge it, as it rolls out it will no doubt impact both on costings and a number of other areas. But right at the moment what is it that you think we need to be doing in terms of public policy?

DR MARGELIS (IGECI): So the biggest challenge for adoption of these technologies has been active disincentives. So where funding models have required physical interaction between providers and patient, that has become a limitation to the use of technology because that same service delivered remotely by technology was not reimbursed. So therefore public policy which recognises that care can be provided without face-to-face interaction, that care can be provided by use of technology with the stipulation that the outcomes need to be equal or better to those currently available. So we're not looking for a decrease in the quality of the provision of care, but we are looking for the taking away of the disincentives of using remote care.

MR FITZGERALD: Do you have, not necessarily now but later, specific areas of programs where think those barriers are significant and need to be reduced? Going forward in the next five years or so, what would be the particular programs that you and your colleagues might think need reform?

DR MARGELIS (IGECI): The classic one - I mean, there is large disincentives at the moment around chronic disease management and that is a huge area in the health

care sector. In the aged care sector things like social interaction, so where we are still requiring caregivers to visit the home on a regular basis rather than provide them with tools to do that remotely where it is feasible and where it is shown to be effective I think is critical. Again, allowing care providers to utilise the technology in ways they see fit without hitting the disincentives. What we believe that will drive is innovations in some of the models. It's very hard to predict exactly what that model of care will be but by taking away the active disincentive I think you will find care providers that will build new models and there maybe totally new business models based around it and, again, it then becomes a question of acceptance. Some people may not want to use them and some people may.

But again if it's available as a service, if it hasn't got an active disincentive against it, I think you will find adoption will be significant in sectors, especially as the baby boomer generation starts to hit that age who are now used to using Skype and using technology.

MR FITZGERALD: Thank you.

MR WOODS: Excellent. Thank you very much.

DR MARGELIS (IGECI): Thank you.

MR WOODS: Can I call One Voice.

MS MACRI: Is it One Voice or United Voice.

MR WOODS: United Voice. I got it almost right.

MS LINES (UV): Good morning, commissioners. Thanks for having us at the Sydney hearing and I know that you have heard from some of our members last week in Queensland and you will hear from members in South Australia and Western Australia.

MR WOODS: Thank you. Can each of you first just identify yourselves and the organisation you represent.

MR PORTER (UV): Sam Porter, researcher with United Voice.

MS HATTON (UV): I'm Kathleen Hatton, I'm a cleaner and I'm a member of United Voice.

MS LINES (UV): I'm Sue Lines, assistant national secretary of United Voice. So we are here today to make four points to the commission and obviously open to the questions. But certainly Kath Hatton who - in our first submission we made two key points I suppose, one was as United Voice, the aged care union, with workers in the sector and secondly, as a union with a significant number of low paid members across hospitality, child care, cleaning and other areas and what an aged care future looked like for those workers. So we want to make that point and Kath is going to talk particularly about the family home.

We also want to make three other points, talk about the wages of aged care workers and our way of moving wages forward, the licensing of personal care workers and ratios were the four points we wanted to make. So I'll just hand over to Kath.

MS HATTON (UV): I don't really have any qualifications to speak to you today other than I am heading towards aged care facilities myself. I'm 60 in May. It gives me goosebumps to think that they might access my hard-won family home to pay for my or my husband's care. We actually have a friend whose husband is in a dementia unit and Val is able to live in her home and treat it as her home without a debt on it while Neville is cared for quite well in this unit. My husband comes from a Housing Commission background. He is probably the first generation in three or four generations to break out of that cycle and the night we paid off our house was probably the proudest moment - other than the birth of our four daughters - he had

ever experienced. We went through the hard times in the 80s, we paid 17 per cent interest, but we did it knowing that we were buying our own home.

You can say all the things you like about how it's only a loan and they take it out of the house when we die and there are so many factors that would come into that. In my generation we believe a debt is a debt is a debt. We don't own the home outright any more because the government has taken a loan on it to pay for the other partner's care. It's a debt and it's not what we want. We want to be able to own that house and if we need to access money on that house for our retirement - we are both low income earners. Cleaners are very low income earners and we have never had a lot because we've had so many children. But we're happy to live that way and we'll never live extravagantly but we believe we deserve the dignity of keeping our own home, of never having to mortgage that house to pay for the other one's health problems.

At times in our life we've both had to care for elderly parents and we've done that with love and compassion, I hope, and probably saved the government a lot of money in the meantime. That's okay, that's what we wanted to do. But we shouldn't now be penalised when it comes to our turn. We shouldn't have our home held as a ransom to look after the other one in an aged care facility. It's just not right. It's not what should happen in Australia. It's not what we believed we were buying into when we bought our home. I am just one but I know so many other cleaners that are in the same position. I know so many other low-paid workers that are in the same position that would hate to think their home was used as a bargaining tool to get you into aged care. Our homes aren't worth a lot. They're not a million dollars, they're very meagre homes, they're just homes; nice homes we're proud of but that's all. That's all I think I need to say. Thank you.

MR WOODS: Thank you for that. We fully understand your view on that. Perhaps have if we go through the rest of the points and then we can come back.

MS LINES (UV): One of the key things the union has really struggled with is how we improve the wages of low-paid aged care workers, a worker with a certificate III relying on the modern award is on $17.46 an hour and tends to work around 30 hours a week, so definitely sit at the low end of the wage spectrum and indeed struggle to make ends meet. Even where we have bargained - and the unions have successfully bargained in some parts of the sector - the rates of pay we have been able to achieve sit at - the best bargain is about 8 per cent above that $17.46 so would still have those workers in a low paid capacity.

The union has currently got a low paid bargaining application before Fair Work Australia that covers off on aged care but even if we're successful there our ability to really move wages to the professional rates that they need to be at will be limited

under the scope of Fair Work Australia.

MR WOODS: Can I just clarify that.

MS LINES (UV): Sure.

MR WOODS: So even where you've got EBAs you're still under $19? Is that the range?

MS LINES (UV): This year in our best enterprise agreements we will have personal care workers at around $22 an hour.

MR WOODS: So $22 is the top level but $19 would be the average through the EBA process?

MS LINES (UV): Yes. So we have been picking up in bargains roughly the equivalent of what the national wage increases have been.

MR WOODS: Thank you.

MS LINES (UV): When we talk to employers they tell us that they don't have the money through the funding to pay additional wages. Now, even if we're a little bit sceptical about that, they probably can't meet the professional wages that we think aged care workers are entitled to do. So the union has been looking at and what we want to pass up today is a scoping paper that we have been talking to employers in the industry to - because we think it's also our responsibilities as unions and employers to come up with a solution on wages and not necessarily leave it to the Productivity Commission, who quite correctly say the industrial arena is not their space - on we get there.

A certificate III is now equivalent to an entry level tradesperson and we also say that there is not an equivalent personal care worker in the public health sector and we will go into why we don't support the push from the ANF for PC wages to be equivalent to the public health sector in a moment. So when we have looked outside of our own area and if we look at the community services and health area the reason we're not particularly impressed with what is going on there, in the community services sectors many of the employers would be aware - and I know that the commissioners are aware we have a major case there under the equal remuneration order that is looking to lift wages. We have the union's application in the aged sector looking to do a low paid bargaining application. So I think it's fairly safe to say that is recognised as a low paid industry so we don't think there is an equivalent there.

We have gone outside of that and looked at what tradespeople get outside of

the community service and health sector and an ordinary tradesperson, so not a person in the mining industry and not a person with a big wealth employer, but an ordinary tradesperson working in a small factory or small employment status is on around $26 an hour. So when we have said we think that is a professional wage for what is expected of a certificate III aged care worker, it's not the sector has thrown their hands up in horror and say no, but they have questioned where the money has come from. So we were very excited when we saw that the Productivity Commission had come up with this notion of developing a true cost of care through the Aged Care Regulation Commission and so we started to think about how we might use that to live aged care wages because, as we have outlined, we don't think getting to professional wages we will get there through bargaining - certainly not in my lifetime.

We looked at that instrument and so we think how that instrument arrives at the true cost of care. If we base it on the current award or the current enterprise agreements in the sector we will simply lock in the poverty wages that are there. So if we were able to, with the sector, come up with industry benchmark rates. So what is the benchmark for a certificate III worker. The union says its $26. The ANF has made its claim for registered nurses, they are after parity for registered nurses in the public health sense and that makes sense, they're licensed workers. You can look at a scope of practice across of those two industries.

But in terms of the PC there isn't a personal carer qualification that equals what PCs do in aged care in the public health sector so we say that is not an equivalent. So we should be able to development what we think are the true costs of care benchmark rates in the sector, so a registered nurse, an enrolled nurse, a PCA and so on and that we then build those rates into the regulatory commission and we attach a value through them and we can do that through Fair Work Australia, through annualised wage increases so that we don't lose pace. Then we develop that with the sector and then we also make sure that that is transparent, we understand it and we understand how it moves. Then what we could do is tie those rates to an industry enterprise agreement to make sure that they flow to workers and that the federal government then fund the gap between where we are now and where we are into the future and that we index those rates.

What the union has done - and we will hand up a scoping paper and it's not appropriate to go into all the details this morning - is talking to the sector to about, talking to employers about it and we will be talking to the government about and we will put some more flesh on that in our submission. So we think we have a solution to low pay. Yes, it does require the government to respond and we're saying that that instrument then could really come up with the true costs of care using industry benchmark rates for key classifications right across residential care and community care. We've done some very ballpark figures and we think that, including both the

community and residential care, is about 2.2 billion so obviously there would be phasing in arrangements and so on. So that is where I will leave that piece.

MR WOODS: So 2.2 billion on the current level of - - -

MS LINES (UV): Yes, and that's very much a ballpark, so we haven't properly costed community care.

MR WOODS: In round numbers?

MS LINES (UV): Yes. So the other piece I want to go to is the licensing of personal carers. We were very forthright in our first submission in opposing that. We certainly don't - - -

MR WOODS: I think we quoted you.

MS LINES (UV): Yes, you did. We don't think really think it's necessary to make the point again. For a start we think that licensing prescribes a minimum set of standards, a limited set of skills and work roles and actually what we think PCs need to be is adaptable and flexible because the needs of residents in both nursing homes and the community setting changes and so what we don't want to do is lock in a minimum set of standards that are prescribed and written down and that if I, as a personal carer, go beyond that or our outside of those set prescriptions that I could risk my job.

We are also very concerned that licensing puts the responsibility onto the lowest paid in the sector and that's clearly not appropriate and licensing regime will do that because you would have an RN who is currently licensed, and that is appropriate, with a broad range of skills. You have an enrolled nurse who sits under that, with a less amount of skills than a registered nurse, and she is licensed. So a PC would then sit under both of those and presumably have a much narrower scope of practice and we don't see that that would - it certainly wouldn't add quality. It certainly wouldn't improve the wages of the personal care worker and in indeed, in our view, would make that person less adaptable and less flexible.

One of the things we have been able to do in our enterprise agreements is to increase flexibility, increase the wage rates. We haven't got $22 currently an hour for a personal carer by maintaining a very strict role, we've had to add flexibilities in. So we don't think that's in the interests of the industry. I'm happy to leave that at that.

The last issue that's come up is the ratios issue and, yes, we want to see certainly more personal carers on than - where we hear reports, and you've no doubt

heard reports, you might have 70 residents in an aged care facility being cared for on a night shift by a PCA and an RN - clearly that's not appropriate - or the evidence you heard from our members in Brisbane telling you that they were responsible for 22 residents. But again we don't think ratios is the answer to that. Why I say that is also the child care union - and we have ratios in that sector - and their minimum standards - and again I would certainly suggest if we went down a ratios prescription in aged care it would be minimums. We never see ratios for maximums, we always see them for minimums.

What we have in child care is that most employers employ to those minimums - minimum ratios. Some employers go above that and that will increase the quality. But obviously there's a cost component. Like child care which is private operators and community based operators - aged care is exactly the same - we don't see that implying a ratios regime will lift quality and we think it will prescribe minimums rather than maximums. We could even have the situation where we entrench existing staff levels and that would certainly not improve quality.

Our members talk about work intensification and not having time to be able to actually sit and talk to a resident. One of them made the comment to me that if somebody talks to you in the morning that's the person you spend the least amount of time with because you're so busy showering and getting people ready for the day. So certainly ratios, in our view - whilst we do want a better skill mix and we want to see a greater focus on personal carers because they are 75 per cent of the workforce - we don't think we'll achieve that out of ratios. That's probably where I'll leave it and I'm happy to take questions.

MR WOODS: All right. That's quite a broad canvas and, thank you. I did mention it before, not only thank you for your earlier submission but for the ongoing participation. Yourself and Sam have been certainly very active in assisting in this inquiry for which we're grateful. I know the union has a strong interest in delivery of quality services, if I can tie that back to your notion of adaptable and flexible, and I'm about to pinch the question from my colleague here but she can elaborate.

As we're proposing to break open the situation where somebody might have a CACP but needing at a later time an EACH package, but the provider doesn't have an EACH approved package, so you go to a different provider, you lose your personal carer. You're getting one personal carer coming in but your partner has a temporary need for somebody, so you've got two fighting over who's going to put them in the shower first - all of those things. By breaking open this and having a more flexible and focused set of services delivered, according to your needs at the time, that would allow them, should the person so wish, to maintain that provider as the need intensity builds up, and therefore keep the personal carer, who they have developed a relationship with, a trust and an understanding - because these are very personal and

intimate activities that they're involved in.

So do you see that that new paradigm of care and your point about adaptable and flexible, sort of interfacing? How would then the personal carer be trained, supported to sort of build with the needs of that particular person who they're caring for? It's an interesting issue but I think there's - - -

MS LINES (UV): Yes, I'll make some comments and then hand over to Sam. I think the parallel for us is we also cover - and this is one of the beauties of being such a diverse union. We also cover education assistants who do do that personal work with children who need extra support in school, and they generally do move through the school with the child, so they don't just stay with the child at preschool, they will tend to even move into high school sometimes. That would be a brilliant model of care. If we could take a group of carers who work with particular clients or residents throughout their needs for aged care assistance, that would be absolutely brilliant.

MR WOODS: That would reinforce the quality side of it, because it's all about relationships.

MS LINES (UV): Yes.

MR PORTER (UV): It also reinforces stable employment patterns as well, so something which you see enhancing the quality for the consumer is also offering a more stable employment for the worker as well.

MS MACRI: Would you see that providing some career pathing as well because, I mean, one of the things - and especially in the community at the moment, you're either this or you're that and that's about it. Whereas this path also allows for perhaps people to move on to aged care working, perhaps even an enrolled nurse, or just to be happy we're they're at, but at least it's giving not only an increased scope of practice but the capacity for some enhancing of their careers.

MS LINES (UV): I mean, a number of employers do work across both residential aged care and home care, so imagine the situation where someone comes in for respite care and that worker that was dealing with them in the residential setting was also able then to go and visit them in their home, I mean, that for us is also career progression. We know where good employers provide competency training and ongoing training of workers and continually enhancing the role, that provides a much better outcome for workers.

There's a situation where you've got one large employer working across both those settings, and you've got workers who can transfer and follow a resident in and

out, if you like, a nursing home, that would also be absolutely beneficial because they're getting to know that person's needs, their wellbeing, and they can make a judgment about whether they need respite or whether they need additional care.

MR PORTER (UV): Can I just add on that point. Yes, I think this is a good model both for quality and for the workforce but I think the key point is that if you're going to give workers additional training and expand their skills and expand their scopes of practice, that needs to be linked into wage progression as well.

MS MACRI: Absolutely.

MR WOODS: Yes, you're happy to have that on the record.

MR PORTER (UV): Yes, definitely.

MR FITZGERALD: So can I just ask about that: your recommendation that you want to see PCAs move to a certificate IV level, we're struggling to actually get good quality cert IIIs at the moment, and that's been a recurring theme in this series of hearings, but more generally. So if you were to prioritise would it not be better to try and improve the quality of the certificate III regime that we have now, before we start to look to certificate IV?

MS LINES (UV): We would argue that the issue in the industry is low wages and certainly a significant number of our members do second jobs because they tend to work six hours a day across five days of the week. Employers want them across five days a week because obviously they want the quality and the continuity of care, but that inhibits our members' ability to earn additional income, so many of them will either work agency, come back into a different nursing home, or take on cleaning jobs or working in hospitality. So, yes, there are issues clearly about the whole training agenda, but the issue is really that workers can't afford to stay in the industry. So we would say that wages is the number 1 issue that needs to be fixed. The reason we were quite keen to make the certificate IV as the entry level was simply to try and look at other ways we could lift the base rate.

MR FITZGERALD: But I just want to be clear, it's not because you actually believe you need a cert IV to do the job. I mean, you're using, as I say, a wage to increase the remuneration of the workforce, rather than a solid case to say, "A cert IV actually develops greater skills." Now, obviously it does but that's not your driver. You really see this as a driver for remuneration.

MS LINES (UV): Yes, I think we were having a bit of a bet both ways - we wouldn't be a union if we didn't do that.

MR FITZGERALD: That's true.

MS LINES (UV): Looking at the available evidence it says acuity levels are increasing, and if we are going to have the most flexible PC worker then perhaps into the future we do need a certificate IV particularly if there are greater needs than are out there now, and I think we were trying to look at that. But we also thought if we lifted the entry level we might - that doesn't increase the wages by very much, I've got to say, we've got a very compressed structure under the award so we were having that bet each way.

MR WOODS: While we have you on the record on the training side, do you have views on both the content of the cert III and on the delivery of the cert III by a range of RTOs?

MR PORTER (UV): Yes, I think the feedback we get from our members is that - you would know this as well - the quality is variable across the industry and the feedback we get about that is you have somebody who has come in and done a cert III course that was done very quickly or wasn't taught adequately that actually makes it really difficult for the other workers in that same facility or in that same community care organisation. That is a big problem.

MR WOODS: So in fact there is the threefold impact, isn't there? There is one in terms of the worker having the requisite skills to deal with the people they're caring for so that has an impact on the quality of the care delivery. Two, the impact it then has on other workers who are having to provide the support and presumably, three, the impact on the provider who is then having to supplement that with additional training and investment to bring it back up.

MS MACRI: Just quickly, there is a fourth impact on that, and that is in fact the person who has undertaken that in terms of understanding that they are going to come out skilled - I mean, we heard from the Ethnic Council this morning about the number of people undergoing the cert III with the perception that they're going to come out and get a job but often they don't because - one is literacy but the other one is that they are ill prepared and have been through an RTO that is not considered to be delivering a good product. So the worker is in fact disadvantaged enormously as well in having undertaken that.

MS LINES (UV): There are significant numbers of workers in the sector across community care and residential care with a certificate III and if you have a look at most ads for workers, even agencies say a certificate III is mandatory, so it is becoming the de facto entry level. But for workers who are currently in the sector the federal government last year put the $1000 in if you do the cert III training but that's not enough money and it's certainly one of the points that we're making very

strongly in our second submission to the Productivity Commission. It is a little bit outside your terms of reference in one way. We need a much greater focus on personal carers. We need good quality academic research and a lot more money spent on what it is we actually need and a lot more money committed to personal carers.

Because paying a personal carer to undertake the training, it will probably cost $2000 so they are $1000 out of pocket and it will take them many, many months - I think we estimated around six months - to make up that gap. If they have done it outside of work, they have done their six hours of work, you know, when do they do it? So there are a number of significant impediments to getting a true quality training agenda in aged care and we certainly need some more dollars in there.

MR PORTER (UV): I think some of that is to do with possibly a confusion in the industry as to whose responsibility training is. If you read DOHA's submission to this inquiry last December they say quite clearly that ultimately training is the responsibility of the industry, of the employers, but I don't think employers would necessarily agree with that. So I think at the end of it you have the worker who is left in the middle and, as you said Sue, is really the end victim. You have a couple of institutions, you have Health Workforce Australia, you've got the Skills Council, you've got what DOHA is doing through their programs and you've got some really good employers, others not as good, at providing training and there just isn't a consistent path to quality training.

MR FITZGERALD: Just one question, if I can. It was put to us the other day that your position and the ANF's position are very different in a number of areas, clearly in relation to ratios and also registration of personal carers.

MS LINES (UV): Yes.

MR FITZGERALD: Somebody said the other day this is no more or less than simply an old-fashioned demarcation or coverage issue between the two unions. Now, I would never say that. But I just want to be clear from your point of view, these differences - and they're quite substantial - that we're not simply dealing with a situation where on one hand if you register PCAs they in fact become the next level of nurses and if you don't, they stay with a different coverage. I just wonder whether you want to comment on that.

MS LINES (UV): Probably whoever said that failed to mention that unions, like lots of associations, have constitutions and for those of you in the room familiar with United Voice it is many, many pages and that sets out which workers you would cover. In some states we share enrolled nurse coverage and assistant in nursing coverage with the ANF but personal carers - and that's what they are predominantly

called and engaged in the aged care industry - are clearly a coverage of either United Voice or the Health Services Union.

If I thought licensing was going to lead to quality and improving the wages of aged care workers, I would be in here putting a very good case to that. But I genuinely believe that putting additional responsibilities on a worker earning $17.46 an hour could see the situation where that person is brought before a board - because obviously as the enrolled nurse union we represent members before the Nurses Board and that is very scary and you can lose your licensing and therefore lose your ability to earn money. For me that is a very serious step to take for a worker who is really supporting the care needs of someone to improve the quality of their life. It's not necessary. Not even in child care do we have licensing of workers. So that is the reason that we are opposed to licensing, to put that burden on the lowest paid and it won't lead to anything, it doesn't in and of itself increase the wages of the worker and all it does is impose an additional burden on the lowest paid in the sector. To me it is simply not fair and it is not warranted. So on that issue I'm very clear.

Our experience in child care, we have recently had a major breakthrough with ratios in child care where we have managed to increase the number of children that a child care worker is responsible for. But even though the union and the sector were speaking with one voice on ratios and we wanted them less than what we have won, we were not able to achieve ratios that the sector believes are in the best interests of children. So we have been in that fight in child care for a couple of years to achieve outcomes that are not the best for children, academic research says that. Again, our experience as the child care union tells us that ratios are not the way to get quality care in this industry.

What residents in this industry needs is someone to sit down and read the newspaper to them, assist them with their cup of tea, to ask them how they're feeling. Yes, they need to be assisted with showers and assisted with eating and taken on outings, that is the quality piece. By simply imposing ratios, which will be minimum ratios as we have seen in child care, not maximums, I think we do a disservice to the people who find themselves in residential care. Yes, of course, we want more personal carers but putting ratios in is not the answer.

MR WOODS: Excellent. We have well run over time but we look forward very soon to your final submission.

MR PORTER (UV): Yes, very soon.

MR WOODS: But if, in your final bits of drafting, you could explore some of that nexus and progression of personal carers and the older people receiving care because I think there is some more to be explored in that. I thank the three of you for coming.

MS LINES (UV): Thank you for your time.

MR WOODS: Can I ask the Australian Institute of Population Ageing and Research, please.

MS HIXON (AIPAR): Good afternoon.

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

MS HIXON (AIPAR): Certainly. My name is Laurel Hixon and I am a senior lecturer at the Australian Institute for Population Ageing Research which is part of the University of New South Wales. First I would like to commend the Productivity Commission for an excellent job in looking at the financing section. So my comments are only going to be on chapters 6 and 7 and as you might guess from my accent most of my experience in terms of and in public policy-making is from the United States. The context in the US is quite different than the context here in Australia.

The wealthy in the US have a lot of choices. There is an array of choices that is available to them and that is quite commendable. The middle class and the lower middle class depend on quite an extreme welfare system to fund their aged care services. So again the Australian context is quite different because both the aged care system and the aged pension system in Australia are quite a bit more generous than what I'm used to and so the discussion that we had in the US in terms of reform is going to take a slightly different tone than what it is here.

From what I understand both the health care sector and the retirement income, the reform approaches in Australia have been to move certain aspects of that off budget and to have greater personal responsibility and that took the form of health insurance subsidy, private health insurance subsidies and mandatory superannuation schemes. So it would stand to reason that policy-makers who were looking at reforming the aged care sector are also going to try and move some aspects of that off budget and to bring more personal responsibility into it. The reason why that is such an obvious thing is that aged care services very much interact with health care services and aged care financing very much interacts with the pension system and so there is just a logic to moving in the future over the long run in to more personal responsibility.

In my written submission last year I suggested that aged care was a textbook example of an insurable risk and I stand by that comment but I think the Productivity Commission was quite clever in understanding that all insurable risks are no created equal. So at one extreme you will have hospital services where the predictability and the probability of needing services are different and the costs associated with

hospitalisation, for example, are quite a bit more extreme than the risk and the probability and the costs associated with a residential aged care placement, for example, and then all the way through down to very predictable sorts of risk like dental care and so forth. So on a continuum residential and community care lies somewhere in the middle in terms of risks and costs.

Also there's a variety of risk selection issues and moral hazard issues that are associated with aged care. There are some aged care services or things that are part of the aged care package that are inherently fairly desirable. I know in the look that I did at HACC services there were quite a few HACC services that I wanted for myself: food preparation, lawn maintenance and so forth, and yet - - -

MR WOODS: They're available in the marketplace.

MS HIXON (AIPAR): If someone else wanted to pay for them, I'd be happy to take them.

MR WOODS: Separate question.

MS HIXON (AIPAR): Some services are less desirable and moral hazard, where if someone else is paying for it, the likelihood that you're going to want it are less and that would be residential aged care. To the extent that more of that is paid for, you don't necessarily want more of it, that's in terms of economics. I have to say that I am very impressed by how the Productivity Commission looked at the various components of financing aged care and pulled them apart. I thought that made a lot of sense to explicitly address the different pieces and then again moving the predictable housing and living costs off budget, if you will, and on to the individual and providing some additional tools to access the equity that is in housing wealth. I think that there is a certain logic to that, a certain fairness to that. And then taking the less predictable parts and keeping that within the government sector.

How do you then fund that remaining risk, the less predictable parts of it and the recommendation is that the government should carry the pieces that are more health related, so how do you fund those if you're going to split them apart? Again, there are two options that the Productivity Commission looked at. One would be a dedicated funding stream, a social insurance sort of strategy that was recommended by quite a large number of people. Then the other would be to stick with the general revenue tax system for pooling risks. Both of these are risk-pooling ideas, they just have a little bit different flavour. There is no precedent for social insurance in Australia. It has always - I don't know if always - but it has its social programming run through general tax revenues generally. So I'm not surprised that there was no call for a new social insurance program in Australia because there is simply no precedent for it.

Indeed, if you do go that route, there are issues around pre-funding and building up trust funds and how do you invest those funds and can you borrow against those trust funds and so forth that need to be very strictly controlled or else you could have unfunded liabilities in the future that can cause you as many problems as you might have in a general tax revenue way. I'm incredibly happy that the Productivity Commission really explicitly separated the housing cost from the care cost and I think that they also should be commended for identifying as a public policy issue access to capital for providers and knowing that it's not the same for residential aged care to access capital in the regular markets as it is for others, it's a riskier proposition and that the housing component of the payments should reflect the costs of that, that those things need to be more closely aligned.

Also the bonds and the accommodation fees topic need to be simplified. I think it's confusing, I think it's complicated and I don't think in the current system that it has been dealt with very wisely. I am going to propose that we just pull this apart a little bit more and there are seven public policy goals I think that are commonly used to judge different strategies for financing aged care: prevention of catastrophic out-of-pocket expenses; efficiency; cost control; rebalancing towards home care - after all that's where people want to be - reliability; equity and simplicity. On those seven measure I would say that if I were grading this paper in a class I would give the Productivity Commission a high distinction.

I don't give out many high distinctions but I was very impressed. First of all it does well in terms of preventing catastrophic out-of-pocket spending or its recommendations would do well in terms of they've explicitly limited exposure to catastrophic spending and providing a safety net for those housing and living expenses that were to be shifted to the personal responsibility. It builds off the existing system that does a very good job of preventing catastrophic out-of-pocket spending. Again, the discussion in Australia has been quite a bit different than in the US; that people feel quite comfortable that if they needed care that it's going to be there and that they won't have to impoverish themselves in order to get it.

In terms of efficiency, there's two aspects to this. One that I tend to think about is target efficiency, and that's if spending is going to the people who need it the most or who are the least able to pay for it. Again, kudos to the commission. The rigorous assessment of need and the safety net provisions of your recommendations meet those - the target efficiency types of criteria. But the other is about economic efficiency, and that is - economic efficiency is basically what choices are available to you. I think that - again, the Productivity Commission's recommendations are especially strong in this because they are trying to remove some of the distortions in the market to make a sort of a more neutral decision between home and residential care, to make a more neutral decision around accommodation bonds and

accommodation fees, to make those decisions to take the economic distortions out of the system and make it more of a level playing field.

Also, in terms of cost control, because general revenue programs have to compete with other spending priorities on a year to year basis, the cost-control mechanisms of a general tax-funded system tend to be stronger. The contrast being that social insurance programs have an entitlement nature and that entitlements tend to be more difficult to reign in and to impose cost controls. So I think that on cost control you've sort of taken the stronger route, perhaps. Also, the fact that the co-contributions are set with regard to issues of moral hazard - again making people more cost conscious about those parts of the system that are inherently more desirable to impose fewer co-contributions on the necessary pieces and sort of greater ones on the ones that are more inherently desirable.

MR WOODS: Just on that area, because we will probably run out of time - - -

MS HIXON(AIPAR): Yes, sorry.

MR WOODS: - - - if you have any further thoughts after this on how to improve incentives - you've mentioned the incentives on the individual that we've built in to give consideration to costs of consuming services, but incentives on providers to be more cost conscious when they're spending public dollars is something - if you could just put that in the back of your head and come back with any further thoughts?

MS HIXON(AIPAR): Yes, I'd be happy to give that some thought.

MR WOODS: But I'll let you proceed because we are - - -

MS HIXON(AIPAR): Yes, and just quickly, in terms of rebalancing towards home care, where people want to be. Implicitly separating the housing costs from the care costs will favour more care at home and will also favour creation of new congregate housing sorts of choices at the margins. Some people really do need to be in a more supervised environment but at the margins the choices should flourish by disconnecting those two things and removing the planning ratios is a very explicit way of encouraging more home care.

The commission's recommendations fair the least well in terms of reliability. Again, if you have to compete on an annual basis for budget, for dollars, at any moment things could shift. Again, as coming from the US where there is a greater reliance on social insurance strategies for the elderly in terms of their health care services, the changes that are made in the pensions, in the superannuation rules on a year-to-year basis I find just mind-boggling, because you make a decision about how much to contribute and then the next year it's only half as much. So that annual - like

the lack of reliability in terms of what to expect from year to year I think is an issue with the recommendations, and also miscalculations about future costs, the market basket that's associated with aged care. If you've messed up your calculations, future - the burden on taxpayers and the users of the service could be quite large.

MR WOODS: Just briefly on that though, with social insurance the taxpayer still remains the supplementer of last resort, so that if you've underestimated what's the cost of the pool, as the US currently shows with its debates about reforming Medicaid and Medicare, the taxpayer is still always there at the bottom end to prop it up if it falls over.

MS HIXON(AIPAR): Yes. There is just more of a cushion. I mean I think that because there's a trust fund that you can see 10 years off that things need to be adjusted in terms of cost control. You can see the tsunami coming a little bit more than if - on a year to year sort of general tax revenue basis you don't have the luxury of the padding, a little bit.

MR WOODS: But if you pad it too much then you've distorted your resource utilisation.

MS HIXON(AIPAR): Absolutely, that's right, in terms of saving.

MR WOODS: We could debate that. Carry on, this is very helpful.

MS HIXON(AIPAR): Equity, again, the fact that everybody has to pay for housing and living costs. You know, my heart goes out to people who think they're going to lose their home if their spouse needs to be cared for. I think that that's not the intent of the Productivity Commission and that spousal impoverishment pieces need to be built into whatever happens, but I think in terms of equity and fairness I think it makes a lot of sense. The fact that there are some strategies that have been suggested in terms of how to draw down equity in the home without losing the home or without risking - you know, being able to sell your home, having the flexibility of not being trapped in a home that you don't want to be in because you're afraid about losing your aged pension. I think that's just, in terms of the distortions to the market, very smart. Simplicity. Gosh, you know, could it get any less complicated? Absolutely. I find it incredibly confusing to tease through all of that in terms of co-contributions and so forth.

Just two final words. One is about choice. More choice is not always better. I mean anyone who has bought a mobile phone lately knows that sometimes choices can just make you go crazy. In fact, research on how well people are able to choose between complicated sets of options shows that in particular older people's actual choices often don't reflect their best interests or even what they say are their true

preferences. So there's a real disconnect between what people choose and sort of what's best for them sometimes. I'd be happy to provide you some of the literature on that.

MR WOODS: We have accessed some but we're certainly happy to cross-reference your list.

MS HIXON(AIPAR): Yes. Also, at UNSW there's a new centre of excellence. One of the streams there is about choice modelling for the ageing population, and so there will be more available soon. Also people's ability to choose between options. I mean I think it's fantastic to say, "Let's go into the market and let's give you lots of choices," but unless the information is very clear about what you're trading off in terms of cost and safety and so forth, I think it's really important. Then finally, because I'm a researcher, I have to say I still want more data around this topic.

MR WOODS: So do we.

MS HIXON(AIPAR): Distributional analysis. Don't leave out people who are in non-private dwellings. People in non-private dwellings are often excluded from data collection and so I don't think you can just say that the people who are in residential care look like the people who aren't in residential care. I think that we need to have more data on that around the financial status, income and assets of people who are users of care. I want to see more information about the out-of-pocket spending, what's happening now and sort of as we shift, as recommendations like this are implemented. Also, the levels of moral hazard associated with more home care and more residential care, I think we need to understand that better; how much more people are going to use a service if it's paid for more.

So that's my quick and dirty grading of the Productivity Commission. Again, I think it was really thoughtful. I thought it was well done and it was easy to read and I appreciate this opportunity.

MR WOODS: Thank you. If there's material there or supplementary material that you haven't read onto the transcript, if you could provide that to us that would be very helpful.

MS HIXON(AIPAR): Sure, I'd be happy to.

MR WOODS: We may come back to you and debate the merits. I mean we still are open on the question of social insurance but we have set out our thinking to date on it.

MS HIXON(AIPAR): Right.

MR WOODS: But you may be a very valuable person to test some of that further thinking as we prepare our final report.

MS HIXON(AIPAR): Okay.

MR WOODS: Very much appreciate it. No, that was excellent, thank you.

MS HIXON(AIPAR): Thank you.

MR WOODS: Good. We will resume at 1.30.

(Luncheon adjournment)

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

MS TURNHAM: My name is Robin Turnham. I'm a social worker by background, and coming here as myself, as the organisation which I was planning to come for has actually chosen an alternative way of representing their concerns as a large group, and I think they might be going to Canberra. So since that was very last minute that I heard that I decided to come and raise some of the concerns that I put to them anyway to pass on.

MR WOODS: Why don't you do that.

MS TURNHAM: Okay. I've had, just by way of background, 16 years in the adult protection field which is guardianship and financial management by a legal order, and prior to that I have worked in residential aged care, including running a dementia unit, so I have a strong interest in aged care. I would like to raise some issues to add to the report. I'd add that the previous speaker - I was very impressed. It was very comprehensive, a little bit beyond some of my understanding. I'm only a social worker. It's a bit like saying you're a mere housewife.

MR WOODS: No, don't do that.

MS TURNHAM: But I'll be concentrating on qualitative information and issues about quality care which I gather are also important to the commission.

MR WOODS: Can I just break there. Channel 10 want to come and do some filming. If there's anybody who doesn't wish to be present, please leave, otherwise you might get caught up in the video.

MS TURNHAM: Some of the assumptions that I was concerned with in the report and disagree with slightly, I would like to add something. Firstly, the report doesn't seem to critically engage enough to me with the fact that large residential facilities, which are institutions, continue to be the primary model of residential care provision for the frail elderly. The report doesn't recognise that this ongoing practice is actually in stark contrast with residential care models for all but the frail elderly. In the case of people with disabilities, people with mental illness, and children, large residential care centres have long been recognised as problematic because of the known inherent risk of abuse, neglect and inferior care which exists in institutional settings, in a sense, no matter how good they are. Of course that does vary.

MR WOODS: Let's pursue, but I'll let you make your opening statement first.

MS TURNHAM: Okay, sure. Thus alternative models, such as small group homes, are used for these groups. In addition I think it's worth looking at what has been done by the gay and lesbian community to explore other options for residential care for their members when they become elderly and frail. Arguably there is a certain amount of ageism in such an uncritical acceptance of large residential institutions as the ongoing vehicle for the accommodation and care of vulnerable, frail, elderly citizens who are no longer able to be maintained in the community, and a brief survey of submissions to the inquiry shows significant concern on the part of recent consumers or their families about abuse, neglect and poor care encountered in residential aged care, and there's been mention of it this morning, and there continues to be media reports itemising instances of abuse.

While this is fairly rare, it's still something that needs to be kept in mind. Most elderly people and their families actually fear entry into residential aged care. I'm actually doing research at the moment for a doctor of social work on community care workers and what they all seem to believe is that one of the reasons people are so keen to have their services is that they're terrified of residential aged care. There could be lots of debate about why that might be.

These homes in fact continue to be described by the elderly, and staff of the homes, as God's waiting room. It's that reputation that is problematic and drives the community care sector. Of interest, maybe, is the comment recently by Stephen Judd, the CEO of Hammond Care, speaking at an international conference on dementia. He reported that:

> Australians in aged care facilities are having their rights as citizens eroded by regulation and regimentation that requires carers to tick a box rather than meet individual needs.

He goes on:

> They're dragooned into group activities reminiscent of school camps and their liberty is restricted without safeguards that protect mental health patients.

Those were his words. I'm particularly concerned about those restrictions.

Another point, Robert Butler, the psychogeriatrician - recently died - an author and aged care activist who coined the term "ageism" because of the systematic discrimination against older people observed in his own country, the US, wrote actually in 1975 about older people being warehoused in nursing homes staffed by under-trained caregivers and seen by doctors who knew little about their particular needs. It has improved but unfortunately it hasn't improved enough, and what he

said is still of concern.

Quality of care in many cases in residential aged care facilities is poor, yet the industry itself, and the Productivity Commission, both take as a given that the residential aged care sector is over-regulated. Maybe it is in some respects in terms of red tape and that sort of thing, but in terms of effective regulation to drive quality care, it's not. I'm just suggesting that.

The accreditation system which has been critiqued, I would also like to add my experience there. In the course of my job I often visit nursing homes to see our clients. I've gone to quite a range of nursing homes over my life as a worker. You will find, for instance - and we found this - there can be residents there, shortly after the most recent accreditation - who are found to have serious, life-threatening skin ulcers, not evident to the agency which goes in and does a kind of paper based system. They interview a few people but they don't examine the residents. Skin ulcers - you may or may not be aware - can be both the result of poor wound care but also the excessive use or abuse of physical restraint.

My professional experience also shows that there is a use of covert and unauthorised restraint in residential aged care that can be quite common. What I mean is me sitting here now up against a table, if I were a frail, elderly person I probably wouldn't be able to get away from that position without the assistance of another person. Similarly, I'll go into a nursing home to visit someone and they're sitting in a chair with a fixed-tray table around it. They can't get out. If I made inquiries I'd find that they had possibly been sitting for hours in this position in a deep chair which looks like, to the average observer, a comfy chair, but in fact the design of the chair is such that they cannot get away. So there is a lot of this which isn't even counted in the stats about restraint in residential care. It's more the use of lap sashes and so on, the sorts of things that require authorisation that are actually recorded.

But this subtle restraint - often by people who don't even realise what they're doing, and for the reason that we probably all can understand, insufficient staffing; the workers fear that the person may have a fall; the workers fear that they might wander away. So this seems to them at the time the best way of dealing with it, but it is a serious human rights issue. It's not yet been dealt with. It's more likely to be common in an institutional setting.

Equally the standard of GP practice which Robert Butler actually spoke about then can be problematic in residential aged care. There are lots of reasons for that and I won't go into it, but I am aware that the standard of GP practice in residential aged care is simply not as good as it would be for the same person if they were in community care.

I have a small comment on accommodation bonds, only from the financial management sector where the person has an order, we come across a lot of large bonds as we have a lot of clients who are in residential aged care, and it's not unusual to have a $500,000 one. But we've had requests for up to $1.7 million. I understand that some facilities charge over two million. The concern is not so much that, that the facilities can actually do this, leaving a person only $39,000. It's the "only $39,000" which I would suggest is the problem, because when you're in residential aged care you have lots of other needs that the aged care system doesn't meet. They meet your basic needs, yes - accommodation, food et cetera. But really comfortable equipment to make you comfortable at the end of your days is often not supplied. So to have good customised equipment you need to spend on that yourself.

In addition, in order for people to have community access, if they don't have family members then it is really useful to be able to hire a careworker to take them out on a regular basis so they can access community and enjoy the sorts of things they enjoyed before, so examples of that. So I would suggest that we really need caps on the accommodation bonds to enable people to have sufficient funds to have a reasonable quality of life when in residential aged care.

Another concern I have is that with the bonds there is a perverse effect of actually causing some individuals to impoverish themselves in order to avoid having to the pay the bond so they will give the money to their children earlier and so on and then end up with far fewer choices about what they're going to do with their aged care or, as I was mentioning to one of the others, there was some research done a couple of years within the Greek community where it was very common for elderly Greek people as culturally appropriate to give over basically their home et cetera to their family members with the full understanding on the part of everyone that they would be cared for until the end of life by the family.

But the situation then becomes different, they may have dementia, family members have a somewhat different experience, there isn't the whole village to call upon to provide additional care and it falls apart and then they have very little choice when it comes to residential aged care. They may even have problems with Centrelink because they have divested themselves of their funds. So I do have concerns about that possibility happening.

I agree with the previous speaker, by the way, that assuming the user-pays system as the best approach, a mixed user-pays system as opposed to a universal system probably deserves a little bit more examination in terms of what Australians tend to expect. I would think that Australians would not probably at this point accept a universal system but it's worth discussing.

In connection with community aged care, I would like to note that the sector as a whole which is largely unmapped, we don't really know who is out there, very little research into the sector as a whole. That sector is not regulated as opposed to the residential aged care sector. The only parts of that sector that are effectively regulated are approved providers. So the rest of the sector is an unregulated sector. The research I am doing at the moment talking to careworkers and their managers suggest that there are a lot of fine people out there doing a really good job coming from professional, ethical beliefs and pride in their work and so on.

I'm not actually saying that there is necessarily a problem with it, but there are risks associated with it and the sector itself acknowledges that from time to time there can be a careworker who acts in a predatory fashion with a very vulnerable person. So they recognise that risk and they have ways of trying to deal with that, including, for instance - and it's interesting that they actually try avoid having the same person in order that they can't form that kind of relationship. That often upsets the elderly person because they want the same person but that's one of the methods that they use to reduce the risk and they have rules about accepting money and so on. But there is a risk there and the sector actually recognises that every now and then there is a problem. Some members of the sector also, by the way, are working towards a form of voluntary accreditation and that is a good thing to be seen. But as a whole it is not regulated, therefore, there is a lot of risk - there must be assumed to be a fair bit of risk in that most of their clients are people who are very vulnerable, elderly people.

I would like to add another point in regard to advocacy and complaints. In my experience about 70 per cent of people in residential aged care would have compromised capacity. Therefore, their ability to actually advocate for themselves is probably nil in many cases and at the same time also their ability to actually engage an advocate is also nil because the advocacy model requires the person to ask for an advocate. So they have to somehow be able to articulate that they need an advocate. I think a lot of complaints for that reason too do not get to where they should be going so I think we need a more active system for monitoring what is happening in residential aged care because of that.

MR WOODS: Given the time, are there - - -

MS TURNHAM: I'm happy to stop there, yes.

MR WOODS: If there a concluding point or two that you did want to raise.

MS TURNHAM: I was just going to make a comment about consumer directed care as well because there is a problem with covering the entitlements of the careworker in that case. There is a real risk that people would not know exactly what

to do and I believe, therefore, that we need a case management model added to that and we also need to explore whether some of the formal agencies would be prepared to provide a simpler model, a cheaper model for covering just the entitlements of the careworkers rather than costing out recruitment, training et cetera which, in a consumer-directed model you would expect the person or their family to provide. At the moment, for instance, the cost of the careworker's wages is about half what the agency would be charging and I would expect that the consumer-directed care model would actually find that very expensive. So there needs to be a way of looking at alternative models.

MR WOODS: Just on that one the entitlement to a set of care services and the price for those services is determined by a transparent process so they're not bargaining and competing on price but on quality and delivery. But we are also providing the gateway as a default care coordination production if need be and the case management would be a separately funded service where that was required. But can I go to your early point that I'd like to pursue a bit more where you were talking about residential care and congregate living alternatives. In fact what we're trying to achieve through these reforms is for many more people to receive care in either their current home or in an independent living unit environment or in congregate care type environment. So we would in fact be encouraging the industry to explore a whole range of accommodation options and that as a separate process to then the care that people are entitled and have delivered to them.

So by pulling apart care and accommodation we would expect the preferences of a number of older people who still want the social support and the security of living in a congregate environment but not necessarily to have to go unless there are clinical or other reasons to go into a current, as we know it, residential aged care facility. So we would hope that there is a much greater diversity in that accommodation set of setting. I was interested in your views on the congregate alternatives and if you have further research or issues that you could put to us on some of those models and from your professional experience what you find works well and what doesn't that would be helpful and if there are any brief comments you could make today on that.

MS TURNHAM: Probably not at the moment. I would be happy to look into it though. For instance, the gay and lesbian community has done quite a lot of work on that and group home models, of course, in the disability sector are quire common now but, of course, they are more costly. We would have to accept that but I think most people would prefer that kind of model. People are really scared of what they see in residential aged care these days. I don't think there would be many people in this room who would say they look forward with equanimity to being placed in a nursing home. I'm using the wrong term, I know.

MR WOODS: It's generic.

MS TURNHAM: Yes. That's the term that still tends to be used by people. I think that people would though be open to paying more for something that would be far more suitable, even clusters of group homes to allow for economies of scale may be one way of doing it. This would also reduce the risk of abuse.

MR WOODS: If you could point us to some literature in that area that would be helpful.

MS TURNHAM: Yes, okay. I would just like to add one more comment, that those people enter residential aged care at this point at a point of crisis. So choice doesn't seem to come into it very much. So education, I suppose, and pre-choice would be nice, if people could actually choose ahead of time before they actually are in that crisis, because most people end up there.

MR WOODS: Yes, and in fact a lot of older people do know the facilities that are in their community, and they've got friends who have moved into this one and that one and have a view on - - -

MS TURNHAM: That's right.

MR WOODS: - - - "Gee, if I ever need to go in, that one is really nice, whereas I'll avoid that one." So there is some information, but I agree, that further education and information at that regional, local level is important.

MS MACRI: Thank you.

MR WOODS: Excellent.

MR FITZGERALD: Good, thank you.

MR WOODS: Thank you very much.

MR WOODS: The Australian International Research Institute, thank you. Could you please, for the record, state your name and the organisation you are representing and the position you hold?

DR NIEMOTKO (AIRI): Mr Chairman, ladies and gentlemen, I am Waldemar Niemotko for the International Research Institute Incorporated. My presentation is in support for ageing people who wish to remain living independently in their own home, specifically in a strata unit. My observations are that of a volunteer, therefore I vented those with a social worker, psychotherapist, a Salvation Army staff member and TAFE teachers. They all preferred to remain anonymous. I also - thanks to volunteers of our institute.

The benchmark has been to me the current report of the Productivity Commission Caring for Older Australians. I largely agree with its findings - but the gaps that I will try to focus on further down the track. It is well known to all of us that the staggering ageing trend has brought the need to encourage seniors to live independently in their own homes for as long as possible rather than queue to retirement villages or nursing homes where there are not enough places. Truly, the preference of majority of people is to continue to live in their home and to receive care in a private environment. This results in the reductions in health and aged care costs. The vast majority of those aged 65 and over, that's around 83 per cent, own or are buying their home. However, the ratio of home owners occupancy is in decline.

Please bear in mind that there are now in New South Wales 72,000 strata schemes, most of them residential in nature. It is interesting what direction will take our new coalition government, considering numerous gaps that were left behind by their predecessors. There was put a lot of effort into translating the ALP voting instruction into 14 minority languages. That's good. However, what niche has been assigned to the generation of baby boomers who are not necessarily a minority? Many seniors have used their life savings to purchase a unit and to make necessary modification internally. The cost of maintenance for communal component of the property though is to be paid for out of the levies fund at discretion of owners corporation and strata agents. On many instances the seniors find themselves on a collision course with profit-minded investors.

This is also a sad experience of young people. An affluent investor on purchasing a unit is motivated to upgrade its attractiveness for an improved marketing effect. A case made headlines when a Japanese property entrepreneur had convinced a local council to use premises; something local journalists has labelled as a move to transform Spit Junction in Mosman to Kings Cross. When the North Sydney Council refused an application for a rooftop entertainment facility in a

school, the New South Wales government approved the very project to go ahead. Should an ingenious investor choose to set up a roof entertainment area on the top of a residential block of units? An opposing voice from an ageing unit owner is unlikely to be heard. Strata managers would most probably support a strong party with a bunch of proxies in hand for voting purposes at the annual general meeting. Ageing people are marginalised and not heard, even though they are contributing large amounts to levies. A need for a quiet place for seniors to live comfortably is neglected in the rush to enhance the investors' and developers' drive for increased profits.

Existence of support for people ageing in their own homes has been officially proclaimed. Those declarations need sometimes tested on a grass-root level with respect to their effectiveness. I undertook this three years ago by submitting the issue to attention of the premier of New South Wales. I received soon a letter with an indication to expect a substantive response from the ministers of planning, disability services, arts and fair trading. What followed up from them was extensive list of recommended resources and the institutions. When the issue was brought subsequently to the attention of the Diversity and Ageing in Action Forum 2010 on 10 May last year in the Parramatta Town Hall again, numerous agencies were referred to. However, each of them one by one refused to attend to an AGM meeting to support a frail, disabled person for one and a half hours.

Longer or shorter refusals came from the Aged Care Rights Service (TARS), Council On the Ageing (COTA), the Public Interest Law Clearing House (PILCH), Public Interest Advocacy Centre (PIAC), Inner City Legal Centre, Redfern Legal Centre, Royal Deaf Society, New South Wales Ombudsman, National Pro Bono Resource Centre, to mention a few. This situation is aggravated by the statement categorising generally seniors as asset rich and cash poor, which made them ineligible for a free legal aid service. A hearing disability would frustrate a telephone consultation. Not all are computer literate in order to access online, free legal service. An ageing person of non-English speaking background is likely to forget most of the learnt English vocabulary and need an interpreter. Paying for the services of a solicitor to attend the meeting is unaffordable to most people and would be viewed by the neighbourhood as something outrageous, resulting in further social isolation of the ageing person. CTTT tribunal would probably not allow for a legal representative of that calibre to plead in a strata case at all.

In conclusion, there appears to be an urgent need to carry out a survey to verify those findings. If confirmed, qualified support service has to be introduced for those people who are ageing to ensure their voices are heard on a grassroot level and decisions are undertaken with due consideration given to those who wish to stay living in their home.

Other unrelated suggestions from our institute are as follows: mediation in a strata matter before the Department of Fair Trading is to be made mandatory to the respondent to participate in order to reduce the number of cases being upgraded for litigation. Another point independent seniors in Newcastle have staged last Friday a independent senior design exhibition. I would encourage this to be brought to Sydney also. Another suggestion: there are retirees who follow the suggestion to abandon or dispose of car, use public transport, still they retain driver's licence. They can offer their services as a voluntary driver for meals on wheels or whatever would be needed as volunteers and for this purpose there is a proposal for decommissioned government cars to be assigned to community centres to be driven by those volunteers to enhance voluntary services.

There is a need for pedestrian-friendly traffic lights. There was a case of an aged person being "run to death" at the corner of Military Road and Wycombe Road. The lights, they change too quickly so every person has to rush but aged persons, particularly a disabled one with a walking stick could hardly negotiate. I sometimes volunteer to help them, "No, stop it," but it is not the way to do it. It has to be better organised, an RTA response. Government online communication, yes, it's good. In strata matters, new rental law is accessible only online. So only computer literate person can access but there is no hard copy available at all.

There is also encouragement for seniors to become computer literate and Seniors Week there was Facebook, Twitter, an introduction to computers. To become part of this project they always answer, "It has been booked." I went to the premises, I saw only six people were inside. But what money was spent to distribute this, to make a big show that everybody is welcome. It has to be said on paper and make more teachers to be available for those seniors willing learn something. Another technical obstacle. The consolation was, "Go online to find those Facebook, Twitter knowledge." I did it and there was a response, "No access," it lacked something which only available by special permission. So this is difficult for ageing person to cope with all those obstacles and in order to make it efficient those things are to be reconsidered for the next round, next year Seniors Week.

Last, but not least, there is a list of plain recommendation for life quality and strategies for ageing person. I will not go through all the points that have been included into the minutes with your permission. This is taken from literature and grassroot experience in attitude; activities within a structured, monitored program; sound music therapy; aesthetics; hobbies; information technology - yes, I love this, I enrolled to TAFE as a student - social function; spiritual guidance; assertiveness; public speaking; nursing staff, mature volunteers who can offer the gift of their experience. Thank you very much for your attention.

MR WOODS: Thank you very much.

MR WOODS: If I could call the New South Wales Nurses Association. Thank you for coming. Could you please, each of you separately, give your name, the organisation you are representing and the position that you hold.

MS McLEOD (NSWNA): Good afternoon. I'm Mary McLeod. I'm an OHS professional officer from New South Wales Nurses Association.

MS BURRELL (NSWNA): Good afternoon. I'm Terri Burrell. I'm a registered nurse that works in aged care and I'm here with the Nurses Association.

MR MASON (NSWNA): Hello. My name is Brian Mason. I'm an industrial officer with the New South Wales Nurses Association and I specialise in aged care bargaining.

MR WOODS: Thank you. We look forward to your presentation. Please proceed.

MS McLEOD (NSWNA): Well, this afternoon my role is just to reintroduce to you issues that you will have already heard before but with some support from Terri and from Brian from the point of view of the experiences of a nurse of longevity in the aged care industry and how these issues affect her. I have been involved in aged care for a long time. Ms Macri and I worked on an aged care package many years in manual handling. Our focus is residential aged care and although the information is not new, for the Nurses Association the most important matter for us is the staffing by registered nurses and its relationship to quality of care.

We feel that the removal and distinction between low and high care could have implications for the Public Health Act here and registered nurses being required 24 hours a day and directors of nursing trying to coordinate care and determine care within the facility.

MR WOODS: If I can just make a point. As we go through the presentation - I mean, we are aware of the current link in New South Wales. What would be interesting to us is not only the industrial issues surrounding that but also your views on the underlying concept of removing that sort of artificial distinction, so from a care and delivery of service perspective as well as the industrial perspective.

MS McLEOD (NSWNA): Terri will go into that and that is part of the brief she has been looking at in what she will present today.

MR WOODS: Thank you.

MS McLEOD (NSWNA): But, I mean, the lines are already blurred really. The

hostel and nursing home arrangements are such that high-care residents are in low-care areas and that has been a distinction that has been blurred for a long time. We comment on the difference between high and low care in the wording of the legislation we have in New South Wales.

Another point is the issue of nurses and staffing levels of nurses. We said in the commission report that accreditation and complaints are likely to pick up problems in that area. We feel that that's a very reactive way to look at quality of care and having quality improvement that you have to wait for something to go wrong in order to be able to correct it. Also a lot of the wording in that document and in the accreditation standards looks at appropriate care. Things like appropriate care are not quantifiable. It's very subjective. Also there needs to be a better way of determining that.

We have some concerns with the gateway as to who would likely be determining the level of care that would be eligible to residents on their entry to residential care, whether nurses would play a role in that area, and also some concerns about how the resident's status will be assessed and upgraded. Will it be done through the gateway or will that be done at a local level. That doesn't seem to be answered in the report.

We also put forward the advantages of nurses from the point of view of their accountability within the framework of health generally to a board; also continuing professional development requirements under the new national system which will always ensure their competence and skills; their ability to delegate coordinate and supervise appropriate care, and the training to a high level in all aspects of care that gives nurses the ability to supervise and become involved in early detection and intervention.

The last point I'll make is the public expectation that nurses will be in aged care. It has been mentioned in the report but not in many places, and even though the opening of the market to freedom of competition under government agreements and all that, public expectation rates highly in that process. It is our view that there is a large public expectation that nurses will be involved in aged care. A personal view that there is not always the knowledge by the public of who's a nurse and who isn't, so everybody assumes that everybody in a nursing home is a nurse.

That was about all that I needed to say by way of introduction. Terri has a wealth of experience in a nursing home that she's been in for 19 years on evening and night shift. She believes that her facility is one of the higher-end facilities. She's very happy with the organisation and she would like to actually put forward some of her experiences in relation to the aspects that we've spoken of.

MR WOODS: Thank you.

MS BURRELL (NSWNA): Thank you. The facility I work in has 59 high-care beds. We also have a hostel attached to us which has 60 beds which are patients deemed as low care. I thought the interesting thing for me as a registered nurse was the amount of time which I can give per resident. I just did a snapshot of what that is. For example, on a morning shift, which I don't work, with the 59 high-care residents, 8.1 minutes of RN care for each resident. That's divided up between them. An afternoon shift, which is what I do do, there is 11.1 minutes of RN care for each shift, and on night shift again in the facility I work from 8.30 pm till 6.30 am, there's one registered nurse and two assistants in nursing. The care that an RN again can give is only 8.1 minutes.

On the afternoon shift and the night-shift I'm also on call for the 60-bed hostel. I'm legally not allowed to leave my facility so the PCAs there have to ring me or come down, if they had a resident come back from hospital, because they cannot administer any schedule 8 drugs. They're out of a Webster-pak, so there's legal issues there. I can just see that a registered nurse is needed in aged care - in low care and high care - because of their qualifications, their experience. The PCAs don't have anything like what we do, as in education, neither do the assistants in nursing or an enrolled nurse.

MR WOODS: Just on your 60 beds - go back seven or eight years - and they were predominantly low care, what would be the current - - -

MS BURRELL (NSWNA): Yes, we were talking about this earlier. We have an ageing population which everyone is aware of. Of course most people came into aged care high-care facility in their early 80s; a lot of them are coming now in their late 80s, early 90s. People are living longer and are getting dementia. Mine is not a dementia specific unit but I would say a third of my residents do have dementia, are on psychiatric medication to try and control that, so our residents are a lot harder to care for, and we don't have the hands-on care to do it.

MR WOODS: What about in the hostel?

MS BURRELL (NSWNA): In the hostel we have residents that are staying there too long because we don't have nursing care beds for them, high-care beds.

MR WOODS: But they're ageing in place and - - -

MS BURRELL (NSWNA): Absolutely. Some are coming in again their 90s, yes, definitely. That's so true.

MR WOODS: Some of the hostel residents would in fact be what you would now call high care.

MS BURRELL (NSWNA): High care, absolutely, yes. That's for sure.

MR WOODS: Thank you. Carry on.

MS BURRELL (NSWNA): So basically what I really wanted to say was the hours of care or the minutes of care which we're giving each resident - and I love nursing, I love working in aged care, but unfortunately it's just getting much harder, I also find, to get registered nurses to come and work in aged care. I know it's been discussed earlier in the day about the pay difference but to me that is a big thing. To me it's more important that to get registered nurses into aged care would be to pay them the same as New South Wales state nurses are. It just makes commonsense to me. That's much more important than the patient ratio because I feel we could definitely get more people into aged care.

MR WOODS: Are you in the metropolitan area?

MS BURRELL (NSWNA): Yes, I'm in the inner west, in Ashfield.

MR WOODS: Okay. When you talked about your minutes of care, ranging through to 11 minutes et cetera, that was for you as the RN, and the EN is then supporting that.

MS BURRELL (NSWNA): No, in my facility of a morning on the floor we have one RN and one EN in our extra services section, and then of an afternoon I'm the only RN.

MR WOODS: No ENs?

MS BURRELL (NSWNA): No ENs, no.

MS MACRI: AINs or - - -

MS BURRELL (NSWNA): Yes. I work from 2.30 in the afternoon. I've got six AINs with me till 8.30, and then from 8.30 pm till 6.30 am, including the last part of the evening shift or night shift, there's one RN and two AINs for 10 hours of the day for 59 residents, yes. Then we're on call for the lodge, which is our 60-bed hostel, and they have one PCA from 8.30 pm till 6.30 am.

MS MACRI: There would be a director of nursing and deputy director of nursing?

MS BURRELL (NSWNA): In my facility, yes, but they finish about 5.00 or 5.30, that's right, yes.

MR WOODS: But the director and deputy director?

MS BURRELL (NSWNA): Yes.

MR WOODS: We'll come back to some of the underlying issues.

MS BURRELL (NSWNA): Thank you.

MR MASON (NSWNA): I'd just like to give a New South Wales context to some of the submissions that the ANF have made about pay rates, staff recruitment, staff retention, and also the need for any increased funding that flows from the efforts of this commission be managed in such a manner that it can be shown to flow to care of residents, and wages and conditions for employment of aged care employees. Until March 2006, nurses in New South Wales worked under a New South Wales award. That was discontinued because of the Work Choices legislation which took most of the industry into the federal system at that time.

The New South Wales commission had a process of keeping award rates up to date. There were annual reviews but there were also things which allowed wage movements through the recognition of productivity improvements. Wages for nurses in New South Wales have been improved significantly in a series of pay rises through till March 2006. Since that time decentralised bargaining has been the only way to improve wages and conditions of employment other than through the very minimal award standards of the Work Choices legislation and the new standards of the Fair Work Act.

During that period of time it would be fair to say that the gap between public sector - New South Wales acute public sector wage rates and aged care wage rates has grown. We simply haven't been able to match the rate of growth that has occurred in the New South Wales public health system. I recalculated the gap this morning in preparation for this hearing and I was surprised by the extent of it. As you may well be aware the New South Wales public health system has just negotiated a new nurses agreement. Yes?

MS MACRI: Very well aware of it, yes. The timing was - yes.

MR MASON (NSWNA): We did that for your benefit, commissioner. Yes, as I was saying, I recalculated it this morning, and with that 3.9 per cent that was added recently to the public health system the gap to the template agreement which applies in the for-profit half of the industry is now approximately 15 per cent at the senior

registered nurse level. So an RN8 is 15 per cent behind her colleagues in the public health system today. That gap will close a bit, as Mr Wirth was hinting, as time cycles tick around, but as of today it's 15 per cent. There's another template agreement in the industry which is for the charitable half of the industry and the gap there is about 11.5 per cent.

The reason that there's a gap between the two industry templates is that the charitable half of the industry started bargaining earlier, so they've increased on a higher base. The for-profit half of the industry started later, the first template agreement only kicking in in July of 2010, and therefore they started moving from a lower base.

MR WOODS: When you refer to the template agreement do you then have enterprise-specific arrangements that are paying a higher rate than the template?

MR MASON (NSWNA): Yes, there are now a large number of agreements in the industry and some with specific organisations - particularly some of the larger employers such as Uniting Care, Baptist Community Services - - -

MS MACRI: Hardi Group is a good one, they're a good payer.

MR MASON (NSWNA): Yes.

MS MACRI: I don't work for them.

MR WOODS: So putting aside sort of naming individual organisations but for those where you have negotiated enterprise agreements what sort of gap are you currently looking at, recognising that the base that you're measuring against is just the very newest public sector. Are we talking sort of a 8 per cent, 10 per cent gap, less?

MR MASON (NSWNA): More the 10 per cent. The importance of the templates is that they cover numerically the greatest number of employers.

MR WOODS: Sure, understand that, but I just wanted to get the range as well as the base.

MR MASON (NSWNA): Catholic Health Care went ahead of the template. They're probably the biggest of the charitables. They went 1 per cent ahead. So they won't be 11 and a half per cent behind, they'll be 10 and a half per cent behind.

MR WOODS: Okay.

MS MACRI: Can I ask just in terms of the private sector, with that 15 per cent what's the catch-up lag and then what will the percentage be when the catch-up lag - how long does the - - -

MR MASON (NSWNA): Not - - -

MS MACRI: Yes.

MR MASON (NSWNA): The New South Wales public sector moved off - notionally off last July. We're beginning a new round of negotiation with the charitable employer organisation in the next few weeks, with an anticipation that a new round of agreements will be agreed from July of this year.

MS MACRI: Right.

MR MASON (NSWNA): It would normally be a two or three year term. Far be it for me to give our bargaining position but the outcomes in that round of bargaining would have to be, well, at leat 4 per cent per annum to keep the gap the same. To close it over a period of time, to make it manageable, they're going to have to be 5, 6, 7, depending on what you thought was a fair period of time to close that gap.

MR WOODS: When you said that you'd sort of just calculated it for the purpose of coming to this hearing - and thank you for doing that, how far back would you go to identify when it was broadly comparable? I'm familiar with the Victorian situation and somewhat familiar with the New South, let alone the other states. But when did that draft, in your opinion, start to occur here and what was the driver of that?

MR MASON (NSWNA): There has always been a wage gap.

MR WOODS: Sure.

MR MASON (NSWNA): Probably the most significant date in recent history was the productivity case in 2003-2004 which resulted in significant wage improvements through to March 2006. At that date the gap was approximately 10 per cent.

MR WOODS: Yes.

MR MASON (NSWNA): So in the last four and a bit years it has blown out 5 per cent, in one example, and 2 per cent say in the other example. All of the academic literature, the HR literature, says that people will move for a 10 per cent gap. People will change jobs if they know that there is a 10 per cent gap. Anecdotally every day we hear stories of nurses at that point in time when they research wage rates, which is when they're looking for a new job - they know that the

gap is there. We anecdotally believe that it's getting much harder for aged care employers to recruit and retain.

MR WOODS: What role does salary packaging, FBT et cetera play in nurses' decisions as to what part of the sector they will operate in. Is it a significant issue, not a significant issue?

MR MASON (NSWNA): It's a very significant issue when people have the knowledge of the difference. The difference can be really very large.

MR WOODS: Can be, but is it always, because not everyone either is in a position to or has situations that would sort of encourage them to take it up.

MR MASON (NSWNA): That's correct.

MR WOODS: But if they're in that particular situation then it can be large, but not everyone is in that situation.

MR MASON (NSWNA): That's correct, and there's sorts of variables whether people are on a high wage or a low wage, whether they're working full-time or part-time, casual or permanent.

MR WOODS: Yes.

MR MASON (NSWNA): But if we would like to see aged care become a career path for nurses to be attractive for a young newly-qualified nurse to be recruited into, to feel that they have a career path and potential over the full span of a working life, then salary packaging will be an attractive feature in making a decision over that period of time. Day to day it's probably not quite that crucial.

MR FITZGERALD: Can I get high and low care - going forward within a few years the vast, vast majority of people in aged care, residential aged care, will be high care.

MS BURRELL (NSWNA): Absolutely, yes.

MR FITZGERALD: But for a period of time we do have still a significant number of facilities that are predominantly low care. So in this transition we've now got in New South Wales, as I understand it, that low-care hostels don't have to have a registered nurse - - -

MS BURRELL (NSWNA): That's right.

MR FITZGERALD: - - - but have an enrolled nurse in their - - -

MS BURRELL (NSWNA): They don't even have to have enrolled nurse.

MR FITZGERALD: No, and most of them would have enrolled nurses?

MS BURRELL (NSWNA): They don't, where I work.

MR FITZGERALD: They don't?

MS BURRELL (NSWNA): Sorry, they have a registered nurse who works the morning shift, 6.30 till 3.30, but the rest of the time there is just personal care assistants.

MR FITZGERALD: So how do we handle this transition period so that as we go through from this move from low to high care we remove the distinction? What's your suggestion for handling, because one of the things we can't have is a shock to the system. So you can't suddenly say we're going to have registered nurses in every low-care facility over night. To do that would add a great shock into the system. So what's the way forward given that over time low care will be an almost irrelevant part of the system; low care in residential aged care facilities. So what's a way by which we deal with this? I have been to a number of hostels and I must say most of them have ENs in charge of but, yes, just to suddenly say, "We're going to change the rules today," would be problematic.

The second part about that is what is the that the quality of care in those facilities is significantly different that would necessitate that immediate change to a registered nurse because in a sense if we're talking about a transitional period you would only want to make decisions based on clear evidence of need. So I was just wondering whether or not there's any clear evidence that the current care for people in low-care facilities with the current ratios is in fact detrimental.

MS McLEOD (NSWNA): I think, as we talked about earlier, the lines have been blurred between high and low care for a long time with ageing place. In the role that I do which is on the OHS side for entry to workplaces - and Terri can comment further on hers - I have yet to see a low-care area that doesn't have high-care residents in it. So I know that you're saying the shift from low to high but it's already there and the mandatory staffing requirements in New South Wales are such that a registered nurse has to be in the nursing home, not in the "hostel". However the care needs in the hostel are rising because of that, the ageing in place arrangements, and another aspect to that which means that the registered nurse then has to cope with both and that's what Terry was alluding to when she was saying the eight and a half minutes down to four and a half where you extend one registered nurse over the

whole facility.

The other point to that is the bulk of nursing homes and hostels and the older facilities particularly are geographically disparate, they have various buildings. So not only are you looking at high-care needs and a registered nursing having to attend both, but you're looking at geographical separation and having to leave one place to go to another which then leaves your high-care people here with no registered nurse available at that time.

MS BURRELL (NSWNA): Which is illegal. It's illegal for me to leave the facility as a registered nurse without a registered nurse. So I can use my registration if I do.

MR FITZGERALD: But how will you then into the future deal with cluster-type aged care residential facilities? I mean, the model we have is a box. The one thing we are certain of is the box won't exist and so a nursing home maybe these two-storey facilities, they may in fact be clusters of facilities. So one of the things we have to be very careful of that having decided to get rid of the box, we then don't have to have the box in order to deal with other issues. I know there is no perfect answer to this because we don't know what the residential aged care will look 10, 20, 30 years from now. But one of the things we're trying to do is free the system up so it's more responsive to consider needs but also to other advances in medical and other technologies as well.

MS McLEOD (NSWNA): I think one of the answers would be to have more than one registered nurse for that cluster and more than one registered nurse for the high and low-care facility because it is impossible for a registered nurse to delegate, to supervise, to respond to and Terri was talking earlier about the calls on her time other than resident care from supporting the staff that look after residents who are becoming higher and higher care. So I think one of the answers is to have more than one registered nurse to fill that gap, be it one and half or however one would do that. To be able to provide the supervision, direction, support as well as the patient care because there has to be someone to delegate to staff.

MS BURRELL (NSWNA): I think for me the hardest thing I find is that most assistant nurses who have worked with me - well, all of them - English is their second language and they're great nurses to work with, they do a great job but they need a lot of supervision, they won't make a decision themselves. So a lot of the time I'm being stopped in doing what I'm doing. Also you were speaking about enrolled nurses being in hostel care. An enrolled nurse is not endorsed to administer a schedule 8 drug so they shouldn't be there because they're not legally allowed to do it. For example, if someone comes back to our hostel after the registered nurse has left there with new medication which is administered in a Webster-pak, they have to come down to me because I can't go up to them. I have to check the medication. I

don't know this resident. I haven't seen this resident. They're coming back from hospital summary of a schedule 8 drug which I have to say to the nurse, "Yes, that's the Endone, give it at 8 o'clock when you put them to bed," but I'm not seeing this resident.

So to me that is not giving proper care. You know, "Is the resident sleepy, dopey? Should they be given the medication. Could they fall?" There are a lot of issues here. Also I found with a lot of my assistants in nursing that with getting more dementia-specific residents in our care - and as I said I'm not a dementia-specific unit - I have nurses that have been attacked, hit. I had a registered nurse the other week who was attacked by a resident. She was bruised and battered. Two nurses and herself couldn't hold him down - this was on night duty - they called the ambulance, one of the ambulance officers refused to take him to hospital. This was after she had called an emergency doctor to write him up for Serenace to calm him down, an injection, because every time we gave him the oral tablet he spat it back at us. So she gave him injection, it didn't work. The other ambulance officer said, "Yes, we'll take him," and he was admitted to Concord psychiatric unit. That time was taken with one resident where we have 58 others who couldn't be cared for because three nurses couldn't hold him down.

MS MACRI: Could I just ask you - and I guess the important thing is which is Robert is alluding to which is this sort of transition period because there undoubtedly the distinction between high and low care is narrowing. The statistics tell us that 60 per cent of residents across Australia in a low-care facility today are high care. So it is happening through ageing in place and a whole lot of issues. Would you see that - and obviously the facility when we look at the report and the residential aged care facility in the future is increasingly becoming very different to the low-care facility or the residential aged care facility of yesterday and today and certainly the report talks around a more integrated aged care model in the residential aged care facilities so that it will be dealing with end-of-life, palliative care, dementia care, all of the things it is doing now but even in a more specialised and integrated way with the community.

So that would you see that - and I'm curious as well - in terms of starting to look at those staffing issues and when do you start to say - this is Robert's question - when should the registered nurse be employed in the low-care facility and would you start to say, well, it's when it gets to a certain percentage of high-care residents? There is high care and there is high care and some of that high care is around behaviour. For us it would be really helpful from the Nurses Association, the ANF, and people like yourself to start to say when does the acuity and the number of residents start to say that a registered nurse is required?

The other thing I just want to say around that which is really important is we

need to be cognisant of the fact that we can't just be metrocentric and we've got to think about smaller, rural, remote facilities, 10, 15 beds, multipurpose centres and everything else. But I think from the PC's point of view from the ANF and the Nurses Association some guidance around that would be very helpful.

MS BURRELL (NSWNA): From me working in the nursing home and involved with the hospital, I think a registered nurse gives the best care. You're dealing with patients but you're also dealing with relatives and I can see what you're saying when a person comes into a hostel. But most of them come in and I look at them and they're frail and aged and in our facility there are ramps up and down and it's not easy to mobilise the residents a lot of the time. They need a registered nurse's experience who has had the training - they have had a lot more training than a PCA, an assistant in nursing and an enrolled nurse. They do more than caring for the patient.

A lot of the time it's the family as well and, as Mary said, guiding your staff and being able to show them what they should do to make sure the facility runs and to keep the patient safe. That's the whole idea. We're there to care for the patients and we should be able to have the amount of registered staff to do it who are trained to do it. Being a trained nurse, you're trained in all care, as in palliative and dementia and ageing and it's three different cares of nursing, as well as someone, if they fall, do they fracture the hip? I'll know if someone falls and fractures a hip by looking at it and I'll send them to hospital straightaway. A PCA, who would not have a clue, could move that patient and cause more damage. So it's experience, and registered nurses are the only ones that can give that.

MR FITZGERALD: Can I just clarify though, it follows on from Sue's point, if we take the rural and remote areas, we are starting to see the multipurpose centres being developed where there's a health centre and what have you, but there's also an awful lot of areas where that isn't the case. We do have very small residential aged care facilities, 10 or 15 beds. Most of them would be called "low care", but yes, they probably have a couple of high-care people in it. Can the system actually withstand somebody saying, "You've got to have three shifts of registered nurses on every day"? Does it make sense? If it does, what gets lost in that?

So I suppose we're trying to not disagree with you about the professional need or the quality of care that's needed, but the contra is we actually have a system that has a huge variation in terms of size and nature of clients. So a one size fits all approach has a cost. I'm just wondering whether or not you see any room for variations if you were dealing with very small facilities. The second point is it's very hard to actually attract staff anyway, so we've got a double-edged sword. We need the facility in the community. You can't get the staff now. We put in a hard ratio; we still won't have the staff. So it's just trying to work through it.

MS BURRELL (NSWNA): I think the reason you won't have the staff is because they're not paid well enough; that's to start with.

MR FITZGERALD: Sure.

MS BURRELL (NSWNA): The ratio doesn't affect me as much as the pay because we can't get registered nurses to work in the facility that I am in and it's an excellent facility. I don't know how they would go - though I have a number of friends that are living in the country and working in hospitals and aged care in the country, they're very happy to do it. But the answer for how you solve the problem there, I don't know. I just know how I think you should solve the problem in Sydney really. I don't know, if you pay them more, will more women who are married in the country go back to nursing as registered nurses? Maybe, yes. Some of my friends are working in pharmacies because they're earning more in a pharmacy than they are as a registered nurse in Dubbo and Tamworth.

MR FITZGERALD: Sure.

MR MASON (NSWNA): Perhaps we could take that line of question back to our organisation and we could come back with some more.

MR FITZGERALD: That would be helpful. As Sue has indicated, part of it is a long-term issue but part of it is a transitional issue. We know that we're on a path but imposing very rigid answers right at the beginning may not be the best way.

MR WOODS: We know that it would be so dependent on circumstances; for instance, a low-care facility that's right up next door to a high-care facility, it's one set of solutions, whereas if it's a totally stand-alone low-care facility, then it has different solutions. So to the extent you can sort of give some thought, that would be helpful.

MS McLEOD (NSWNA): Just before you move on from that point, and I know we're out of time now, I had a look at the building block arrangement and even though I don't have a solution to the question that was posed at the moment, it seemed to me that those building blocks, particularly the second and third building block, the distinction between the two would be very, very difficult in residential care because of a nurse, specialised care, being on the third rung and then personal care, and the association believes that nursing is part of personal care. But how can you say to a resident, "I can't attend to you, I can't - - -"

MS BURRELL (NSWNA): No, that's not the intent.

MR WOODS: No, it's not intended as levels, but a person's need would be drawn from a range of different types of care and support. The one person would have some specialist care if needed in relation to dementia or continence or palliative, as well as personal care, as well as - - -

MS BURRELL (NSWNA): That didn't come out well in the report.

MR WOODS: No, that's all right. Don't think of it as residents at different levels, think of it as a menu of services that would be crafted for each individual person and that flexibility therefore.

MS BURRELL (NSWNA): And that could be in residential or the community.

MR WOODS: As well, yes, both.

MS BURRELL (NSWNA): Yes.

MR WOODS: We are out of time. Just briefly in terms of the assessment process where a nurse, particularly one who specialises in aged care or within subsectors of that, would be drawn on as required to be part of that assessment process, changes in the older person's status, in most cases, particularly for residential, would be driven by the provider, therefore the nursing staff in the facility, but you'd still need the gateway to authorise the changing level of resource. But the sort of care and support and attention to the changing needs of residents that nurses do every day of their lives now would continue on but it's just that the gateway has to authorise, "Yes, that's a new and improved level of services," but they wouldn't come out and check - unless there was a provider that they thought, "Well, that's interesting but we'll come out and have a look for ourselves, thank you," or send a third party out - but in most cases, that would just be the normal activity that carries on.

There are a whole range of other issues but no doubt they will interact somewhere and we'll chase a few of them up, but thank you very much.

MS McLEOD (NSWNA): The association is also supportive of a number of the recommendations.

MR WOODS: We saw that in your document. Thank you. We appreciated that. We will have a short break and then ask Carers New South Wales to come forward.

MR WOODS: Thank you. For the record, could you please indicate your name, the organisation you represent and the position you hold.

MS KATRAKIS (CNSW): Elena Katrakis, Carers New South Wales, chief executive officer.

MR WOODS: Thank you very much and thank you for coming personally to make a presentation. I got your earlier submission which you made for which we were very grateful; in fact you went through quite a range of issues.

MS KATRAKIS (CNSW): We've also made two submissions to this round.

MR WOODS: And now we've got the second, yes.

MS KATRAKIS (CNSW): We've made one specifically from Carers New South Wales which is quite brief. Carers New South Wales also prepared the submission for Carers Australia, on behalf of Carers Australia and the network of carers' associations nationally. I won't go into detail because I know Carers Australia will present on that larger submission in Canberra later in the month.

There was just I suppose a few points I was going to make in relation to the submissions into carers specifically within the context of the Productivity Commission's report, specifically, how Carers New South Wales and the carers' associations I suppose see carers need to be considered as separate to the person that they're caring for and that they have needs and rights that are separate to the person they're caring for. Within the complexity of the aged care system where carers fit into that and where they fit into these reforms, I suppose we've been trying to grapple with that in the context of the report.

We are very supportive of the concept of the carer support centre if that's going to streamline service delivery to carers because at the moment, particularly in this state, carer services are quite fragmented. We've got 17 Carelink and Respite Centres across the state, one Carers Association where there's a bit of crossover in some of what we do but there's also a distinct difference in what we do. So that means that the system for carers is quite difficult to navigate. We're absolutely supportive of the concept of the carers support centre as long as it is well resourced and accessible. I know that's the aim, but as long as those things flow on and go with it.

Within that, I suppose we're still a little unclear about where the carer assessment would fit into the model and whether the detailed carer assessment occurs at the gateway level or whether that would then occur at the carer support centre.

Certainly we would want to avoid a duplication of assessment for carers and we would probably see that the detailed carer assessment should be at the carer support centre level.

The other thing in terms of points of where carers fit, where the carers are eligible for assessment and entry and services from the carer support centre in their own right and separate to a care recipient, that might be an older person because within this scenario, you have got carers that are themselves over the age of 65. At the moment there's a million or so carers over the age of 55 in Australia. So you've got carers that are over 65 maybe caring for their elderly partner but you also have carers over 65 that might be caring for an adult son or daughter with a disability.

So the other complexity for carers is grappling with the disability services sector and the aged care sector and making sure that there is synergy between the two, that there's streamlined access to services for carers no matter what system they might be accessing because of the person that they're caring for. I suppose they're just some key points in respect of carers specifically and what that model might look like.

We've made some very specific comments within the Carers New South Wales submission to make sure that the needs of older parent carers are dealt with in a little bit more detail. Their issues can be quite unique and again they are carers that are grappling with and crossing over two systems, but they are carers that are also ageing, so also may have age-related issues and need to access the aged care system in their own right but are also caring for someone with a disability.

So our submission is focused on older parent carers; it's also focused on the needs of Aboriginal carers. We feel that needs to be addressed a little bit more, the same with culturally and linguistically diverse carers and also carers of people with younger-onset dementia and the very specific issues for people with younger-onset dementia and their carers and where they fit into an aged care or other system. That is still very difficult. It's not necessarily the disability. It's an aged-related illness. It's about how they navigate the service system. That's I suppose our key points there.

The other point in terms of our New South Wales submission is the issue of transport and the availability of transport; community transport in particular, but transport generally. People are unable to access services if they don't have transport infrastructure to support them to do so, particularly in rural and remote and regional areas of New South Wales, but obviously that applies nationally as well.

It's just a particular area that I think we commented on in our very first submission but felt we needed to come back and again draw to the commission's attention, the issue of the transport, to make sure that people are able to access

whatever services, whatever the model is, wherever they are, so around equity of access, but just making sure that those needs and the needs of carers are distinct and that the needs of the carers do not end when someone enters residential aged care services either, and there's a particular role for carers there and they need to be incorporated and part of that system and service response and work with the primary paid carers within the residential aged care service as well and that they need to be acknowledged within that system.

The only other point would be around the issue of the family home and utilising the family home, and I know there has probably been debate and discussion about that earlier today, but there might be a younger person who is the carer that's caring for their parent, they may not necessarily be eligible for the carer's payment or carer allowance, they might be a working carer, but then is the family home still going to be utilised. You may also have then that person, the older person, caring for someone with a disability that could benefit from having that home, and not have that utilised. So again it's just different scenarios that need to be taken into account.

When we talk about carers we talk about the carer life course and we also talk about the dimensions of caring. People can be at different points within a continuum of care and they can be at a different life stage, and all of those kind of things intersect at different points and it's very important that there's different responses for all of those different intersections and scenarios for carers and the persons for whom they're caring.

MR WOODS: We have got a lot of material that we can work through with you. We will in a minute get back to the specific carer-focused issues. But just so I don't lose it, I am interested - given that as carers of older people are becoming more frail or have needs, and you have a very unique perspective on where the system is falling down for those you care for as well as for the needs of carers - and I was wondering if you had a view, either now or in the immediate future, on some of the more structural changes that we are proposing.

For instance, that you would remove the supply side restrictions and constraints of packaged care, so that you're not trying to get the person you're caring for to fit into a limited number of packages that look like this, but instead have a system whereby you're more confident that the care being delivered is tailored to their individual needs and what benefit that then would provide to carers as well so that you're not having to pick up stuff around the fringes that the current system doesn't provide.

MS KATRAKIS (CNSW): We are supportive of consumer-directed care and that purchasing of services and having that flexibility for services. A downside to some of that consumer-directed care is that the - I don't like to use the word "burden", but I

have to use the word - the burden falls on the carer then to maybe navigate the system, purchase the services, and I think there needs to be a choice about whether or not carers want to have control of that package and whether there's an intermediary or someone else to assist and support the carer within that. There is a model of care that's provided; Ageing, Disability and Home Care in Department of Human Services New South Wales funds a small program, which we deliver, for ageing carers in the mid-north coast, and the role of the non-government organisation - in this case, Carers NSW - is to be that support intermediary.

So Ageing, Disability and Home Care develops a plan around the carer and the care recipient, and we are that support intermediary, to purchase the services, to navigate the system on behalf of the carer and the care recipient, to get the things that they need and purchase those services for them. Sometimes that might mean employing family members to deliver support or to do gardening and general duties around the house, but it might also mean construction and building ramps and a whole range of different things. It's a small pilot program that involved 10 families within the mid-north coast area, and it has made a lot of difference, and there's packages of support up to about $50,000.

MR WOODS: Is there an evaluation of it, and is that on the public record, or could it be made available?

MS KATRAKIS (CNSW): It has only been operating for just over 12 months. We're unsure about whether the funding will continue with it. We're one of three providers. So it's 30 families only within the program across the north coast area. There hasn't been a formal evaluation. Whether Ageing, Disability and Home Care will do that to determine the next round, I'm unsure. There was to be an action research project running alongside this and some other models that were very similarly funded under the program, but I'm unsure whether that's commenced.

MR WOODS: Yes, well, we should chase that up.

MR FITZGERALD: Just in relation to the assessment issue, if we have the carer support support centres, one of the things that we're fairly clear about now is that the carer support centres would care for all carers: people caring for older Australians, people with disabilities, people with mental health conditions and those that are frail or have medication conditions. So there would be a level of assessment for the carer in the carer support centres. But in addition to that, in the gateway we still would take the view that there needed to be an assessment of the person that's ageing and the carer, to actually try to work out the total packages of entitlements.

But one of the things that arises from that is we are still seeking advice, from your Australian organisation but more generally as to what are the sorts of services

that lend themselves to an entitlement and what just should be referred to the carer support centre, and in particular the issue of respite, and you may or may not have a view. We think at this stage that planned respite lends itself to an entitlement. So the gateway would assess the carer and the person with ageing and identify that there is a need for planned respite. But in relation to emergency respite, peer support, counselling and those sorts of things, they tend to lend themselves to a referral to a carer support centre which is block funded. I just wonder whether you have a view about that.

MS KATRAKIS (CNSW): Yes, I would agree with that. I think there needs to be planned respite. I think that would be an entitlement. But I think the respite response needs to be that there is the availability of flexible respite that is available across the country, whether you're in a rural town or whether you're in a metropolitan area. I know we always come back to these issues, but it is the reality that a lot of times there isn't the flexibility or the availability of appropriate respite services within some rural locations. But I would agree that planned respite could be seen as an entitlement and that the other functions, education and training, peer support, advocacy, counselling, all of the other things that I suppose we're seeing would be within the carer support centre, that would be there as a plan, because people will phase in and out of different aspects of that as their needs might change over time as well.

MR WOODS: With the unplanned or emergency respite, we're sort of exploring the idea of how you would broaden the definition of "approved provider." So it might be the neighbour down the road who has known the family and that both the carer and the person being cared for are both comfortable with them and know them and that they would know that family situation. It might be a broader range than currently what we think of as approved providers. What sort of balance needs to be struck between extending the range of people who could fit into that role, still ensuring proper care, safety, quality? One model that you could draw on is the family day care type approach where there's at least a minimum of police checks and first aid and the like, so that if they had those beforehand, they could go on a list of people who could provide that, whether you would extend it to non-resident family members. If you start extending it to resident family members, how do you distinguish between what is publicly funded approved service versus normal activity within the family. So could you sort of explore some of that?

MS KATRAKIS (CNSW): I think it's very complex. I really don't think there's an easy answer. I agree with, I suppose, the broad concept of broadening out the approved providers for respite, yes. When you start using family members for respite, you're then taking up and you're turning what is the informal support system into the formal and that can have its pros and cons. That will suit some families. We've got I suppose a bit of evidence that maybe that will fit with the Aboriginal

community and Aboriginal families and that might be a better fit there, but it may not work for other families. Other families might want that total break away from that, not relying and not having the informal formalised. So I think it comes back to that there needs to be choice and there needs to be a range of options that people can then opt in or opt out, but if they want formalised respite, they can use that. So if you have a broad range of providers, then that gives you that choice.

MS MACRI: Can I just get your comments or thoughts around one of the issues that came out recently which was around the fact that people may be a carer in the community and the primary carer and then the care recipient ends up going to residential aged care and all of a sudden there's this cut-off from having been a carer to not being a carer and there's sometimes a little bit of conflict in residential aged care where the carer wants to come in and still continue to do a degree of caring within the residential aged care facility and I just wonder where your organisation fits in terms of (a) encouraging carers to continue caring, even though the person goes to a residential aged care facility and then you how you educate residential aged care facilities to not cut that person off from the caring role.

MS KATRAKIS (CNSW): We would support, if carers want to choose to continue to care when someone goes into residential aged care and continue with bringing food or be there for showering, all those kind of general activities and things like that, that's the carer's choice and we would support that. I think it comes back to education and training more broadly of the residential aged care system and the providers of that system about the role of carers within that. Some aged care providers do that very well. They acknowledge the role of carers. There's carer programs, there's a lot of support. They are probably few and far between but you can have that good working relationship and carers can be there as partners in care which is one of the pivots of one of the key actions under the Carers New South Wales action plan.

MR WOODS: But are there regulatory issues that either inhibit or deter that? The obvious one is duty of care, so if somebody slips over and they're being showered by their partner rather than by trained staff, the obligation is on the facility, but even if it's back one from that, even if it just appears in the statistics, but of course it doesn't differentiate as to what the circumstances were, you would imagine that facilities would start to become nervous at more than being there and providing comfort and companionship and maybe feeding and other things. But in your sense, do the good providers who acknowledge and support the ongoing involvement of the carer somehow get around that and others use that as an excuse and a barrier?

MS KATRAKIS (CNSW): The good providers get around that. The carer may not be the person necessarily doing the bathing by themselves. They might be there to be able to enable the care recipient to have the shower because they might be able to

assist in the process. They may not be doing all of the work, they might be there with a nursing assistant or whatever. They might be helping with that. So I think there's ways around that and there's different ways that carers can be involved within that care within the residential aged care facility.

MR FITZGERALD: Just further to that, when does the social security support cut off for a carer? I haven't looked at this for a long time; I used to know it. So if the person being cared for ends up in a residential aged care facility, what's the time frame after that by which you have to notify Centrelink to say you're no longer a primary carer?

MS KATRAKIS (CNSW): There is a period of time. Just off the top of my head, I don't have it there, I'm sorry.

MR WOODS: We'll chase it up. That's all right.

MR FITZGERALD: Because it goes to that issue about - we've heard from carers, saying that of course their caring role doesn't cease when the person leaves. On the other hand, we do know that the social security system says in fact it does cease at some stage.

MS KATRAKIS (CNSW): My colleagues are signalling me, saying it's about four weeks.

MR FITZGERALD: About a month, about four weeks.

MS KATRAKIS (CNSW): Yes.

MR FITZGERALD: Okay. Thanks for that.

MR WOODS: But there are then other pressures and demands that come on and we're well aware that when the person being cared for moves into a facility, then suddenly the daily transport task for the carer to get to and from a facility, particularly if it's late evening, can be very difficult and stressful for the carer, so other supports need to kick in to counterbalance the changed circumstance.

MS KATRAKIS (CNSW): That's right.

MR WOODS: Your reference in here on transport, your submission was very helpful in that respect of reinforcing those points.

MR FITZGERALD: Can I just ask about transport. Every single inquiry that's ever been done in relation to aged care and many others have always identified

transport as the critical issue and I have to say for 30 years that's been at least the case that I've been around. Obviously everybody will say it needs to be better resourced, but I ask a different question: are you getting from your members that the actual, for example, community transport services, in and of themselves, are they the right vehicle by which we should be increasing that resourcing? In other words, I haven't heard much talk about new models. I've heard lots of talk about needing to improve transport and we do. Everyone agrees. The question is: what's the right way to achieve that?

MS KATRAKIS (CNSW): I don't think it's just about community transport. I think that's one example and that's the model that we've got here, so that's what people tend to I suppose focus on. If you're in Bathurst and you need to go to a service, no buses run after a certain period of time, so there is no public transport infrastructure to support the community, whether it's people that are ageing, carers, whoever it might be. So I think there needs to be a mix of things; whether residential aged care services have their own bus and go and pick up carers, it could be a range of different models and options.

MR FITZGERALD: Okay. Thanks for that.

MR WOODS: Given the number of issues that you have raised in your written submissions, we've fairly much covered it, but is there any particular point you want to reinforce?

MS KATRAKIS (CNSW): No, that's all.

MS MACRI: Excellent.

MS KATRAKIS (CNSW): Thank you very much.

MR FITZGERALD: Thanks very much.

MR WOODS: Could you please for the record state your name, the organisation you represent and the position you hold.

MS PUGH (NEHD): Sure. My name is Debra Pugh and I work for New England HACC Development as a HACC Development officer. I guess I've had a bit of discussion with these guys already about some of our issues and I want to start by saying that our organisation supports the submission that's been put in by the HACC Development Officers Network of New South Wales which covers some more of the general issues, I guess. What I wanted to do was focus more on our specific rural problems.

I'm sort of wandering from what I've got written in front of me, but that's fairly typical. I think that we feel a little bit left out in a lot of ways and from the report as well. I don't really mean that as a criticism. It was 500 pages long as it was and it would have to be reams and reams of paper to cover everything. But the devil is in the detail and we need more of the detail of what would be different in rural areas. Just as background, I want to talk a little bit about the New England, just to sort of put me in context, I guess.

MR WOODS: Just for the record, we did go there and have an excellent series of consultations and it was very helpful.

MS PUGH (HACC): Our organisation works across the New England local planning area and that's an area of 98,000 square kilometres, which is roughly the same size as Tasmania, so we're not the most remote place in Australia by any stretch of the imagination, and we've got a couple of fairly major towns or cities; Armidale and Tamworth would both rate pretty well. But the majority of New England is made up of villages or towns. Around 10,000 people would be your sort of Gunnedah, Narrabri, those sort of towns. We've tried to consult with all of the HACC services across New England around the report, because we think this is really crucial, that this is really important stuff. I guess a lot of the feedback that we've had from the HACC providers is that we're not in there. It doesn't talk about us.

While we support so much of what's in there, I think some of the stuff about removing the burden of assessment and fees and so on from the service providers is just fantastic that that is the sort of stuff we want to see. The stuff around entitlement, as I go on to say, as you know, you have to have something to be entitled to and that is the bit that we're worried about. So the ABS reckons that 25 per cent of Australians live outside of cities of 100,000 people. That's obviously not small, but you're going to start falling into your Tamworths, Dubbos, those sorts of areas once you get down to that.

So we've got many villages that have numbers of old, so people that are over 65, and very old people, over 85, that are significantly higher than the national average, and we've got 8.3 per cent aboriginality, as opposed to 2 per cent, as the national average. This is just in New England, as I say. This isn't really super remote stuff. So compared to our urban counterparts, rural Australians face less access to public transport, that we've just touched on, to healthcare, to education, to effective telecommunication systems, and we've got higher unemployment and higher suicide rates. Rural Australians are likely to be poorer and to have a lower life expectancy. It's really attractive, isn't it?

The health of rural and remote populations is worse than that of urban areas. Mortality and illness levels increase with distance from metropolitan centres. People who live in rural areas face higher costs of living associated with transport. Again, there's that word. So we talk a lot around the stuff that the population is ageing, but if you sort of drill down into the demographic features of rural and remote communities, it gets fairly interesting.

Compared to urban areas, rural and remote Australia has got a deficit of young adults and a slightly higher proportion of children less than 15 years of age, which is way different from the city. Males are more numerous than females in remote and very remote areas. Older people make up a larger proportion of the inner regional cities, roughly the same proportion in outer regional areas and a smaller proportion in the remote and very remote areas. Some of that is because they move. They move into town as they age, so they'll come in off the remote properties. So population decline in remote areas is primarily the result of more people moving out of the area than moving in and in the inner and outer regions, population decline is also associated with a high proportion of older residents, combined with a loss of our young people as they move away to get work, and low fertility rates.

The draft report doesn't give us much insight into what you're going to do in a rural setting where some of the market weaving its magic just isn't going to work. We've got 25 per cent of the population and an even higher percentage of the 65 pluses, but we don't get much attention. There's a small section that deals with older Australians living in rural and remote areas and it's five pages out of the 500. We don't get a single recommendation. That's just about the rural bit. We get the "all Australians" and I understand that that is trying to say us as well, but it's how that would work. That's what we need to know.

That section of the report, it looks at our plight and it discusses what goes on, acknowledges that there are difficulties, but it doesn't sort of give us any indication on where we're going. So the things that are our biggest concern aren't given much attention. I get now into a bit of a word count and while I realise that that is - - -

MR WOODS: I've read it with interest.

MS PUGH (HACC): I realise that that is a fairly simplistic approach to analysing the report. When I was getting this feedback about, "There's nothing about rural areas in there," I'm a fairly simplistic girl and so I had a look at it and there were over 200,000 words in the report, but the word "rural" only pops up 96 times and over a third of those are in those five pages, so we're just not there. So transport, I was really pleased to hear it discussed in that last session, but is it really our biggest issue, and it's only in there 57 times. There a little bit of a touch on isolation and that's seven times and six out of seven of those times it's talking about social isolation, rather than geographical.

We're sort of feeling like our stuff, as I say, isn't there. One of the strongest concerns that's been fed back to us has been that we could end up with a system that replicates or that looks a lot like our health system in New South Wales. Under that system too, we have entitlement and we have equity of access, but our reality is that there isn't very much service that we can have access to, unless we travel to the larger centres. We've got poorer health and we're more likely to die as a result of treatable illnesses than our city counterparts and yet we receive less service and have less of the health dollars spent on us per head.

People literally make the choice to stay home and die because getting treatment is too difficult. So we need an aged care system that aims at equity of outcome, not just around access. We've also had concerns expressed about the gateway and that if that's the way into the system, that we could end up with a bottleneck that was actually slowing down the flow. Across the New England area, we work pretty hard to try to foster a no wrong door approach so that people can get the services that they need. A lot of country people, they have a tendency to like a more personal approach and want to talk to people that understand their geography and aren't saying, "That's only that far on the map," which we sort of get a bit.

Telephone based assessment isn't really that popular amongst our client group. They've got a bit of a reluctance to stay on the phone for a long time, especially long distance phone calls. Even if they're not paying for it, it's an issue. There's also usually a degree of hearing loss that is associated with ageing and it makes this whole telephone thing even more difficult. We're seeing a push towards this re-ablement and building people's independence, and that's also got a focus on basically thorougher assessment at intake so that you can set people up to maintain independence rather than be supported and needs to have assessment at the beginning. We have problems around that because we haven't got the therapy staff and allied health staff that you would need to do some of those assessments.

The guy from Intel that spoke this morning, I thought he was fascinating.

There are a whole pile of things that we could do with technology and local trained staff who could then feed back to - I don't know how it would work. But I think that we could build on that concept. There seems little chance that a community care system funded by a government subsidy, care recipient's co-contribution and market forces could be operational in towns that currently can't support a 24-hour taxi service. Some of our town don't have a taxi at all and that's because the market just doesn't work for us.

Yes, housing equity, we've got towns where the median house value is less than $100,000 and so there is not a lot to use there. I guess it comes down to there is a city model. It is a pretty metropolitan model that you have developed and I don't think that has been an easy task by an stretch of the imagination and I don't think I could tell you what you need to do but we need some models thrown back to us so that we can throw them around a little and bend on them. We need some real consultation on what it would like for us. Thank you.

MR WOODS: Thank you for that and, as you pointed out, we have had the benefit of some discussions during the day and I did express to you my surprise that word counts would reflect the approach we had taken and consultation that we did have a very successful, very positive round table in fact in the New England area where we sought advice from local providers, residents and carers in that area. But putting that bit aside we, at the commission, do have a very strong recognition of the needs of rural and remote localities and communities, not only in this inquiry but as a general principle we spend a lot of time going out beyond metropolitan into rural and remote because the one model has to apply in a whole range of areas and we do recognise where markets can work and where markets don't work and - - -

MS PUGH (NEHD): So what's the cut-off? Where does it stop?

MR WOODS: Some of that comes from experience, some of it - I mean, different markets, like, a market for transport is different from a market for residential aged care facility versus a market for community based care. You have multiple and competing providers for meals on wheels, for instance, in your region but you don't have as many major providers of residential aged care facilities. So there are different ways in which some of that operates.

MS PUGH (NEHD): I don't know about competing for meals on wheels.

MR WOODS: You do have several different providers.

MS PUGH (NEHD): Yes, across the region but they have all got a geographic area. They're not competing.

MR WOODS: Even in your largest towns of Armidale and Tamworth?

MS PUGH (NEHD): No, there's one.

MR WOODS: Single in both?

MS PUGH (NEHD): Yes.

MR WOODS: We will discuss the detail separately. But the point is that there is a need to assess in each area just how far a market can work. But where it can't then we have in our draft report proposals about block funding, about additional support, about the cost of care reflecting delivery in those local areas. So that's where we'd like to spend some of today of going through those issues and pursuing what are the ways that we have proposed and what are the ways that you think the system needs to be fine tuned to reflect the actual situations on the ground. Because it has to apply as equally in your region as in the Kimberleys, as in metropolitan Sydney or the western suburbs.

MS PUGH (NEHD): Sure.

MR WOODS: So we would like to explore some of those. Robert.

MR FITZGERALD: I think in the final report what we can do is in the section that deals with regional rural area is bring some of this together because it's actually in the report and we're finding that in a number of areas that it's there but because it's across the report people have a view - - -

MS PUGH (NEHD): And it's huge.

MR FITZGERALD: Yes, so I think we can do that and we welcome that sort of approach. But if I can just take the gateway. I would, for example, imagine that the gateway would operate at a regional level, we have said that. One of those regions unquestionably would be the New England region. So the actual gateway we haven't yet described what the regions but what we have asked people to do is to tell us what are the principles which we could base a region on and give that to government. So just in that area we would absolutely see that there would be a region, if New England is the right region it would operate at that level, because for the very reasons you have said, we don't want something in Canberra or Sydney, we want it local. So we have said it is regional but we haven't actually said what they are.

The second thing is it is important that it will have an outreach so that information and advice will be provided through a number of service agencies. So again we know that older Australians access their information from a number of

different sources. It's a bit like Centrelink in the sense that Centrelink uses up a thousand different agencies to put out its information but there is one repository of that information and one organisation that sits behind all of that information, so again we see that. But coming to the point about HACC and one of the things that is clear is the HACC program would disappear, that is true. So you're very much in our mind. But the HACC services could continue and this is the difference. Right throughout Australia it's the same thing.

The HACC program disappears because from now on the consumer takes the entitlement to the provider they wish to provide the services. So with the exception of some areas which would remain block funded, like community transport, meal preparation, you're right, the HACC program disappears but the actual services continue. The question I've got for you is: what are the services in your mind - and you don't have to be prescriptive about this - that could actually work on the basis of a consumer taking an entitlement to your service and what are those that actually need continued block funding? We've said that in the report. We're very open to it. It's not a residual system, we just think that some services lend themselves better to block funding. Some of those are in regional and remote Australia, some of them are in metropolitan area.

But as a practitioner, what are the sort of services that you think, even in the New England area given its variations, work well with people choosing to go with their entitlement and those that you would have to keep block funding.

MS PUGH (NEHD): That is a really tough one.

MR FITZGERALD: I know. You have been tough on us. You may not have the answer but that is the sort of thing we are looking at.

MS PUGH (NEHD): I would really like to go away and play with that a little bit and come back to you.

MR FITZGERALD: Have a think about it.

MS PUGH (NEHD): It's not something that is sitting there. It's a novel concept in a way. I know the report has been around for a little while but, yes, it is hard to imagine and I think that you would have to be pretty careful that you don't have people not doing things because it's going to cost them a little or whatever so that they are not going to get the services that they actually need because they are going to have to - - -

MR FITZGERALD: Just to put that in perspective, we believe that the number of services will increase and we want the coverage to remain as it is or better. So the

first thing about it is we are actually looking at more, not less services and we are looking at a broader range of services. The question is how do you deliver that? So just for your thinking and for other HACC workers - no doubt we will have this discussion - it's not about producing services or access to services. It is about saying, "What's a better way of delivering that?" Some of those should be block funding and some of those should be entitlement based. We are not being prescriptive, we're trying to work that through. Your feedback and other people's feedback would help that and at the end of the day government will have to look at that.

MS PUGH (NEHD): So even when they're block funded they would still be entitlement based?

MR FITZGERALD: No, not necessarily. For example, let's say community transport. People have said to us that community transport is a HACC scheme which should remain block funded and so Sue can simply access that. If she has a need for community transport, she meets the criteria, she can access that or she can go through the gateway and the gateway refers her to that. But that's one that people are saying to us lends itself to block funding, not to entitlement. You heard before in our discussion with carers, planned respite lends itself to an entitlement because you can actually go to a service provider and say, "I'm going to get two hours every fortnight but that's it," whereas emergency doesn't. It's unpredictable, it's difficult to administer, you need to support the agency. So we think, yes, that's block funded. It's that sort of stuff.

Now, your feedback as somebody on the ground would be invaluable. We're not going to be that prescriptive in the final, but that's how it would work.

MS PUGH (NEHD): Okay. I guess the way I read it or the way I interpreted it was that it was all going to be entitlement, which I almost thought was good, especially for transport.

MS MACRI: Explain that view to us.

MS PUGH (NEHD): At the moment, so much of it is around the provider trying to juggle resources and the resources are inadequate. So in order for it to be entitlement, that would have to be better funded in the first place, I guess; that's where my head was at.

MR WOODS: So that's a question of funding though, rather than whether it's entitlement or block funded.

MS PUGH (NEHD): Yes, it is. But we've also got providers - under the current system, the actual providers are having to make decisions about who they're

providing the service to. If you read the national HACC guidelines - a spare time moment, I think - - -

MR WOODS: We've been there.

MS PUGH (NEHD): - - - but if you read the guidelines, it talks about the special needs groups and people in remote and isolated areas as being a special needs group and that they should be a priority for service and all the rest of it. But then in the next paragraph, it goes into the fact that the provider also needs to balance what would be of greatest value to the community. So we've got the little HACC worker sitting out the back of Bourke somewhere, making a decision about whether we provide a service that's quite expensive to one client or whether we service 10 in town. It's that sort of stuff. That's a huge burden, I guess, to put on a person and an organisation even, especially these tiny little organisations that are often funded fairly poorly and supported by community volunteers. So there's some stuff there that's just rural.

MR FITZGERALD: Well, it is and it isn't. It's more widespread than you think because those sort of small HACC providers exist everywhere.

MS PUGH (NEHD): Yes, I talk to my colleague Melinda over there and she talks about Sutherland.

MR FITZGERALD: One of the great things about HACC is it's everywhere and one of the great problems with HACC is that it's everywhere; in other words, there's lots of different organisations running it. Some are not viable, some are very viable.

MS PUGH (NEHD): Sure.

MR FITZGERALD: So it's not just a rural issue. But that's the sort of stuff we're looking at, and again we'll make that clear in the final report, absolutely. But HACC is very much on our mind and rural HACC is very much on our mind, but we will pull it together a bit better so people can think it through.

MS PUGH (NEHD): Sure.

MR FITZGERALD: But they're the sorts of issues we're looking at.

MS PUGH (NEHD): Yes. The transport stuff is huge. We've got the health system sort of contracting into the larger centres and people are travelling really long distances while they're really sick.

MR FITZGERALD: Yes. Can I ask this other question: there would be service

providers that are delivering both HACC and non-HACC services in New England that would like the opportunity to grow, expand, not everyone.

MS PUGH (NEHD): Sure.

MR FITZGERALD: And at the moment they can't. They can't get access to packages, they can't get access to enough HACC funding and the system is very disparate right across. It has benefits but it's also got enormous inefficiencies in it. One of the things we would have thought is positive is for those organisations that want to grow, local organisations, and extend their range of services. This is a model that allows that.

MS PUGH (NEHD): Yes. I'm not arguing, not on that count. But I think that, yes, there's less chance of doing that growth stuff. I think the whole idea of getting rid of HACC - and far be it for me to say that's a good idea - - -

MR FITZGERALD: HACC program.

MS PUGH (NEHD): Yes, the HACC program - but getting rid of some of those artificial barriers between each sort of CACPs and the nursing homes themselves I think is a really important thing. We've got stuff around who can use community transport services and who pays what and all of that stuff, you know, when you've just got people that need basically the same service that everybody should be combining forces with - - -

MR WOODS: It was one of your points precisely that removed some of the silos and guidelines. Hopefully, although some of our recommendations appear generic, they will indeed focus and give considerable benefit specifically to rural as well as metropolitan; I would have thought that one is one that you highlight and hopefully our reforms will meet that need because having the conflicting guidelines in smaller centres makes it even harder. You're there and you deliver the care but it just means that you've got to work around the guidelines more often because there aren't the number of providers to deliver these services. So hopefully you'll have to bend the rules less under the new arrangement which I'm sure would be a relief to you.

MS PUGH (NEHD): Absolutely. I was talking to someone earlier on today about some work I did several years ago out in Lightning Ridge with the Orana Far West people and we were talking guidelines and stuff out there because we were talking compliance, and one of my favourite quotes that came back from there was, "In the city, they have red tape. Out here we've got pink elastic." I thought that sort of summed it up pretty well.

MR FITZGERALD: I'd have to say in Lightning Ridge, about two-thirds of the

population doesn't actually exist.

MS PUGH (NEHD): Don't exist.

MR FITZGERALD: It's one town in which the census is of absolutely no relevance at all.

MS PUGH (NEHD): Yes. Okay, thank you.

MR WOODS: Thank you very much.

MR WOODS: We now have a joint presentation from Dr Peter Foltyn and Mr Clive Wright. We've joined two sessions but if each of you could give your name, the organisation you represent and position you hold.

DR FOLTYN: Dr Peter Foltyn, I'm a consultant dentist at St Vincent's Hospital. I'm not presenting on behalf of the hospital, it's my position. I'm also a consultant to a Sydney nursing home which is probably the only one in Australia that has a fully functional modern dental clinic with an employed dental hygienist, so I'm presenting more as a clinician. I thought it would be appropriate to combine the presentations because Prof Wright is the chief dental officer for New South Wales and may able to provide you with some of the background information and administrative side of the problem for oral health care.

PROF WRIGHT (NSWH): My name is Clive Wright and I'm the chief dental officer for New South Wales. My previous employees have been the University of Melbourne where I held the distinguished position of professor of preventive and community dentistry. I've also been chief adviser in oral health to the Ministry of Health in New Zealand and had positions as director of oral health promotion and research with Dental Health Services Victoria.

MR WOODS: Thank you. Who wants to go first?

DR FOLTYN: I might just present on some clinical issues. I did make a submission.

MS MACRI: Yes.

MR WOODS: Thank you.

DR FOLTYN: That covers a lot of information in there that I won't go through today. The two-page article that I gave you just earlier was quite opportune because there was an editorial in the Australian Dental Journal March edition and the header was Nursing Home Care, We Only Have Ourselves to Blame. It spoke about an Australian dentist who was extremely concerned about the lack of support he received in a nursing home where he sought to remedy the poor oral health of an individual, it goes through that, and I took advantage of that editor's comments to respond, but I won't read the response, I'll leave that to you.

My concern as a clinician, and I've been involved in looking after medically compromised patients now for over 35 years being attached to St Vincent's Hospital. But in more recent times, going back to the mid-90s I was involved in a senate submission to the Commonwealth government on medical-compromised patients and a big part of that was on aged care.

Nothing really has happened since then. One of the big problems we have with the elderly in Australia is that 40 to 50 years ago most nursing home residents just had false teeth. The role of a dentist was negligible. All we had to do was adjust a denture, replace a denture, so there really wasn't a lot to be done. Now, the average age of entry to an Australian nursing home is in the 80s. 40 to 50 years ago it was 10 years less. The difficulty we have now is a lot of residents are entering the nursing homes with many natural teeth present. In addition to that they've got complex dentistry provided, crown and bridge implants, and sadly within 12 to 18 months of entering a nursing home with the type - and again I'm generalising - the soft, sweet, sticky comfort food that a lot provide, the ready access to cordial, you get a degradation of teeth and oral health very rapidly.

At this point I would like to just relay an example which brings home the problem and this was a colleague of mine whose father was a former president of the New South Wales branch of the Australian Dental Association, he was a specialist in a prosthodontics which looks after crown and bridge and his own mouth was full of excellent crowns and gold crowns and fillings and whatever. But his father needed to go to a nursing home. Within 12 months of entering that nursing home he needed all his teeth out. This was through a combination of decline in cognition, decline in fine motor skills to be able to look after his mouth. But the problem, as he said to me, his father regularly drank a cup of tea a day but it didn't take too long in that nursing home for his father to have six or seven cups of tea day but with 10 sugars.

So there is a failure to recognise some of the dental problems that do occur. The nursing staff have other priorities. They are not trained to understand the implications of poor oral and dental health is a serious health issue. It is associated with higher levels of morbidity and mortality. I just will leave these with the commission and these are just some photos of what can happen to the mouth. This is just complete breakdown of the mouth after a very short period of time in a nursing home. This is from a colleague. This is another mouth where the false teeth just haven't been taken out and complete neglect of the mouth. This leads to major systemic consequences.

As I said, one of the problems is that our residents can't look after their mouths and for obvious reasons. I mean, there is dementia and fine motor skills that are setting in. We also have situation where they are just not looked after. This is one that I actually found on the Internet but is very relevant to this discussion and this happens to be somebody who has some lower teeth present but with maggots just surrounding the teeth because this person had, in the Australian vernacular, blowfly strike and nothing was done to look after them.

So I thought that you may have more questions for me. I think one of the areas

of great concern is that there is a lack of understanding of the oral health needs of our elderly and one of the major deficiencies, if there is one thing that I would like to see changed and that is there needs to be an oral health assessment as part of ACAT and that is a principle that I'm sure Clive will support and it is absolutely essential today. There is no doubt that the problems that our elderly are developing are as a result of that period between the time that they were healthy and their admission. People don't go into nursing homes by choice. As has been said here today, the reason they go in is because there is a crisis, poor health, systemic health, deterioration of health and/or inability just to look after themselves, the partner has passed away and the nursing home environment for some provides comfort, caring and community. So people go in for various reasons.

But generally in that year or two prior to admission is when a lot of the poor oral health sets in. I think it's terribly important that through the Commonwealth that we do provide information to doctors, nurses, the community at large on the interrelationship between oral health and the aged. I make that point in the original submission. Thank you.

MR WOODS: Prof Wright.

PROF WRIGHT (NSWH): I don't want to be too emotive about the issue of oral health and the ageing process but I do believe looking at the evidence internationally and locally that we are heading for the crisis in the same sorts of proportions that when we look back into the 1920s when we look at the schoolchildren and the rates of dental decay we saw that as being a crisis where we intervened by establishing school dental services and a very high focus on children and we introduced water fluoridation and a variety of things.

I think that we have to look at the same sorts of level of intervention, especially for the frail aged in terms of providing supportive care throughout the residential care population. That is going to be difficult because as you alluded to before, we've got small residential accommodation areas in rural areas and we've got large accommodation. So when we look at the infrastructure support, I think we've got to consider that. Equally importantly, and you talked about marketplaces, how well does dentistry work within the private marketplace, especially for those whose opportunities and incomes are fixed after retirement. What I tried to illustrate there was in fact there's a drop off in private health insurance and there is a far decreased capacity to purchase dental services for older people. The average cost per year was something like $562 in 2005 per older person.

There are a lot of people who just can't afford dental care, let alone the access and let alone the support to be able to maintain their oral health, even in their own homes. So I think we've got a real issue. When you talked about insurance

eligibility, we don't have dental health insurance as part of our Medicare process. When we introduced Medicare in relationship to chronic program, as I've illustrated, 42 per cent of the expenditure from that program was on people over 65. But remember that also the system for the gateway there, the gatekeeper was in fact the general medical practitioner, not a dental practitioner or not a residential ACAT needs based gateway person and I think it also left a lot of people on public waiting lists with severe chronic diseases that could not be managed, especially those that required a general anaesthetic or multidisciplinary activities. So we've got some real system and across all sectors problems there.

I have tried also to look at where interventional points within your recommendations could be for oral health and I think they can be embedded in a number of your recommendations of where you could bring or consider oral health entry points. Also a very important point is the structural aspects of the dental workforce. Although we believe that a dentist sits at the top of the pyramid when it comes to providing oral health services, a lot of care that is needed, especially in residential care, is maintenance care which can be easily provided by dental hygienists and dental auxiliaries. We have a regulatory framework which actually acts as barriers rather than centres to those forms of dental professionals working in those institutions. So I think there are ways and means that we should be encouraging the use of dental auxiliaries in those places too. I think I will leave it there.

MS MACRI: I just wonder - and this is a little bit like the GP problem in actual fact and a lot of facilities over many years that I've been involved with and also coming through to the Productivity Commission is around not enough dentists being prepared to visit residential aged care facilities and access. I mean, obviously again sometimes it's very difficult to access teeth and provide any of that sort of care (a) if somebody has dementia and depending on the environment, and then the other one on top of that quite often is the cost. A high proportion of pensioners and the gap and the cost between dental care and being able to afford it and getting even carers or relatives involved sometimes is incredibly difficult. I'd be interested in terms of how many dentists are out there that are really, at the end of the day, when a facility picks up a phone and says, "I need somebody to come and look after Robert's teeth - - -"

DR FOLTYN: It's a very good question, but we've got to go back a bit further. We shouldn't need to be providing extensive dental work for residents of aged care facilities because the mouth should be in a reasonable condition when they arrive and we should be able to maintain.

MS MACRI: But often it's not.

DR FOLTYN: Often it's not. So we go back to there being the need for the aged

care assessment and the responsibility has to be taken by family to ensure that, if they know that they're going to go into an aged care facility within the next few weeks, months, whatever, they do go to a dentist and this is where the benefit of a Commonwealth brochure pamphlet looking at the interrelationship between good oral health and aged care is absolutely essential.

MR FITZGERALD: Just for my ignorance, currently if an ACAT assessment is done, largely it will determine whether a person should enter residential care, whether it's low or high care. So at that point - - -

DR FOLTYN: That could be the ideal point for - - -

MR FITZGERALD: - - - there's no oral assessment at all.

DR FOLTYN: Correct. There's none. There's no obligatory one.

MS MACRI: No.

MR FITZGERALD: So when a person enters a residential aged care facility, high or low care, doesn't matter, and the staff identify that there is a problem, what then happens in the current system?

DR FOLTYN: In the current system, in some places nothing, because the majority don't have facilities on site to enable the dentist to come in and treat the individual. Some dentists - and I know of a couple - have got portable equipment that they can come in, but there's only very few of those. In some instances, the resident may be able to be taken by transport - - -

MR FITZGERALD: Just so that I can understand the current system, let's assume for a moment you were able to have the dentist or one of the dental health workers come in. How does that get funded? Who pays for that? Does the - - -

PROF WRIGHT: Currently it's paid by the individual or there is some public health services that do visit particular residential care facilities, but these are extremely thinly spread and it's essentially on emergency call. But there is a standard 3.1.2 or something which obliges residential care facilities to provide a basic oral healthcare plan. There is no policing of that and there is no systematic organisation behind that, and that is something that I believe that we should build into the structure. Part of that should be that the institution should have a dentist or a number of dentists that are available to that institution that they can call on for advice, whether they be public or private institutions. The way it's structured at the moment is extremely ad hoc. There's no referral pathways that have been built in to those processes. So there is a lot of infrastructure development that has to occur, as well as

the workforce development and the linkages across the other health and caring professions.

MS MACRI: Some of this is around the debate between state and Commonwealth too, isn't it?

DR FOLTYN: Agreed. There's a huge discrepancy between the amount of money spent by individual states for their - - -

MS MACRI: Yes. You look at access to the dental health clinic here in Sydney and the waiting list even for people out of the community - - -

DR FOLTYN: Years.

MS MACRI: Yes, absolute years. So it's a hugely complex issue, but a really important one.

DR FOLTYN: Extremely important, because poor oral health has been identified by so many sources as being directly related to the health of the individual.

MS MACRI: Absolutely.

DR FOLTYN: There's plenty out there to indicate that the leading cause of death of an elderly person/nursing home resident is pneumonia and aspirational pneumonia, that is inhalation, is right up there. The link there is the bugs and debris in the mouth being breathed into the lungs is responsible for aspirational pneumonia. The Japanese have addressed that and Clive might like to talk about his sabbatical from a couple of years ago in Japan where all dental schools, no matter what dental discipline you're involved in, dentist or dental hygenicist or dental therapist, you go to a nursing home and you provide education. They do everything possible to maintain oral health. We're not talking about fancy work in nursing homes. They're just basic preventative strategies to limit the debris in the mouth and maintain a clean healthy mouth. It lessens the incidence of pneumonia and therefore saves lives.

PROF WRIGHT: Also the evidence from those sorts of studies that were done in Japan shows that you can reduce a lot of febrile illnesses and reduce the rate of prescription as well, and that's actually a cost reduction overall. It's relatively simple, basic oral healthcare. It's preventing, as Peter said, just the extremes in gross sepsis or in the change in diet.

MS MACRI: The Commonwealth's program, they did have - - -

PROF WRIGHT: The Better Oral Health in Residential Care program, which was

a one-hit educational program. We know the turnaround of carers and nurses within nursing homes, so the one-hit program with something that goes on the CD-ROM is brought out so often. No, it has to be far more systematic.

MS MACRI: It's got to be ongoing.

DR FOLTYN: Back in 2008 when there was an expose on the ABC's 7.30 report about the quality of oral health in our nursing homes, the response to that was $3 million towards a dental plan for nursing homes, but that was divided amongst the 2830 nursing homes. That provided some educational support to create a dental advocate for each nursing home, but, as we've heard today and we're all aware, the wages are lower in nursing homes, there's a high turnover in staff and those few that did get the training, many of those are no longer at those nursing homes. Before I arrived today, there was a meeting outside. I don't know if you're aware of the rally. I took advantage of that and I accosted half a dozen of those people involved in the rally and I asked them a simple question, "Do you know what OHAT is?" "No. What is OHAT?" "Oral Health Assessment Tool." "Never heard of it." This is what Clive is referring to.

The OHAT, Oral Health Assessment Tool, was part of this Better Oral Health in Residential Care package. It's an excellent tool. It's a basic assessment of oral health. It can be applied by a person with limited training, a nurse or doctor. It doesn't have to be a dentist, a non-trained person can apply this, but most nursing homes are not even aware that it exists.

MR FITZGERALD: In your paper you have a number of recommendations in the last part, one of which is compulsory placement for at least 100 hours at aged care residential facilities as part of a student's undergraduate studies.

DR FOLTYN: Correct, yes.

MR FITZGERALD: How do you actually operationalise that?

DR FOLTYN: An ambit claim.

MR FITZGERALD: That's all right. A lot of them are. But even if it were a more modest number of hours - - -

DR FOLTYN: No. I think 100 hours is reasonable.

MR FITZGERALD: How do you operationalise that?

DR FOLTYN: Dental students, a dentist, for instance, a four-year course. I mean,

100 hours for a student, you're talking about a minimal number of hours over the life of that course, going out in groups of three or four to individual nursing homes, providing that level of either hands-on oral health care of individuals or showing other nurses how to do it. I don't think 100 hours is a lot spread over a university course.

MR WOODS: But why does that require regulation? Why can't the industry work with the - - -

DR FOLTYN: Well, it hasn't to date.

MR WOODS: I understand that, but I'm just trying to work out what the government needs to do, as distinct from - - -

DR FOLTYN: Support it.

MR WOODS: Well, yes, but what that in practical terms means. Why can't you, working through the education institutions, come up with the idea that this is very good and would have enormous public benefit and of its own merit be adopted.

PROF WRIGHT (NSWH): Yes, and I think we can, because what we are actually seeing is, especially in the bachelor of oral ageing programs there is growth within those programs of taking the students out to residential care and taking oral health promotion plans and experience with them. But I think what Peter is saying is that these are again on an ad hoc basis, there's no network, there's no linkages, there's no continuity guaranteed at all, and I think it's that sort of infrastructure, linkages and glue that we are looking for through the Productivity Commission report.

DR FOLTYN: The same applies in the second recommendation, which was to do with on graduation, a graduand of whatever dental discipline should spend some time in the public sector. A doctor once they graduate can't get a Medicare number, they have to do a residency. Not in dentistry; you can open up your own practice the very next day, and I think there needs to be an obligation to be involved in the public sector.

MR FITZGERALD: I should know this, Michael and I did the Health Workforce, I used to know, but what is the peak body for dentists in Australia?

DR FOLTYN: Australian Dental Association.

PROF WRIGHT (NSWH): Yes, that's for the peak body of dentists. There are other associations too: the Australian Dental Prosthetists Association, and dental prosthetists provide a lot of care to older people. The Australian Dental and Oral

Health Therapists Association is another group that brings together the hygienists and oral health therapists.

MR FITZGERALD: I'm not asking you specifically to commit, but do you think those associations would lend their weight to these sorts of recommendations, in relation to students and also to some modest of commitment by graduates.

DR FOLTYN: I don't think it's unreasonable what I've suggested.

MR WOODS: No, but your understanding of the organisations. What is your rate of - - -

PROF WRIGHT (NSWH): Yes, I think the only thing that the Australian Dental Association Inc wouldn't support is denticare and dentistry being part of Medicare, and that's where I think Peter would part company with our association on.

MR WOODS: We are well aware of this view.

PROF WRIGHT (NSWH): But on the other issues I think that we would be well aligned together and supportive.

MR FITZGERALD: Again this looks at bringing in those that have been appropriately trained in dental or oral health. One of the issues that arises endlessly is the actual training of mainstream nurses and enrolled nurses and AINs and so on and so forth. Does training in relation to oral health in those sorts of generic degrees actually help or is it really only when you encounter the circumstance if you become employed in the aged care facility.

DR FOLTYN: It certainly would help, and just exactly on that subject I have had occasion just in the last few weeks to write to a colleague who is involved in the program for medical students at the University of New South Wales. There is no oral health. There is no dental component to medical undergraduate training. I get to see the students when they're fourth year medical students at our hospital, and I do with about a group of eight just a bit of oral health care, and it's nothing.

Three weeks ago I presented on oral health at the Alzheimer's Master Class in Brisbane, this is a peak body giving you recommendations, giving us all recommendations on Alzheimer's. It's the first time in 11 years, since they started, that they have had anybody present on oral health. So there is this lack of either interest or recognition that the mouth is more than just the gateway to the stomach, and we need to address oral care as being extremely relevant to the systemic health of our elderly population.

MR FITZGERALD: Given that, I just want to go back then to this process. Let's assume that you get some sort of informal assessment, or formal assessment, being undertaken in the aged care facility. Correct me if I'm wrong, but there then seem to me to be barriers: one is a physical barrier, where often you actually have to take the person to the dental practice, and that is true of many of the special treatments that are required; the second is the payment for that, and so if you could actually get somebody into a dentist's room is the payment a significant barrier to this cohort, and, if so, what is the response to that.

DR FOLTYN: It generally will be. The EPC scheme, which was the recent scheme brought down through Medicare, that has had reasonable acceptance in the big cities. Not that many dentists like to bulkbill under that scheme. But I'm aware from rural colleagues that most are not prepared to get involved, because the fee is so heavily discounted that it actually is less than half of what they would charge their normal patients. So they're not interested at all in participating in this scheme, and certainly cost is a barrier, there's no question about it.

It's much more difficult to treat an older person, for a number of reasons. But I think we have got to start somewhere. I think we have got to go back prior to entry to the nursing home; we need to better educate family carers about the importance of oral health. The families have to take some responsibility. It may well be that there needs to be a better mechanism for those that are entitled to public health dentistry to access an appropriate level of service to enable maintenance to occur when they enter an aged care facility. At the moment that doesn't really exist in a formal manner. Maybe that's something we do need to look at.

From a payment perspective, there are some that still can afford to pay for their own treatment. At the nursing home that I go to regularly we are fortunate enough to have a dental clinic, but we have recently introduced an oral health levy of $1 a day per person. This is only for new residents. That is going to enable those residents to have three visits with our dental hygienist per year, a dentist to provide assessment, and that will cover the cost of the education. Having developed that levy of $1 a day, you could provide a levy at other nursing homes which don't have facilities. 30 cents a day per resident would buy you a level of assessment and oral health education that would be beneficial, but that is up to individual nursing homes to take on if they are serious about integrating oral health for the betterment of their residents.

MR WOODS: Do you find a number of dentists, understanding this growing number of elderly people, are starting to specialise in that area? I would have thought working with people living with dementia particularly and providing dental services would require particular skills and understandings.

PROF WRIGHT (NSWH): No, I think, regrettably, the answer is almost the

reverse. I think there are actually fewer of our graduates now that are showing an interest and moving into this area than before; largely because a lot of them have enormous debts when they graduate from the university. They will come back into a caring system once they have paid off a lot of their debts. I think what Peter was also saying is there are different models of care that can be provided through residential care.

There are a number of trials in South Australia. We have here opportunities of going into different levels of care and taking mobile facilities. They have for example in Victoria a domiciliary dental unit. The issues of taking a van and things is that its efficiency and cost efficiency is not as high as transporting an individual there; I think it's about three to four times as great a cost. But it is another model of care.

MS MACRI: Yes, it's one I'm a bit passionate about personally.

MR WOODS: Certainly with some of your proposals here we can see them readily fitting in; the oral health care assessment and dental care plans and the like, they can just slot very readily into the report. So we thank you both for (a) agreeing to put it together so that we could have a focused discussion, and (b) for the very practical suggestions you have got here, which we can absorb more readily.

MR FITZGERALD: Thanks.

MR WOODS: There is a request for a five-minute break. So we'll resume in five minutes.

MR WOODS: Ladies and gentlemen, we'll resume. If you could please for the record give your name and whether you are representing any organisation.

MS KEARNEY: Right. My name is Margaret Kearney. I'm here as an individual but I do work with or I'm involved with an organisation called Older Women's Network, but we decided not to put this in as a submission from the group because of logistics; it has to go up to the committee and everything else and it takes too long.

MR WOODS: Yes, up and down and around about; we understand the process.

MS KEARNEY: So that's the reason why I'm coming as an individual. Today what we wanted to highlight was about three or four key issues that we were a bit concerned about. One was the whole issue of accessing the aged person's home as a potential for funding the individual's aged care and some of us were concerned that this started looking a bit like asset stripping of home ownership and transferring it all to the aged care industry without any accountability. There was a major concern with that.

The other thing was I think everybody agrees that the whole issue is the lack of overall federal funding and state funding for aged care services over the last 30 or 40 years and the reason why they're looking at issues like this is because of that. So that was one thing: why is it that the federal government hasn't been funding it? We do come up with a recommendation for that but I'll go through a couple of other issues first of all.

The other issue that we had was that whilst they're talking about current needs of the current over-75 age group, looking at the future - time lines is what I called it in my submission - which is the issue of superannuation, I think there was a mention in the report that in the future, superannuation could also be used as a potential asset that could be used for helping with aged care. But in the future, we've got a situation where many people in the 40 to 50 to 60 age group now are finding that they're working part-time; a lot of the industries that they were working in, the manufacturing industry, has closed down and has gone overseas. The very group that's getting close to retirement is the group most likely to face discrimination about getting long-term permanent jobs, so that makes it more difficult for them to acquire assets or retain their existing assets which could include their own home, so that was another issue.

Another issue I did raise in this was this year, we've seen one disaster after another around the world and it's a bit like watching a horror story, but one of the issues that came up after the floods and cyclones in Queensland was that the insurance industry is not covering for flood insurance. Now, Queensland is an area

which has got a high aged retirement population. That group that has an asset that's been destroyed will find that they may not be able to get that replaced. It's a group that may find themselves going into aged care earlier than they really needed to because of that trauma but they don't have any asset to access to sort of go into that. So what we were suggesting is it should be mandatory for all home insurance policies over the age of 60 to be covered for all flood disasters, whatever, so that that group at least would be able to get some income asset if this was an issue.

Another issue was access to jobs for the over 40s; the other is of course the issue about aged care workers. The issue about affordability of housing, there was an article in today's Sydney Morning Herald talking about lack of access for schoolteachers and other professionals. Nurses or other aged care workers are finding themselves being priced out of the housing market. This is not just for home ownership, this is for rental. This is one issue that does need to be addressed in the long term, that there's no targeted housing program for, say, community workers or aged care workers. This could be part of the community housing sector. It could be rental accommodation or it could be home ownership accommodation. There's no sort of targeted program. It's one reason why I think aged care workers leave; they simply cannot afford to stay within the industry because they're being priced out of the housing market. There are a whole range of other issues but that is a big one.

MR WOODS: Are you thinking of that particularly in relation to rural areas?

MS KEARNEY: I think both. Each area is a tiny bit different. They have got their own different demands. You will find that there's significant retirement population groups, say, on the Central Coast and North Coast, but there's also the issue of course in Sydney. But across New South Wales or across Australia, every state has a housing affordability problem. If you're looking to the future in terms of how we deal with funding aged care, what sort of resources or assets people have that they can use as a backup.

The younger generation or the group getting closer to retirement is finding it more difficult to have those sorts of assets but for aged care workers, irrespective of whether they're in Sydney or out in the country, they find that they can't get access to affordable housing. An example would be Orange, which is in central New South Wales. That's a booming area. It's a mining town. I know from personal experience with friends and relatives who are up there that their housing prices, whether it be for home ownership or rental, particularly for rental, is targeted at the mining industry. So an aged care worker who wants to come in and help out, wherever in the sector, is being priced out and actually a lot of people have been terminated - you know, once they get to the end of their lease, they're told to leave "because we want to get somebody else in who can pay more money". So that's an example of a rural area or regional area where it would be difficult for aged care workers.

So what we were looking at was that there needs to be some form of future fund for aged care. We've had the future fund for investment and infrastructure and everything else. What we really need is a future fund for aged care services and we need to be looking at something where we can actually allocate funds on an annual basis which goes in, which can target its services, health care needs. Also I've suggested in our report targeting aged care workers and providing them with affordable housing, whether that be a rental program or some form of home ownership program, that could be done through the local community housing sector which has existed for the last 25 years. That could be one way of sort of managing that housing program.

So what we were looking at is that the report itself didn't support the idea of a national levy similar to Medicare, but we thought some form of levy like that is really going to be the only way to raise the funds across Australia on a guaranteed, secure standardised way which guarantees that you've got the funding there. So we were looking at something along the lines of the rate of the disaster levy for Queensland. That's expected to raise $1.8 billion in the first year and it's the equivalent for everybody of about $5 a week which is nothing. Everybody can cost different parts of the system and everything, but if you're talking about targeting it, if you were to say $5 a week or even five to 10 dollars a week, within the space of a few years, you've got $10 billion that you can target solely to the aged care sector, going either into the intensive 75-year plus or it can go into other parts of it and start working with state governments on an affordable housing program for workers and also talk about all the services that people need.

We also felt like there was concern, going back to the idea of having to sell the house, that then the person could choose where they wanted to go; I think other people would have said that there's really not much choice. I think the difficulty everybody has is that there are limited services - depending on the need, like, for dementia or somebody who needs high intensive services - throughout Sydney and the competition across Sydney to get into that. That's generally the issues that we wanted to raise. But to set up - rather than concentrating on the idea of accessing the asset of the home is to actually be talking about what we would call a national future fund for the aged care sector and actually targeting it that way which gives it a positive ring; it also highlights the need that we need to focus on it properly. You set it aside and you actually then can access different parts of the rest of the system, sort of getting extra funding.

MR FITZGERALD: Thanks very much for that. Just one thing, I noticed in your submission, I think it's on page 1, you raised a concern about the stoploss. We've talked about $60,000 being the total that you pay for care. That's not accommodation, that's care. That's a total figure, a lifetime figure.

MS KEARNEY: Right. Because there was an issue - this is the whole thing about access to the home. If it was a fixed capped cost over the life of the time of the care - because for some people, they can be 10 or 15 years with intensive care.

MR FITZGERALD: And the point that we've made with the 60,000 is that you have to be receiving the highest level of care, you have to be on the highest co-contribution, you have to be the wealthiest and it's only for five years, so it's an absolute maximum and most of us won't get there.

MS KEARNEY: Right.

MR FITZGERALD: We hope. But the second thing is we understand your concern, the Older Women's Networks' concern, about the use of the house. But if I could just contrast that with the disability inquiry, because we've got those two running at the same time. In the disability area, the vast majority of people with disabilities, unless they've got insurance, have very limited means.

MS KEARNEY: Yes.

MR FITZGERALD: And if they have means when they incur the disability, they're likely not to have any shortly thereafter.

MS KEARNEY: That's right.

MR FITZGERALD: So there, you might argue more strongly for a levy, and we have proposed, as you know, a national insurance scheme.

MS KEARNEY: Yes.

MR FITZGERALD: When you look at aged care, the profile of us ageing is that we actually do have wealth, not all of us but many of us. It just seems to us that in that case, the case for a levy or a special insurance scheme is much less than it is in the case of, say, disabilities. I suppose our point is that we have wealth that's available, to some degree, with a lot of safety measures in place, that's a reasonable thing to be used, in the case of the family home. So we understand where you're coming from but at the end of the day, it's hard not to say that Australians that have a degree of wealth in their family home and otherwise, that shouldn't be used to some limited degree in funding aged care, rather than either increasing taxes or having a special levy or a special insurance scheme, contrasting that to the disability area, where I think the case is much, much stronger.

MS KEARNEY: Yes. There has been a strong case for some form of insurance

scheme for people with disabilities, but I think what we were trying to raise in our submission was the fact that in the future - this is what I was talking about, time lines - that you've got a different demographic and income group coming up where manufacturing and a whole range of industries have gone overseas, the ability of that group to develop assets is more problematic. The fact of these environmental disasters in Queensland with the floods and everything else, that can cause a problem. That needs to be addressed. I suggested we talk about mandatory insurance for that age group, over 60 for floods and things like that. I think that would address that sort of issue, so that they've still got something that they can then use for their more long-term care.

MR WOODS: Also, for those that don't have assets though, we have a lot of safety nets in place.

MS KEARNEY: Yes.

MR WOODS: You don't need wealth or income to access care. The care will be provided and whether you can or are unable to make a modest contribution to the cost of that care will depend on your own situation. So if you are a pensioner with very limited housing assets such as in many rural areas, then your contribution would be 5 per cent or even, in cases of hardship, nil. It would all be fully publicly funded. So we are very conscious of that situation. You do talk about the desperate situation facing those who have lost assets and don't have sufficient insurance to recover them. When it comes to needing aged care, that situation will be taken into account and their co-contribution would be very modest or nil.

MS KEARNEY: Yes. I agree if people are on pensions or low incomes, that's a different situation, but I think also we were a bit concerned that there could be potential for a two-tier system, that if you've got certain assets, you'll get an X-plus sort of service and if you don't have certain assets, you could be means tested in or out. That's a concern. Also, that means testing these days has in some cases gone to an extreme - there was a report a few weeks ago of a single mother trying to get public housing. She's got a disabled son. They were rejected for public housing because her disabled son is working in a sheltered workshop. Now, this is what's been happening in the Department of Housing in New South Wales, it's actually become extreme. This is where when we mention means testing, I think our concern is not about getting rid of the Kerry Packers of the world - you know, being included, it's actually making sure the means testing doesn't become extreme.

MR WOODS: Sure, we agree.

MS KEARNEY: The Department of Housing unfortunately in New South Wales has had major problems with means testing and that's been one case in that area that's

been a bit of a concern.

MR WOODS: All right. We take that on board. Certainly in terms of care, there will be no two-tiered system, that everyone gets assessment for care and that gives them an entitlement and that would be provided to them, irrespective of their financial means. Care has no tiers to it.

MS KEARNEY: No, it shouldn't.

MR WOODS: Their accommodation, some people choose a higher-cost accommodation if they have got the wealth and desire to use it on that, but they do that in the community now anyway. People live in a whole variety of different levels of accommodation.

MS KEARNEY: Thank you.

MR WOODS: Thank you very much. That's been very helpful.

MR WOODS: Thank you very much. Welcome to this part of the inquiry and thank you for your contributions to date. If each of you could for the record please state your name, the organisation you represent and the position you hold.

MS TRIMMER (MTAA): Thank you. I'm Anne Trimmer. I'm the chief executive officer of the Medical Technology Association of Australia.

MS MAIDMENT (MTAA): I'm Kylie Maidment, and I'm the research manager at the Medical Technology Association of Australia.

MR WOODS: We have your early submission and we have your submission on our draft report and we have had discussions. My colleague, Commissioner Fitzgerald, was just reinforcing the quality of the submissions and how they focused very clearly on the relevant issues. But, please, make a presentation.

MS TRIMMER (MTAA): Thank you very much and thank you for providing us with the opportunity when you have such a full agenda. I guess what we are trying to frame is a circumstances where ageing Australians can remain in their own homes and be better supported to do so. We applaud the commission's draft report. We think there is some excellent material there. But if there is to be a criticism of it, this is an area that is very underdeveloped in the report and we think that more attention could be given to it, whether as a separate chapter or whether as extrapolation of the existing chapter that deals with supporting patients and the elderly in their homes.

We take very much an integrated care approach. We have an ageing demographic, we obviously have reducing carer availability and, as we already know, many older Australians are cared for by family, by friends, by their communities. What we have been very interested to see is the extent to which the growing use of technology can enable those older people to still remain in their communities. We believe that there is value in looking at a national agenda around technology and ageing. There have already been many pilots undertaken in Australia for different sorts of outcomes and we know you've heard from some of those who have conducted pilot studies already. The benefit of looking at that is that we will start to get a good evidence base to support the uptake and the investment in technology. Like so much technology in the health space, there is always a reticence to make the investment because of the apparent up-front cost. But the derived benefit from making the investment can also be measured and certainly we have done quite a lot of work and it has been enunciated in our submissions in trying to quantify that.

Our view, I guess, is that the home is an appropriate place for health care and if

we leave that out of the equation in trying to cost the provision of good quality health care for ageing in the future, then we are shifting the cost burden onto facilities that would be strained and, to be frank, are more expensive than caring for people in their homes. We think that there are probably multiple funding mechanisms that can be looked at and we have touched on these in our submissions. We have put, not just to the commission but also to the government in our pre-budget submission, that there should be an extension of MBS items numbers to cover areas such as telehealth and home-monitoring of vital signs. As you are no doubt aware, the government in the last budget extended MBS item coverage for diagnostic and consultation services but not for these sorts of patient-related, active monitoring which would, we believe, certainly enable more people to remain in their homes and without the perverse cost to the health care system of patients having to go to a doctor's surgery or go to a hospital in order to have equipment that they're already using checked and the vital signs that come from that already checked. So whether it's heart rate, whether it's blood pressure, whether glucose, blood sugar, et cetera, all of these can be managed remotely.

We believe that there could also be more work done in the community care packages looking at how the provision of carers packaged together with combinations of home visits and technology for ageing in place. There may be some circumstances where private health insurance can contribute to this as well and, of course, individual contributions through co-payments. At the moment this is nearly all individually funded. So parts of this are available to those Australians that have the pocket to enable it to happen but we believe that it could be more widely made available. I'll get Kylie just to touch on some of the specific examples.

MS MAIDMENT (MTAA): We've outlined in our submissions in a lot of detail some of the quite specific strategies that could be used to assist patients to remain in their own homes and the strategies all have slightly different approaches and they could be worked either into a different chapter or perhaps into chapter 10 which talks about modifying homes and keeping people in smart retirement-type homes. One of the first areas we have looked at is providing access to technology to support telehealth and we have divided this into three areas: so telecare, so the first generation type items like alarms, alerts and pendants. The next one is telehealth so remote monitoring of vital signs. Then getting a little bit more complex, remote monitoring of more complex devices like implantable cardiac devices which can be done from a distance without the person having to travel long distances to see specialists.

We have looked at the types of technology that can enable patients to stay in their home and some of these types of technology might be, and I'll just give a few examples: implantable cardiac devices, peripheral to vital signs monitoring, so heart rate, blood pressure, just a subjective questionnaire saying, "How are you today?

Are you having any symptoms," et cetera which can be monitored from a distance, videoconference consultations, that type of thing. We have done quite a lot of work developing an essential care list and this scheme would be designed to provide access to patients in their own home with consumable medical items and subacute items. So examples there might be continence products, modern wound care devices, CPAP devices for patients who have sleep apnoea, diabetes consumables, that type of thing. Some of what we're looking at there is bringing this all together under one umbrella and replacing some of the existing schemes.

We have had quite a focus too on looking at providing better access to healthcare to older Australians who might be in rural and remote communities. This again falls under the telehealth umbrella, so videoconferencing to assist with specialist care, medical care, vital signs monitoring and again, remote monitoring of high technology items. One of the other strategies that we have thought could be important is there is a lot of research that has been done that tells us exactly what the predictable factors are that lead older patients to being placed into residential care or leading to them having to be taken out of their homes. These include - dementia is high up there, incontinence is high up there and a really, really big one is falls. So once an elderly patient has had a fall, you know that they are at risk of having to move out of their own home and there are a number of technologies that can be used to assist these people. So if somebody has access to just a care alert that is going to alert emergency services if they fall. I might even be activated by a puffer switch, for example, so they just breath on it rather than even having to move their arms and touch it.

Under chapter 10 we've thought about a lot of technologies that can be used in what we're terming broadly "smart homes". So this is the design and development of homes that are set up for older people, depending on the type of illness or chronic disease or just frailty that they have. Some of these things might be assistive devices, support rails, mobility aids; automatic lighting, for example, from the bedroom to the bathroom to prevent falls in the night; motion detectors for monitoring and inactivity; environmental detectors, so smoke alarms; epilepsy detectors; communication devices; vital signs monitors and just other medical devices for disease prevention and alleviation.

A big area too is that caregivers are also ageing and with an ageing population you have an increased stress on caregivers so there is a large number of technologies that can assist caregivers. A big one is, for example, if you're caring for a patient who has dementia you might be too afraid to go to sleep at night because you think that that person is going to leave the house by the back door. So simple technology, such as an alarm that wakes you up if the back door is opened can really make a difference in you being able to take care of that person in their own home, rather than having to put them into institutional care. I won't go into a large amount of detail but we've

done quite a lot of work in terms of - - -

MR WOODS: No, it's all set out here though. It's excellent.

MS MAIDMENT (MTAA): We have also looked broadly at the cost savings that are associated with the use of these type of technologies.

MR WOODS: Some of the figures in terms of reduction in hospital admissions speak for themselves and they're all reputable studies so we read those with interest. I was also at the GPS. I can think of parents with some teenagers who might want to implant. Do you want to continue on or - - -

MS TRIMMER (MTAA): No, I guess the summation of that is that we really urge the commission to perhaps give a little more consideration to the use of assistive technologies. It's one thing to look at packages that support in terms of housing and feeding and clothing and so forth, but the technologies are the things that are really going to take the pressure off, enabling older people to remain in their homes, both for themselves, but also for their carers and others in their family who might be otherwise concerned for them.

MR WOODS: We have visited a number of residential aged care facilities which I've been very impressed with the technological support, so monitoring of door openings or movement or continence, et cetera, and also talking to some providers of community care who explain the increased use of these technologies. What puzzles me is why these enhancements to care don't spread more rapidly through the providers of care and so learning from each other. Where are the barriers to take-up? Obviously cost in part is one, but as your benefits show, there are benefits. Some of those of course are captured by the public system, ie because they're reductions to admissions, et cetera, and so the provider has no incentive to necessarily reduce somebody else's costs, so we understand - - -

MS TRIMMER (MTAA): The eternal healthcare problem in Australia.

MR WOODS: Yes, it is. So we understand that bit of it, but in terms of the providers themselves, if you take even community care, is part of the problem that they get paid for what they deliver and that deliverable is usually in terms of staff hours and the like and therefore they're not able to capture the cost savings themselves? Where are the barriers to the up-take of these technologies which make sense and are demonstrably proven?

MS TRIMMER (MTAA): It's a good question. I suspect a lot of it's just structural, that the system is not set up to enable those sorts of things to happen. The number of small pilots that have been undertaken in Australia prove the value, but

it's - - -

MR WOODS: Why don't we ever move from pilots?

MS TRIMMER (MTAA): That's a good question.

MS MAIDMENT (MTAA): That's where we're looking at this like a national agenda on this, because I think a lot of that information is there and it's about compiling that information and putting it together. I think a lot has been done in Australia. I started looking at telehealth pilots in Australia and I was overwhelmed with how much had been done and I think providers are taking up this. I know Feros Care, New South Wales, they were providing telehealth services for, for telecare, about $3 a day, telehealth about $7 a day. Silver Chain in Western Australia is a really good example of a provider who - they were offering it to tens of thousands of their clients, so it is happening.

MR WOODS: But even at the peak level, there are certain people who are very focused on this. Even Rod Young himself is very active in this area. Yet there seems to be some reluctance or under-investment. Sue?

MS MACRI: There's a couple of things. There are two things when we were doing the report as to whether we did an IT chapter, as you discussed, or whether we saw IT as being so important that we felt that it really needed to go across every part of the report. It seems to me again that this is fabulous stuff, but there's still some really basic stuff from an IT level that doesn't appear to be working, and that's that even the e-health record and the interrelationship between the healthcare facility, the pharmacist and the GP and I think there's a little bit of an attitude out there, we haven't even got that going, how do you then take the next step in terms of some of these other really fundamentally excellent ways of delivering care.

MS TRIMMER (MTAA): I think in some ways these are simpler than trying to build an e-health record.

MS MACRI: I agree, but I think people see it as more difficult and sort of seeing that as being fundamental before they move.

MS TRIMMER (MTAA): I think the problem is a lot of healthcare delivery, because it gets very fragmented through public/private, federal/state, no-one takes ownership of it and unless we have some ownership of it or leadership in it, it just won't happen. You can have these providers that Kylie is talking about who do a brilliant job to their own customers, but really unless you've got some leadership saying, "This is the solution that as a country we need to be investigating and we need to be investing in," you just won't get the deployment.

MR WOODS: It is a great opportunity to look at these issues. The inquiry into the National Disability Insurance Scheme obviously is also trying to comes to grips with the best system to provide aids for people with disabilities, whether it's sensory disabilities or any other form of disabilities, and equally what you've raised and others have raised with us is the same issues in relation to the general aged care population, so it is a good time to do that. In relation to your 6.3 where you talk about the development of potentially an essential care list, superficially that's very attractive, especially when you say we would replace a whole lot of these other schemes down the bottom, many of which I am quite familiar with. Many of these of course provide appliances and aids to people with disabilities.

MS TRIMMER (MTAA): They do, and we've made similar submission.

MR WOODS: In New South Wales they're nearly all that case. I'm struggling to get my head around - and it is quite complex - how do you operationalise this? I've used that term a couple of times during the day. There are elements here which are extremely important, but in a sense, they're pure health. There is stuff here that is absolutely related to people that are ageing and people with disabilities. Trying to work out the right operationalisation of this is quite tricky and I must say that is perplexing me just at the moment. Is it better to collapse these multiple schemes into a national scheme? Is it better to use the existing networks by which you supply these sorts of aids? But the more fundamental issue to that is what gets funded, to what extent, and what doesn't get funded? I just finish that off. The commission did a report into medical technologies.

MS TRIMMER (MTAA): Yes. We're very familiar with that.

MR WOODS: You probably remember the recommendations better than I do. But one of the issues there was - and it was a much more overarching issue - was that not all technology is in fact cost-effective, that everybody wants the newest and best, but often the newest and best isn't the most cost-effective, but there was no means by which we could actually assess that. We can assess drugs absolutely through the pharmaceutical schemes, but we can't assess medical technologies. The pressures are on everybody to have the latest. It's not a big issue with many of the items you've got here, but there's another issue to it. So it's how do you deliver the scheme, these aids and supports, how do you fund it, but then the third thing is how do you actually know that it's good value. I know you've given us a detailed list of possible savings in your first submission, but what is the structure for all of that?

MS TRIMMER (MTAA): I think that that has been one of the challenges. Going back, I understand, about 20 years, a lot of those things were federally funded and like all of these circles, it got pushed out to the states, so you've got state aids and

appliances schemes. Funding for it was transferred from the Commonwealth to the states. Over time what has happened is that all of the schemes have got out of sync with each other. So in some states you'll get access to certain products, in other states you won't, you'll get different levels of access. Some of these products which are pretty essential for particularly the ageing to stay in their homes like wound care are just not funded at all. The only way that you're going to have this work on an equitable basis is to have it federally funded.

We've proposed something like a very, very simplified PBS scheme. The person would have to get a script, for want of a better description, from a healthcare professional. It doesn't have to be a doctor. It could be a specialist nurse in the area. Wound care again is a good example. That would give them access to subsidised access to the product. The delivery mechanism, which is the other part of your question, doesn't have to be federally delivered. It could be delivered through a variety of different mechanisms. In fact the UK under an analogous scheme, they have distribution agents who, for a fee, provide the products to the patients: it could be through patient associations, as some of these are delivered now; it could be through chemists, as the default position, because there's obviously an add-on in doing it through chemists. I don't think that all of that has to be done through the one mechanism, you can fund and you can give the access through different mechanisms.

MS MACRI: I am passionate about this and I'd just love to see a lot of this really move forward.

MR FITZGERALD: Just going to smart homes, again same issue, but a slightly different set of issues here. Here you would essentially start from the proposition, wouldn't you, that improvements to the home is largely the responsibility of the homeowner or the renter, that proposition. But moving from that basic proposition there's a whole lot of stuff where you might be able to say the public benefit is such that it warrants a subsidisation, or, in fact, a total.

So when you've got this list in 6.6 - and a lot of those are not home modifications but they're simply alarm systems and so on - how do you guide us in terms of public policy as to which the government itself should be particularly interested in, largely, funding? Because governments are fine, but the only thing they're really interested in are things that cost the money, to be honest, and getting of the way and letting other things happen. So in this list - and again I don't want to be prescriptive - are there areas where you think this is the stuff for government where you get your best bang for your buck, in terms of a public value proposition?

MS TRIMMER (MTAA): Again that's going to vary a little bit from user to user, and perhaps one of the mechanisms is using those deliverers of services as the vehicle to determine what each aged person's needs are. So that you might have a

small level of government contribution or government funding in the same sort of way that we have talked about with the essential care list. I agree there needs to be a finite list, otherwise you've got no way of quantifying what it is you're funding, and we have done that with the essential care list. But you could do something similar with this, where you have a group of useable technologies that can assist the ageing person to remain in their home but the actual provision of those is determined by the needs of that aged person. You might not need alarms in every case.

MS MAIDMENT (MTAA): No, you wouldn't. The way that some providers do it is they have case scenarios where they have 10 different types of patients that might have this type of issue - like, people who are prone to falls or patients who might have dementia - and they would be fitted with a home with three or four different types of technologies.

MS TRIMMER (MTAA): Tailormade.

MR WOODS: Just one standard roll-out.

MS MAIDMENT (MTAA): I think that one of the challenges is it's not really that the items themselves cost so much, the monitoring of the item might be the thing that costs. I mean, the falls detector itself is probably not an expensive piece of equipment, but it's having that system where somebody is actually going to come when there's an alert.

MS MACRI: Yes, so it's responding to it.

MS MAIDMENT (MTAA): Yes.

MR FITZGERALD: You mentioned the UK health system. Are there models around the world to which we should give consideration? I don't think that we'll ever do justice to it in the detail that you would want us to, but, to try to give us some sort of sense of how this might look, are there jurisdictions to which we should have regard?

MS TRIMMER (MTAA): Certainly on the essential care list, yes, there is an analogous system in the UK, it's not as comprehensive as what we have proposed but it operates in a similar sort of way on the delivery side. The funding is slightly different because their system is different. I don't know in terms of the telehealth.

MS MAIDMENT (MTAA): Yes, in terms of the telehealth, there is something that's analogous and at the moment in the UK they have this what they call the whole systems demonstrated where they are introducing telehealth. I think they have got 6000 older people all over the UK, and they're using that as sort of a way of

deploying the technologies also. They don't call it a pilot, it's a proper, real, clinical trial, and they're going to use that to establish some of what is going to work best for them, so the types of technologies that will work best. I think once that project is completed we'll be able to take a lot of that information, because it will be very similar to the types of challenges that we have here.

MS MACRI: So looking at providing access to medical consumables, DVA actually provide - - -

MS TRIMMER (MTAA): Yes, they have the gold standard scheme.

MS MACRI: Yes. You've got that scheme, where it's happening, and then you move out of DVA and it's not happening.

MS TRIMMER (MTAA): There's nothing, yes.

MS MACRI: So it's quite interesting.

MS TRIMMER (MTAA): It's perhaps incorrect for me to say it's not happening. It does happen, but it is so variable from state to state that for a person to try and navigate the system to work out what they might be able to access is very, very challenging. If we're talking about people without access to that type of information or someone to mediate for them, they will never know what it is that they could be having access to. There's just no visibility of it.

MS MACRI: Any final point you want to emphasise?

MS TRIMMER (MTAA): I think we have covered what we wanted to cover. Thank you.

MR FITZGERALD: Thank you very much.

MS MACRI: Thank you, and thank you for the well-researched submissions, as always.

MS MAIDMENT (MTAA): Thank you.

MS MACRI: If the Macular Degeneration Foundation could come forward, please. If for the record you could give your name, the organisation you are representing and the positon you hold, please.

MS HERAGHTY (MDF): Julie Heraghty, and I'm the chief executive officer of the Macular Degeneration Foundation.

MS MACRI: Thank you. Thank you for a very detailed submission to this inquiry. Please proceed.

MS HERAGHTY (MDF): Thank you. As you know, the foundation is the peak body, a charity, that aims to reduce the incidence and the impact of this disease in Australia. Very soon, in a few years, every one of the 50 in this room will know someone who knows someone who has age-related macular degeneration, which is the leading cause of blindness and severe vision loss in the country. Just to put this into perspective for everyone, before I go on to my major comments, the macula is responsible for your central vision, and right now you're looking at me using your macula and you're reading your documents using that macula. That central vision is critical for quality of life and independence.

You can read about it, you can see it on my submission, but just to get a better indication it's always a good idea to just take two fists, put them between your eyes, and you'll get a very good idea of the fact that the centre of your vision is blocked, and for many that's distorted with wavy lines and the peripheral remains. I think what is really important is to just very quickly describe to you the landscape of macular degeneration, because it has changed dramatically in the last couple of years, and in that change has come an enormous impact related to the area that we're dealing with today.

There are two types of macular degeneration, dry and wet. Dry is very, very slow and it will cause blindness and severe vision loss. There is no treatment. Wet is very severe and dramatic and can happen overnight, and in 15 per cent of cases dry turns to wet, and there is a treatment. That treatment has changed, has only come about in the last four years. Why? Because this particular disease is caused by a bleed at the back of they eye, in the form of the wet macular degeneration, sudden growth in blood vessels.

A couple of years ago a very smart little scientist said, "Hang on, that's exactly what happens in bowel cancer, and when I put a little anti-VEGF, anti-growth factor in the bowel, the tumour is reduced. What if I injected that into the back of the eye?" Lo and behold, for the first time in the history of opthamology we have a treatment that can not only stop this in its tracks but reduce the damage up to three lines on an

eye chart, the difference between you reading and not reading, or driving and not driving. All of a sudden, early detection can save sight, and that is a critical message. The primary risk factor for this disease is age, followed by family history and smoking. The primary group, over 97.6 per cent of the group in the late stage AMD, that's when you have severe vision loss and blindness, are over the age of 65 years, so we're talking about almost the perfect synergy between these two Productivity Commission hearings, aged and disabled, because when you have severe vision loss and you are blind, you are disabled. I won't go through the statistics, you have them there, but 143,000 Australians have that late-stage AMD and the 97.6 per cent are over the age of 65, so you're beginning to see that picture of the relevance here to this disease.

The other thing is that the impact of this disease is the same as coronary heart disease or cancer. You don't die from age-related macular degeneration but the impact is the same. So I'd like to set the scene there for what I want to talk about today and I guess it follows very much the continuum of care, this important aspect of early detection, where if we save sight, we can keep people in their home. We know that visual impairment increases risk of falls two times, depression three times, hip fractures four to eight times, admission to nursing homes three years earlier, social dependence increased two times, social independence decreased two times, and lower employment rates. So it's very important to have early detection to save us money and to save us pain.

The next part is treatment and I've just talked to you about the treatment for macular degeneration but there's one thing I haven't told you. There's a window of opportunity of about a week to get to that ophthalmologist and have that injection and most elderly people ignore the symptoms of a blotch in front or distortion. They put it down to just getting older. If you're in an aged care situation, most aged care workers do not know about macular degeneration. So if you miss that opportunity, you can go blind and then we have the follow-on effects. So it's a very important thing to understand that changed landscape in ophthalmology and the importance of early detection and treatment. Then we get to rehabilitation. So if you have gone blind, it's so important to have access to the areas that Anne just talked about in terms of low-vision aids and technologies and the proper care.

Now, in this country, if you have a hearing impairment, you're a concession card holder. You can get a hearing aid across this country, the same level; not so if you have a vision impairment. It is totally inequitable across this country. Where you live determines how well you will read. So I just put that in context for the moment and I go now to my major concerns about the inquiry in creating an effective aged care framework, because it was interesting listening to the smart house because my analogy today was about the framework of a house, timber or steel, relies upon strength and design and that the house doesn't sit alone in a street. It must integrate

into the character and the streetscape and ultimately accommodate the needs of the infrastructure of the entire community, so we're not sitting here in aged care - as I'm sure the commission is very aware of the integration between the other areas and this is my concern.

From our reading of the draft report of both inquiries, there's a clear gap emerging between the draft recommendations and this gap for those over 65-year-olds who are most at risk of going blind. It seems to me that there's a gap which exposes them for the care provisions of the two sectors, ageing and disability, to fall between that crack. That relates to the national disability insurance scheme.

It recommends that the scheme cover up to 65 years of age and then the pathway seems to be through this route, and I can't find that pathway in this report for the constituents that I'm representing here today. So if you're over 65 years of age and you have a disability at 70 years of age, you become legally blind and you need to be accommodated in the aged care framework, there's no clear pathway that makes me feel confident about that care at the moment. Remember, this is an eye disease where you're most likely to be severely disabled and aged.

So consequently, I really think unless we build a solid bridge between these two areas of disabilities and aged care, there will be a huge gap through which the vulnerable and elderly will be very much exposed. I'd like to give you an example of that. For three years now, the MD Foundation has been working to ensure accessibility and affordability of low-vision aids and technologies for the blind and vision impaired and I talked about the gaps in the states. It's all different, a $20 subsidy here in one state, nothing in another, and private health insurers all over the place. But I did get a win the other day, one was prepared to provide that, so that's good. Thousands of elderly and vision impaired have communicated this through two federal government campaigns to their local federal members.

It's clear when I read the Disability Care and Support draft report that there is a good section on aids and appliances, but then I go to aged care and I can't see where this group would be accommodated. I'd like just to quote to you a letter from parliamentary secretary Jan McLucas. It's in response to the Honourable Tony Windsor representing a constituent on 7 February 2011. For many years, I've talked to government about this and they have been taking me down a pathway which in this letter was really guiding me to this disabilities report, where the Honourable Jan McLucas says:

The Productivity Commission inquiry -

the disability one -

will be considering a wide range of service delivery issues, including the provision of aids and equipment for people with vision impairment.

It goes on about that. But quite honestly, I think the government has invested in that outcome, but I think we're now caught between two areas. I may be wrong and you may correct me later but that's my impression from this particular reading. So it appears now - and I'm not talking about a smart house, I'm just talking about a simple magnifier. You don't go to $2 shops and buy magnifiers, you have a proper low-vision assessment or should have and get the proper thing to help you, proper aid. In most cases it's very simple. But then we go up to electronic magnifiers, talking books, digital technology and computer software that will talk to you. But most elderly people who can still have some vision, all they need is good lighting in their home, low-vision aids that are simple and practical.

So this simple magnifier, for a 70-year-old Australian with severe vision loss, will now disappear possibly down the state based gaps and perhaps through the crevices of the Productivity Commission inquiries, and that's my concern.

MR FITZGERALD: Can I ask a question now? What's the current system for a 70-year-old who needs that magnifier? What happens now?

DR MAIDMENT (MTAA): What happens now: depending on the state in which you live - and I can send that to the commission, we did an audit across Australia - there are various subsidies. Some don't have any, some states; others might have $100, $200, but even finding out where to get that information, you have to go through this amazing pathway to maybe Vision Australia, who operates in one state but not another. So it's disparate, all over the place, and very poor return.

The private health insurers, I did an audit of them and I've written to everyone and lobbied them, et cetera, and I'm pleased to say several of them have come good, and it just dropped off their radar, they didn't understand it. So it's disparate, it's an uneven playing field. It's supposed to be state based. We have been to COAG and we do something about it, but never ever happened. So this group is greatly disadvantaged as compared to hearing-impaired in this country. Does that answer your question?

MR FITZGERALD: Yes, but let's just go back a bit. Why do you think that happened? Why do you think that Australia took one course in relation to hearing impairment and another in relation to vision impairment?

MS HERAGHTY (MDF): Probably because of the development of aids and technologies. I mean, these have come on from a simple magnifier to - I'm sure you'll remember the old cassettes that go in for talking books. We're past that. In the

last five or six years technology has blossomed. So we're into digital technology, with a very small hand-held navigator that elderly people can use so simply and access it through their local library. We're into computers, but for most people simple technology is the best. Technology has changed. The early days, I don't know, I'm not sure of that history - perhaps their lobby groups, perhaps it was not a national organisation, I can't answer that.

Certainly in my six years in the foundation - and I have to say - I worked as a senior policy adviser in government to Minister for Education and Training and my primary area was disabilities - I do remember in those days that the hearing-impaired had a very strong lobby, and I don't recall the vision-impaired being quite as strong in that lobby. They're the only guesstimates I can make on that.

MR FITZGERALD: If I can just conclude. You're the third participant we have had in the last week that has raised these issues around vision impairment. So we welcome that. Clearly we do want to make sure that the two reports, the aged care report and the disability report do cover it. It's not intentional, it's an oversight, but one of the things we raised in our report was this issue about what to do with people with disabilities who are ageing, and you have raised a number of issues. What do you think should happen? I notice the recommendations that you have. But how do we best deal with this issue of aids and supports for people with vision impairment both under 65 and over 65? What is your view of what it should look like?

MS HERAGHTY (MDF): It's a good question. I noticed Anne said before about, is there some sort of Medicare component in aids and technologies for elderly. I know Senator McLucas in the election before last was very keen on that approach and we had long discussions about it. I think that we could make it work. If that's the way it went, with the 65 cut-off, I think that we could look at a system that could cover it off through a Medicare component, with low vision aids and technologies, and the private health providers beginning to kick in, in a better way. We are just talking low vision aids and technologies at the moment.

I think that there are ways to educate the people who care for people in retirement villages or aged care where we'll be able to access it at an affordable rate. So they could have a CCTV machine, an electronic magnifier, that is used by everyone. Not everyone has to have one, but if there's one there in the centre, then if you've got an optometrist coming in - and I haven't read or heard of the OAA's submission, but optometrists are going to say a range of magnifiers in this aged care setting is going to suit the needs of most people, "This is what Mrs X needs," and I think we could do it well. I think if this is the way the inquiries went, I think there's a framework we could put in. But I do believe we need to go back to the education also of the aged care providers - so the ACAT teams, etcetera - for the early detection, so we stop people going blind, we save their sight beforehand.

You know what? I don't have the answers right here but I think I could work it through if I knew what the ultimate picture looked like. I think we could interweave it. We could interweave it and we could do it with affordability and we could do it with accessibility if we weaved it and provided it in the infrastructures. You don't have to have a blanket system, you can make it fit the house. So I think we could do it, yes. So you have my recommendations to review it and I am very grateful for that.

MR WOODS: Thanks for those.

MS HERAGHTY (MDF): It was very, very nice of you to let me speak today and to put the representations of these people who are aged and disabled and who ask very, very little of the system.

MS MACRI: Can I just ask you how - I mean, I look on page 9 and you talk about the role of aged care service providers and workers and I suppose understanding that around 60, 65, 70 per cent of people have dementia or some for of dementia, in terms of these sorts of checks, how responsive are they to people with dementia? I guess for early it's okay but as it becomes more advanced - - -

MS HERAGHTY (MDF): Very difficult. You're relying on the person giving the ophthalmologist feedback that you've had vision loss. There is a little grid we use called the Amsler grid which is a self-testing tool for those who don't have dementia and are able to look at because they can do one eye and the other eye. So there are tools that we can give the aged care providers to give people who don't have those problems. But you're absolutely right, that is a very difficult thing and I suspect that the early indicators are tripping and falling and somehow observation of not getting - food dropping et cetera.

MS MACRI: Yes. Then following on from that the other assessment is through an ophthalmologist or - - -

MS HERAGHTY (MDF): If there are symptoms of what I have described of wet macular degeneration an ophthalmologist is required urgently. For the normal looking at the back of the eye and having a looking at the macula and the retina and seeing if there are any signs of early macular degeneration right up to mid or late, an optometrist can do that with a retinal camera. Don't forget also - and I haven't mentioned - that in education of aged care providers that nutrition and lifestyle are critical. It's fish and spinach, it's not carrots. We do do a lot of talks at the foundation to various groups to educate them about nutrition and lifestyle. That's all we've got for dry macular degeneration and the injection in the eye which is a monthly injection for ever.

MR WOODS: When you refer to education, of course, people tend to listen more closely if their GP is suggesting this as a way that they can take some corrective action themselves. But what's your sense of the level of (a) education and (b) active dissemination by GPs in this field?

MS HERAGHTY (MDF): I love that question because we did put in for a federal grant to do a pilot study with GPs in New South Wales and we did that a year ago and I have to say the level of knowledge was appalling. It was appalling. Not through any fault of their own, they get three hours' education in their degree on eye health, and they're tired and they're going to every possible CPD program and to keep up with many, many things. But the Division of General Practice said to us, "You will not get many people to come." It was packed. We could not accommodate it. We had two strands, one was about the eye and the other I presented as the emotional impact and looking after the patient. We did a pre and post-evaluation and in that we asked very simple things, just even about dry and wet if they knew that; about the new treatment; about what is the best food; what is the chance of macular degeneration if someone in your family has got it. It is 50 per cent and very few knew.

The qualitative results of that was unbelievable. Fantastic. The answer to your question is the level of knowledge is very small but we have done massive work there and we're hoping it's going up but more needs to be done. So if they go to the GP and they say, "There is something wrong with my eyes," they're most likely to automatically refer to the ophthalmologist but elderly people, as you know, don't say, "There's a blotch there. I got up this morning, there's a problem." They'll say, "Something wrong with the eyes a bit, doc. I guess I'd better have a" - and that's where we need the doctor to go, "Hang on, what is it that's wrong with your eye."

MR WOODS: Excellent.

MR FITZGERALD: Thank you.

MR WOODS: Are there other matters that you want to raise?

MS HERAGHTY (MDF): I'm really challenged by your question, thank you, about what it is that we can do and I am very conscious of the fact of "not all care and no responsibility".

MR FITZGERALD: Just go away and think about it. That's all right.

MS HERAGHTY (MDF): I certainly will. But I do think there is a way through. There always is.

MR FITZGERALD: In several participants we have asked the same sort of thing and how do you operationalise this and what does it look like in practice because at the end of the day you can have great policy but you have actually got to deliver it. So if you have a think about that, that would be great.

MS HERAGHTY (MDF): Thank you.

MR FITZGERALD: Thank you.

MR WOODS: So that completes our scheduled set of participant hearings for today. Is there anyone present who wishes to make a brief, unscheduled presentation? That being the case, we will resume tomorrow at 8.40 am. Thank you very much.

MR FITZGERALD: Thanks everybody.

MS MACRI: Thank you.

AT 5.42 PM THE INQUIRY WAS ADJOURNED UNTIL
TUESDAY, 29 MARCH 2011