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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 TUESDAY, 29 MARCH 2011, AT 8.37 AM

Continued from 28/3/11

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MR WOODS: Could I please call forth the Younger Onset Dementia Association. Thank you for coming. Could each of you, for the record, please state your name, the organisation you represent and the position you hold.

MS EASTON (YODA): My name is Alison Easton. I'm the executive officer of the Ellis Centre and the chairperson of the Younger Onset Dementia Association.

MR RUSSELL (YODA): I'm Will Russell. I'm the operations manager at the Ellis Centre and a member of the Younger Onset Dementia Association.

MR WOODS: Thank you.

MS EASTON (YODA): As professionals working in the field of younger onset dementia we're very concerned that there is a belief that dementia is an ageing illness and that because of this community care services for younger people with dementia are best provided through the aged care system. With more 15,000 people across Australia living with younger onset dementia, I would suggest that it is not appropriate any longer to refer to dementia as an age-related illness. Neither the person with the diagnosis of younger onset dementia nor their carer identify as being aged or in need of aged services. This means their initial foray into the community care system - assuming that we have the gateways - will take them to the disability gateway first off rather than the aged care gateway. If dementia services are being placed within aged care, does this mean that they will be turned away at their first step?

We believe that at present the disability sector is best suited to meet the needs of people with younger onset dementia and to support the carers of these people. If a choice has to be made between the two sectors as to where younger onset dementia services sit, then we believe it should be with the disability sector. Community aged care services tend to be based on a sedentary model of care for aged day centre, respite care, dementia support services et cetera. The target age group is 75 plus years. This means community aged care services in their current format are not able to provide to the two main things that clients and carers are looking for which is community based physical activity and social engagement with their peers. Disability services in their current format have the flexibility to provide a more responsible service based on a community participation model. This can provide for a much greater level of physical activity and social engagement with the client's peer group.

One of the reasons put forward as to why dementia services should sit with aged care is that community aged care services have staff trained in working with people with dementia. Surely imparting skills in working with people with dementia is a matter of training people, not a question of an inherited skill. Training in dementia skills should be made available to all community care staff as the issue of

dementia will be cross all boundaries age wise as the years progress. Another reason put forward is the suggestion that people would have to transition to residential aged care as they progress in their disease. This would not be necessary if appropriate residential facilities were made available in the community for people with younger onset dementia.

Additionally, many people won't actually live to be 65 with younger onset dementia and those that are passing away are increasingly being cared for in the home until the time of death. This means that palliative care services are going to need to become involved in supporting the carers of people with younger onset dementia to allow them to care for the person at home until they die.

Another concern that we have is the proposed method of funding aged care services would have a very different impact on people with younger onset dementia as they may well be in a very different financial stage to retirees. They may still have a mortgage, dependent children et cetera. However, if the proposed changes in the report are about empowering people and providing them with more control over the care they receive, then it shouldn't actually be about whether you receive community aged care services or disability services, it should be about receiving appropriate community care services through the provider best able to meet your needs.

We have based our findings on the fact that the Ellis Centre, where we're both actually employed, for the past four years we have run a program for people with younger onset dementia and their carers. So we have been working directly with these people for a number of years now and listening to their concerns, listening to what it is that they want and our responses to your report are based on that feedback that we're actually getting from clients and carers. The people that we have been working with include a very articulate group of people both with younger onset dementia and their carers. For example, we have worked with a research scientist, a doctor, a lawyer, a teacher, a graphic designer, physiotherapist, builder, draftsman, real estate agent and a public relations consultant and they're the clients.

They're the people with younger onset dementia that we have worked with and many of them we have worked with from the very early stage of diagnosis, some of those actually through to their time of death in the last four years, they have passed away quite quickly. Their carers are also nearly all in the workforce at the time of diagnosis and have very strong views on the types of services that they want for their partner. It is not a very long presentation but we're more than open to questions.

MR WOODS: I think your concluding statements just prior to talking about your work at the Ellis Centre sort of encapsulated it completely, that what they need is services is appropriate to their situation.

MS EASTON (YODA): That is our greatest concern.

MR WOODS: We don't want to talk about whether it's aged care or disability services, we're talking about delivering services that this group of people need.

MS EASTON (YODA): Our feeling that we have been getting is that everybody keeps saying that dementia services should sit with aged care all the time. What we're saying is in some areas it may only be aged care services that are able to provide those services but in other areas the disability sector may be more suitable to do that. Our personal service that we run is funded as an aged care service but we run it on a disability model along with our other community participation programs, so we kind of twist it.

MR WOODS: When you go through your issues, community based, physical activities, social engagement, staff trained in dealing with dementia, palliative care services that is what should be delivered and available to people with younger onset dementia and a focus of our reforms, albeit for the aged care sector, is to deliver services that meet people's needs, not have people conform to the current packages of services that happen to be available. So to an extent there are two issues: (1) what are the services that need to be delivered and people who currently work in the aged care sector have a lot of these skills in terms of support for carers trained in dementia, palliative et cetera but, as you say, some of the day centre activity et cetera is not oriented to meeting the needs of this group. Then there is the separate question of funding and we would need to work through the different situations of this group compared to many others.

MS EASTON (YODA): Some of these programs I think are still going to need to receive some block funding, especially social support services, as in aged day centres or social support services for younger people. It would be very hard just on a user-pays type model because you've got those base costs, especially transport. I know transport was talked about yesterday and it's sort of beaten to death but if you're going to be providing a service that picks these guys up, you need to have that initial block funding to be able to have your vehicle and have your driver to do that, even if the actual people coming are more on a user-pays system; you've still got to have the initial funding to manage that.

MS MACRI: What about respite care? That obviously is another dilemma in terms of giving families that time out and access to respite. Where is the most appropriate place for respite? Obviously in the home to a degree but there may be time when the family want to go away or do something.

MR RUSSELL (YODA): We attempted a model of an overnight respite cottage which started from our younger onset dementia group for overnight respite over weekends. It was very well met by the carers and obviously respite is a very

important factor. The clients benefit from respite but really respite was developed for carers. I guess the concerns are there is never enough respite but what package of respite? Would you do the disability which has the flexible respite package which is like one-on-one services in the community or would you look at some kind of age-specific respite service not looking to social support, not in group in activities? So what I would see with younger onset dementia is that one-on-one engagement in the disability form of respite.

MS EASTON (YODA): Another problem that we have had is that some of our clients with younger onset dementia are almost to the point of being compulsive walkers and if they are having respite in a residential aged care facility it is a real issue because they will basically walk through anybody who is in their way. So if you have an elderly person on a frame et cetera, they will basically just be bowled because they really have this compulsion to walk.

MR RUSSELL (YODA): A lot of our carers have noticed when they were trying to initiate intervention care services when they first found out about younger onset dementia was the first question was, "Yes, we can provide some respite as long as it's in home." So when you've got a constant walker around the house respite is you want piece of mind for the carer. They want to know that the significant person they are caring for is still at home. Where we see if you're going to be walking all the time, then you want to be out in the community accessing age-appropriate services out in the community. So in-home respite is the current model which we don't see fits well with younger onset dementia.

MR FITZGERALD: It's a difficult choice because up until now very few people would ever have wanted to go into the disability system because it has provided anything but consistently good services, as you know. In fact it has been hard to get services at all. The aged care system in relative terms has seemed to be a much stronger system. Now, obviously the report that the commission has done in relation to the national disability insurance scheme hopefully changes that substantially. But at the end of the day you're actually creating a system, as distinct from the aged care system, which is reforming a system.

I am interested in your position that you believe the disability system may be more appropriate and I can understand the reasons for that. But at the end of the day we have been getting mixed messages, I think, from the dementia community. You're right, most have been indicating to us that this is an age-related condition and most have been saying the aged care system - not aged care residential but the aged care system is better able to deal with that. So your insights are very valuable but very different.

MS EASTON (YODA): I said to you at Alzheimer's New South Wales forum the other week that maybe that's because you're mainly talking to older people with

dementia - - -

MR FITZGERALD: Absolutely.

MS EASTON (YODA): - - - and people that worked in the aged care sector.

MR WOODS: Yes, we understand why - - -

MS EASTON (YODA): We come from a unique point of view because we have both aged and disability services where we work professionally and so we can see both sides of it and we just know the model that works best for our group of carers and our clients with younger onset. But also through the association I am touch with carers from other states of Australia who want to know how we do our model, you know, "How come you've got this really great model that works for your people? Why can't we have one of those. My mother is only 52, she doesn't want to go and sit in an aged day centre and play bingo with 85-year-olds."

MS MACRI: Again, it's a little bit like the dilemma that we have had about younger people with other disabilities, brain injuries, whatever it may well be, being in residential aged care facilities - which we all know is not appropriate - however, there is not a big enough mass of people, and especially when you get out to rural remote, and you want to keep people close to their families, the options become even less than in metropolitan regions.

MS EASTON (YODA): I don't know whether you're aware of the Hammond Care facility down at Horsley. They started off about this time 12 months ago and had one, two, three people, after six months were panicking that they weren't going to get anywhere near and now they're almost up to their 15. They have actually taken people from all over New South Wales because people are willing to - to have their person in appropriate they're willing to move them and travel the distance to visit them or even relocate. There is one family that has relocated so that they now live close by to the facility for their person.

MR FITZGERALD: Is that funded as a disability or an aged care service?

MS EASTON (YODA): It's funded as an aged care service. The bottom line is the funding, that's the problem.

MR FITZGERALD: We would say the bottom line is the services and we would see going forward the trend where aged and disability providers will merge whereas there has been a growing separation because both the disability system and the aged care system will be largely client directed entitlement based. We would see that service providers will probably have a very different mix of services, some of which care for older people, some of which cater for people with disabilities. So this

distinction in service delivery we would think will change but that is up to the market in a sense.

But you are right the funding and the assessment point is really a critical issue. The funding we have still to work through. The assessment one is you're really saying you would prefer to start the journey through the disability gateway, whatever they call that rather than the aged care gateway.

MS EASTON (YODA): We would be concerned that people would, "Okay, I'm only in my 50s, that makes me under 65, I go to the disability gateway." I'm concerned that if people went there they would be turned away and said, "Oh, no, that's the wrong one for you," which happens a lot at the moment and people then don't access services because they get turned away at the first step.

MR FITZGERALD: By the final report we will be saying to government collectively as a commission, "This is what we think should happen in relation to this group of people with disabilities and what should happen to this group of older Australians, including those that prematurely age," for example, indigenous men and women. So we want to be clear. It's up to the government to determine what they do. But by the end of June there should be a very clear understanding of what we are proposing.

MS EASTON (YODA): I just think the cohort of people now with younger onset is large enough that you can't just say it's an age-related illness. The latest figures were 15,000, at the moment Alzheimer's Australia are quoting 16,000 with younger onset dementia. I think it's a large enough group now that you can't just tack it on the end of an ageing-related illness.

MR FITZGERALD: We're going to run out of time but I just wanted to clarify. I don't want to get into prescription but when you talk about younger onset, is there a particular age group that you're most concerned with? One of the dangers in designing systems is you end up with rigidities - you know, you pick a date - but just avoiding that, is this really a concern for those that get younger onset below 55 or below 50?

MS EASTON (YODA): The people that we've been mainly working with are in their 40s and 50s and dementia is their primary diagnosis. We're not talking about people so much that have MS or Huntington's and get dementia, these are people whose primary diagnosis is dementia, predominantly in their early 50s.

MR FITZGERALD: If you had people that acquired dementia in their early 60s, would your view be the same that they would enter the disability system?

MS EASTON (YODA): If they're still physically fit and active, yes, because it's

that activity that they want. The man I assessed yesterday morning was 64 but still as fit as a fiddle and absolutely horrified at the thought of going to an aged day centre.

MR RUSSELL (YODA): Or being even classified as an aged person, and that's from the carers as well.

MS EASTON (YODA): Yes, and because most of them are still in the workforce at the time of diagnosis, so they have a sudden retirement forced on them and that's bad enough without suddenly being told, "Okay, now you're old as well," because depression is also a very big issue with people with younger onset, so let's not make it any worse.

MR WOODS: I think the focus still needs to be on delivering the right service support to them and then our challenge is to work out how that's best put through the systems. Thank you very much for your time.

MS EASTON (YODA): Thank you.

MR WOODS: Can we ask ACON to come forward, please. For the record, could each of you identify yourself, your name, the organisation you represent and any position you hold.

MR WALKER (ACON): Ian Walker from ACON, director of client services.

MR BROTHERTON (ACON): Alan Brotherton, the director of policy, strategy and research at ACON.

MR WOODS: Excellent. Thank you very much for coming. Do you have a presentation you wish to make?

MR BROTHERTON (ACON): Yes, we have a number of points, key recommendations, we'd like to make. Firstly we would like to acknowledge the recognition of GLBT, gay, lesbian, bisexual, transgender populations in the final report. That's a major step forward. We've put in a number of submissions to aged care review around issues around these populations to date and haven't received a lot of response to those recommendations to date.

We do have some concerns with where the population group is placed under culturally diverse populations, primarily because if we think there's an ethnic aged care strategy which arguably falls under meeting the needs of that special needs group, that would not be the appropriate strategy to meet the needs of GLBT people. The actual needs and issues are very, very different. The kinds of issues of discrimination and stigma that are experienced are very different. One of the issues about people's sexuality is it's understood or felt to be something that people could choose to withhold disclosure of, which our experience shows that many in fact older GLBT people do so, but of course over time, particularly in a residential aged care setting, the issues then become apparent and they need management I guess in a much more proactive forward-thinking way. So while we appreciate the recognition of the population, we would suggest that they deserve some special attention, particularly at this moment.

One of our key recommendations is the need for a time-limited strategy to try to address the ways in which we think probably minor adjustments to the whole range of policy documents and framework documents such as the accreditation standard as major care principles could be adapted to meet the needs of this population. Part of the reason we would make the case for the time-limited strategy is also that unlike many of the other special needs populations, there is to date very little knowledge or research around GLBT people in aged care settings and if you consider the generation of people that are presently going into aged care settings, they are people who through a large part of their adult life have understood their sexuality to be actually illegal, if not classified as a psychiatric illness and to have

been the subject of a great deal of stigma and discrimination from their peers with whom they now might be sharing a residential aged care setting. We do know, in terms of the distribution of discrimination, that it tends to be older males who are more likely to hold highly negative attitudes towards homosexuality.

So there are a raft of very specific issues that we don't quite have a handle on how they will play out in these settings. We feel that a strategy that looks at all the instruments and how the aged care system works together is one way to get a better picture on this.

The other points we have made are that there's no mention of the needs of older people living with HIV. At the moment, those numbers are small but those numbers will be growing, given that the age of diagnosis in Australia is increasing. Those people will live to retirement age. There still remain quite significant issues, fears and concerns. The way that a number of concerns that we think might play out in terms of the new system, one is the legitimate locational need to be near services which tend to be concentrated in very few areas in inner urban areas, and under the new proposed funding model and the costing model, obviously setting up services, particularly residential services in inner-city areas is necessarily going to be more expensive. This is likely to be a population with less assets. That's not entirely clear but probably so.

There's also the issue of coordination with people's primary health care providers. You already have a fairly complex set of health care needs and I'm sure this is the case for many other people with chronic illnesses. That's not such a special case but we make a recommendation that the proposed seniors' gateway should take on a role of coordinating primary health care with aged care planners.

The other issues around people with HIV are for those who are homosexual men which is the majority. There's a double issue of stigma there, but for those who aren't, one is the imputation that if they're men, they are necessarily homosexual, which they may not be, but also for people from specific ethnic and cultural backgrounds, there may be an assumption that the natural source of support for those people coming into aged care facilities or contact with aged care services is their community of origin and that's often not the case. There are a number of communities in Australia with a relatively high prevalence of HIV where there is still a massive stigma and a massive level of denial. Often members of those communities are arguably the last person people would feel safe in being referred to around their HIV status and it's just a question of finding a way to sensitise care providers around making a set of assumptions about where people might draw their natural source of support. I think that broadly covers our recommendations.

MS MACRI: There's been two debates around this. One is around specific services for people from that community and then there's other people that say, "No,

we don't want specific services. That's sort of like a ghetto for the gay and lesbian community and we'd rather be integrated into the local community or the general community." What are your thoughts around that and what are you actually seeking in terms of those sorts of services?

MR BROTHERTON (ACON): I think that's very true. Many gay men, lesbians, transgender people want to live in a relatively integrated way with their peers and I think certainly for people of my generation, that's more likely to be the case. I think for those currently entering aged care, I'm not sure that that is entirely as comfortable. But certainly there's a set of tensions - you know, there's some research with aged care providers in Western Australia where the providers say, quite appropriately, "Sexuality isn't any of our business," which indeed it isn't, but at the same time that they provide an environment that is supportive of people's social, spiritual or personal needs. The issue is that you may wish to be discreet around your sexuality and integrate but ultimately that's hard to sustain. Through people's life stories in close contact with each other, the fact of people's sexual history becomes apparent and then of course it ceases to be private and it becomes the subject of conversation among others.

So I guess what people want is a guarantee that some kinds of signals, depending on how the situation changes, that it will be dealt with sensitively and won't result in, for instance, being at the brunt of discriminatory attitudes and behaviour from other residents. That is quite a challenge. So it's about the value of the staff, it's about the values of the other residents, about the way in which it's managed and where are the legitimate boundaries to be drawn around what is an appropriate expression of someone's sexuality. What we're probably really talking about is just affection or demonstrated affection.

The difficult issue is that at the moment sexual orientation isn't covered under anti-discrimination provisions and, as you would know, a significant proportion of providers are affiliated to religious organisations. While the providers themselves would have their own policies, when people go into those settings, they're aware that the religious organisation to which the provider is affiliated may have made or may still be making quite strong statements against sexual diversity. That brings a level of fear. So the issue is what can providers do to indicate on entry that however people wish to manage the management of their life story, that that will be dealt with sensitively and they won't find themselves in a situation where they can't move and they're in an environment that is widely abusive.

MR FITZGERALD: That goes to the way in which the service providers operate and the culture that exists within the facilities. To some extent, the report tries to deal with that, but there is a limit, because in a sense you're trying to bring about cultural change. Governments are not able to really make a huge deal of difference to that, except through the formal instruments, the standards and the principles and so

on. You made comment of those and I'm just wondering whether or not you see that there are specific problems in the current standards that need to be amended.

The question is whether or not that is the right way to address the issue or not, because once you've put it in standards, you then go into the debate about the faith based organisations would say they don't want to be compelled into this and we'd get into that debate. So sometimes using formal instruments actually is not necessarily helpful. But in this case I was just wondering whether you have a view about whether or not we need to or should be making recommendations more specifically around the standards and the formal instruments that affect aged care.

MR BROTHERTON (ACON):   Yes, and we have made a submission to the accreditation standards, a submission or review which we should send in, but, yes, I agree, formal documents are not necessarily the way to achieve this and it's not the case, I suspect, that every provider will have to be able to provide a GLBT-sensitive environment in order to meet the needs, ideal as that might be from a purely ideological perspective or a non-discrimination. Nonetheless, if it is mentioned in the standards, one is we would like GLBT people to be included in whatever anti-discrimination laws are written into the standards or principles written into the standards, and I believe they're not covered at present.

The other is the issue of the role of the assessors. So where it's likely there is a high concentration of GLBT people in a population and it's likely that services should be expected to meet their aged care needs, the assessors should be skilled in working with those services to assess whether in fact they have the right systems in place and also have links to organisations that now build the capacity for those services to meet the needs. So I think there should be some mention in the standards, but making it prescriptive is probably not going to be a helpful way to go or is not necessary.

MR WOODS: Our proposal that in fact the empowerment goes to the person who requires assistance and therefore they can take that entitlement to a range of providers and discuss with them the facilities, the operation, the culture, will that to some extent allow those providers who are operating in areas where there is a concentration of people or even elsewhere to say, "Yes, I'm going to make this a particular focus and I'm going to ensure that my facility provides appropriate total care"? So a question of whether you see some opportunities through that for this community to be able to express its requirements and have them responded to, but also the move to have much more support delivered at the community level, rather than in facilities. So if you could comment on both of those and to what extent you see they provide opportunities to more completely provide care and support.

Yes, absolutely. If the consumer, the client, the customer or whatever the preferred term is, has some control over whether - or place funds for those services,

that that does actually offer quite a strong lever for the consumer. I guess the issue there is there have to be the services available and in some areas, depending on the distribution of services, that may not be the case. So there needs to be some kind of a process of monitoring the availability of appropriate services.

The other issue there is of course I think the stereotype is of our population that there is a high socioeconomic standard and high levels of education. That's a bit of a self-image that's been created for various purposes, but in fact it's a diverse population and you do have many people with low income, certainly a lack of confidence in asserting their needs and certainly among an older group of people who are GLBT, there would be a great deal of reluctance, I guess, to be able to use those tools in the way that they are intended. They assume a certain kind of empowered consumer that isn't always the case.

MR WOODS: But presumably there is also a support network that assists them, and progressively so.

MR BROTHERTON (ACON): Yes, and then the question is what sort of services can help to support and help people and certainly organisations like ours with connections with those communities can work with people and provide a sort of interlocutor role, I suppose, in those. But, yes, in terms of community care, we would expect that that is where the majority of people would want to see their care continue to be delivered, and again the issue of disclosure is almost unavoidable. If people are entering people's homes - - -

MR WOODS: Sure.

MR BROTHERTON (ACON): So it's then just a question of sensitivity training with those providers around how that is managed and understood.

MR WOODS: They should be living as they wish in their own home environment and that the formal care workforce provides the care that is necessary.

MR WALKER (ACON): Can I just talk to social networks and social supports in that quite often for GLBT people, that's different. It's not the biological family that's looking after older people. Family tends to be people of choice that people are surrounded by and quite often people are not in contact with their biological family and that isn't necessarily recognised in terms of services across the board in the community and also in aged care and quite often questions around family history is more related to biological family and can be difficult for people approaching a service to feel that their needs are going to be sensitively met. So it's about establishing a baseline, I think, of - - -

MS MACRI: My understanding is the commonwealth have just put some funding

out for some education for aged care around this whole issue. Are you - - -

MR WALKER (ACON): Yes, it's actually a project that we're working on. We're working in collaboration with Aged and Community Services in New South Wales and ACT. It's a 12-month pilot project looking at cultural sensitivity in aged care facilities in New South Wales and at the end of that, it's hoped that that would be rolled out nationally. So that is a fantastic step forward.

MR FITZGERALD: That probably answers the question because I was going to say, in relation to your time-limited strategy, how did you actually see that facilitated, with government or with the industry itself, but perhaps what we've seen there is a tripartite approach between an organisation such as yourself, the industry and government and maybe that's the best way to achieve that. I have to say that, notwithstanding that I work for the government, I'm always cautious of government and how much you actually want them involved in some of these issues if you can achieve the same ends through industry collaboration, but in this case that seems to be a positive move.

MR WALKER (ACON): We'd just like the money really.

MR FITZGERALD: Thank you. That's good.

MR WOODS: Sue?

MS MACRI: No, look, probably just to make the comment that in terms of where this issue is in the draft report, we've had a number of comments around even the title of that particular chapter, what it really means, and where the various special interest groups sit within. I guess there was a propensity in the first instance to pop it into special needs but there are a whole lot of other issues around cultural diversity, additional needs, so we are looking at that.

MR WOODS: We're conscious of we just don't also want 30 different chapters.

MS MACRI: No.

MR BROTHERTON (ACON): Sure, absolutely.

MR WOODS: It's a structural issue first, but yes, we are very conscious of that.

MR FITZGERALD: I must admit when you said you thought we'd put you in with the CALD community, the Culturally and Linguistic Diversity community, I can assure you we wouldn't see you as part of that strategy which is largely dominated by ethnic and language issues, but we will work on this and come up with something.

MR WOODS: Any guidance you can provide - - -

MR BROTHERTON (ACON): Absolutely.

MR FITZGERALD: Good. Thank you very much.

MR WOODS: Any final comment that you wish to make?

MR BROTHERTON (ACON): No, other than to say if we could consider the notion of a strategy over a few years that attempts to map our way through this largely unknown territory and what to me is a fairly confusing set of instruments that may or may not have a role to play that we see is the most useful way forward. We have to acknowledge that we can see what the cultural needs and issues are but it's not entirely clear how those map against the current range of service provisions, particularly one that is going through a state of change. So this is an ideal opportunity, and if we can assist in that in any way, we'd love to.

MS MACRI: Yes. We are aware of the Curtin research; Robert and I met with Curtin and some other representatives in WA, yes.

MR BROTHERTON (ACON): Good.

MR WOODS: Thank you very much for your time.

MR WOODS: I'd ask the College of Nursing to come forward, please. Welcome. Could you please for the record state your name, the organisation you are representing and the position you hold.

MS OSMOND (CON): Certainly. Tracey Osmond from the College of Nursing and I'm the CEO with that organisation.

MR WOODS: It's a pleasure to have you here.

MS OSMOND (CON): Thank you.

MR WOODS: Thank you for your early submission. You were one of the first through the door with your submission and then you've provided us with some notes on matters that you wished to raise with us, but please proceed.

MS OSMOND (CON): Certainly. In opening, the College of Nursing believes that the majority of the aged care sector provides quality care to their residents and clients. However, there are issues around the funding instruments and implementation, community mind-sets about aged care and affordable options in aged care across the board. In order to meet the future challenges, there needs to be recognition that acuity of care needs will have a significant impact on the expectation of the consumer and the skill mix of the aged care staff who will be delivering the care. Without significant change, the existing infrastructure and current nursing workforce will not be able to meet future demand.

The profile of residents will continue to change, particularly as the baby boomers age and enter the system. Their expectations for care and at the same time independence will impact on the nature of services to be provided. A one size fits all system will not be sustainable in the future. From a nursing point of view, residents with low care, frail low care, complex high care, dementia and palliative care all need very different models of care.

In relation to workforce issues and one that the college is particularly interested in, issues around models of care, skill mix, wage parity, education, multiculturalism of both staff and residents and licensing of the workforce will need to be resolved to take the aged care sector into the future. The role of the nurse practitioner in the aged care sector has a very exciting potential. Funding models that support the nurse practitioner role are needed, as is funding for nursing staff to deliver a range of acute nursing interventions that are often the cause of admissions to hospital that could be managed in our view in the aged care facility or as a hospital in the home service.

The current disparity of remuneration between the acute health sector and aged care nurses strongly supports the community and health professionals commonly

voiced belief that aged care nursing is inferior. This has created workforce issues around the recruitment and retention of nurses and severely impacts on aged care sector workforce planning and modelling, and it is critical that this issue is addressed. There are many professional nurses who would wish to take up positions in aged care nursing but are precluded from doing so because of the economic realities of the current pay rates.

While the college supports the principle of regulation of workers providing care, it also recognises the complexity of this issue. In the first instance therefore, we would like to see a recommendation about the need for nursing accreditation of educational programs that lead to a care qualification, to ensure national consistency of those programs and also an improved level of competency of the unregulated worker. The college also believes that an agreed staff to residents staffing level which incorporates an appropriate skill mix for the resident mix is an important tool in ensuring quality care and staff satisfaction. It also recognises that the issues around staffing mix and levels will not be entirely addressed with a simple mathematical ratio of staff to resident being put in place. Addressing this issue may require a comprehensive review of care requirements and associated models of care and staffing skill mix and the college would be happy to participate in such a review.

Issues in relation to care and support: the establishment of the Australian Seniors Gateway Agency we feel should resolve the many issues facing the aged and their carers as they negotiate their way into what is an extraordinarily complex system. However, the college wishes to emphasise the need to make certain that the gateway agency seeks to simplify and streamline communications and processes at all times to ensure maximal benefits to the aged and their carers. We understand that care coordination would be the responsibility of the gateway agency and that case management would be the responsibility of the organisation. We feel it would be helpful if this could be further expanded in the reports so that those roles are clearly delineated.

The College of Nursing supports the notion of in-reach services as outlined in draft recommendation 8.5 and the visiting health care teams, and would again highlight the potential for nurse practitioner services to participate in these roles. We note that there is some discussion in the report about linked electronic health records which would assist in the interface between health and aged care. However, there is no specific recommendation identified. Electronic health records are a crucial tool in providing continuity of care, particularly in the management of people with chronic and complex conditions, many of which of course are associated with ageing.

Access to and integration across the primary, tertiary and aged care sectors is crucial. Therefore, the aged care industry must be engaged in the development and uptake of these systems, and that's a crucial aspect. In our original submission, we highlighted the need for the recognition of the benefit that aged care directives would

have in the overall advanced care planning process. We are disappointed that there's no mention of the ACD in the draft report, while acknowledging that this element could be part of the care, coordination and case management roles.

Around compliance, accreditation and funding, regulation of the sector is a major issue. Currently there are a variety of accrediting processes for acute hospitals, aged care facilities, disability services, community based services and primary care services. The aged care sector is subject to a far greater level of scrutiny in comparison to acute hospital accreditation processes. This is putting an enormous burden on staff, particularly at the management level in aged care, including the financial implications of a negative outcome. We are concerned to hear reports from our members that suggests that the complaint system is very complicated with aggressive monitoring, presumption of guilt rather than innocence, lack of independence between specific compliance agencies, for example, the Aged Care Standards and Accreditation Agency, ACFI review officer and the Office of Aged Care, Quality and Compliance. The college is therefore pleased to support draft recommendation 12.1 as this would address some of the key concerns of these managers.

Some nurse managers are saying that it is impossible to survive the scrutiny within the system. Their professionalism is being challenged at times and this is leading to difficulties in recruitment and retention at the senior level. The funding issues include inadequate coverage of higher acuity nursing needs when transferring from hospital to the aged care residential setting, pressure on the directors of nursing to maximise funding through resident assessments because of unrealistic funding levels. Funding for care has not flowed to the ageing in place philosophy and under the current ACFI review funding needs to match acuity and care needs, care delivery and be realistically aligned to the broad scope of nursing practice.

The College of Nursing has focused its comments on those aspects of the review and draft report that have significant impacts on the delivery of nursing care which in turn has a direct impact on the quality of care delivered to our ageing citizens. The college recognises that the aged care sector requires a system that is flexible and adaptable and as a nurse we love our five rights and we feel that we need to ensure the five rights that the right care is delivered, at the right time, in the right place, by the right person and at the right price. Thank you for the opportunity to address the commission this morning.

MR WOODS: Thank you for coming. I was waiting to hear the words from your cover letter where you applaud the work of the commission in preparing such a comprehensive report. A couple of issues that you do raise, I think we can resolve fairly quickly. The care coordination function, we identified that as a default for the gateway where it wasn't being provided as part of the entitlement. For instances, if somebody chose to have a multitude of different providers for different parts of their

service requirements, somebody kneads it together and in the absence of any one agency that naturally comes to the fore in that, then the gateway would ensure that that function is undertaken and so has a default responsibility, whether it would deliver it itself or whether it uses someone else, as distinct from case management which is a sort of entitlement in its own right and it's to be intensively delivered.

Your point about the electronic health records, we do see those as absolutely central and I did just do a double-check back then, we have no problem about putting it into the recommendations because it is a fundamental part. In fact we have tried to limit the recommendations to a discrete number of the highest priority issues, rather than have a report with 300 recommendations that will get lost in the wash and of different magnitudes but certainly that one can be dealt with.

MS OSMOND (CON): I think particularly around that point is about looking for funding and encouraging the aged care sector to be involved and be at the forefront of development of these systems rather than being on the back foot. I know there is work undertaken at this point in time.

MR WOODS: Yes, it has to be with them rather than to them.

MS OSMOND (CON): Yes.

MR WOODS: Advanced care directives certainly are a very important feature of allowing somebody to express their views and have it heard not only by providers but by family and we have had a number of presentations on the benefit of those and we are certainly supportive of the role that they can play.

MR FITZGERALD: Can I just be clear about that. Whilst recognising the importance, as Mike has indicated, you think that as part of either the care coordination and/or the case management that is something that needs to be promoted and dealt with at that point?

MS OSMOND (CON): We do believe so, given that are crucial decisions made and one of the prime examples is the decision to transfer from the residential aged care facility to an acute care hospital. Now, those advanced care directives become very important where the family and the resident's wishes are particularly clear around what types of care they do and do not want to receive at particular points. Once you transfer to that aged care facility, that then sets off a trail of events that often is a runaway train and not having the opportunity for those advanced care directives to be understood clearly. In a residential aged care facility sometimes that's the easier aspect.

When care is being delivered in the resident's home, if they are not readily accessible and we feel that that electronic health record is a primary tool in terms of

being able to share those advanced care directives initially so that if there an admission to hospital that is clearly communicated at that point in time.

MR FITZGERALD: In relation to the transfer to residential aged care, it is your view that case management is actually an almost default function of aged residential care provision? In our setting we are trying to unpack that a little bit, certainly for those still living in the home. In a sense is advanced care directives and the planning that goes around all of that too late by the time you actually move into the residential aged care facility? In other words, once you're in that setting, it's almost - well, nothing is too late but I get a sense you think you've got to do it well before that.

MS OSMOND (CON): This is the complexity of being able to establish the parameters around these. Some people might think in fact that's a bit to early. So it's about what the needs of the individual is at any given time. Sometimes it is not even thought about until that person enters the aged care residential and the questions are asked, "So what do you want to do if." I don't think there is a line in the sand that you can draw around when is the most appropriate time.

MS MACRI: There are two issues, sometimes there is planned assessment and admission and it's through the gateway so it could be talked about at the gateway. But 60, 70 per cent of admissions to residential aged care are from acute care hospitals after an acute episode. So the issue is somebody may not have even thought about that until they had a fall at home, you have a fracture, gone to hospital and then to residential aged care.

MS OSMOND (CON): That is the most common. There are some acute care facilities that discuss those issues well with the family and the individual, there are some that ignore it. It is a conversation that we feel really needs to be had. In terms of seeing that the wishes of the individual are carried out and particularly from a nursing perspective having that clearly articulated with the individual and their family and carers becomes supremely important.

MR WOODS: Short of issuing and decreeing and watching it being ignored, what is the practical way through? If we talk about somebody who has moved into a residential aged care facility, then that is part of the conversation but I'd have to say they are very variable in quality and quantity, what the content is as well as how well it is done. So that is an issue first up. Then the second issue, if they are then subsequently being transferred to acute care (a) does the information go with them; (b) does the treating doctor give time to actually read it and (c) do they actually understand it and take any action that might be contained in it? At each of those points there is a lot of degradation of quality of information and observance of the wishes.

So in practical terms we can talk about capturing it at the facility end but as

increasingly people remain in their own homes and are supported there, how do we migrate that process out further? Does that then become not a responsibility of but part of what a provider of services for community care starts to delivery. At the moment it has been the RACF but perhaps providers of community care should pick that up more often.

MS OSMOND (CON): I don't think there is a single answer. I probably align it to the organ donor issue that we face. No-one thinks about it until a family - and I think that that public awareness campaign has gone a long way in encouraging those conversations to happen. I feel that the agency might be a point but a public awareness campaign about, "Have you thought about? What would you wish? Have you had these conversations with your family?" I think would be a really good start in terms of having those things thought about and making them overt is the most important.

MR WOODS: But if we did also migrate some emphasis to the providers of community care and not just rely on the resident care providers.

MS OSMOND (CON): Yes.

MR WOODS: We're supportive of the concept. We're just trying to look for more ways of meaningfully contributing to them being implemented. Workforce issues. You expressed views about improving the competency of the unregulated worker. Again, from your experience and those of your members who are constantly delegating functions to the third level in particular, what are your views on the quality of the cert III that most now seem to be at least achieving? Is that of such a uniform quality that that gives you greater confidence or - - -

MS OSMOND (CON): The short answer is no, in terms of a confidence that if I have someone with this qualification, I can be guaranteed I know that I can delegate this level of work to that individual and I will expect a quality of care at this level, and that truly is the issue. It is around that confidence in an even and understood level of education and care delivery and I talk to members who have nothing but glowing reports of that level of worker all the way through to, "It's just a minefield and I can't rely on those individuals."

MR WOODS: So when you're preparing your answer, is it the question of the quality of the content in the cert III or is it the delivery of the cert III or is it the standards that you have to achieve to pass the cert III? There are three different bits there.

MS OSMOND (CON): There are three different bits and it could be any of the above. From our college's perspective, it is who is delivering the course and any VET sector program in terms of the units of competence that must be achieved.

When you sit down and look at what is delivered under those units of competence from one educational facility to the next, there is a huge variance. Some can be done in a weekend, others take time, so there's no time frame.

A lot get RPL on the basis of the work that they're currently doing because they don't have that qualification and sometimes that's just a paper exercise of ticking boxes, so it's our college's view that - and we understand the very difficult position of trying to reign in something that's already in place - we would feel very strongly about those programs that are established by the VET sector and reviewed by the VET sector also undergo a nursing accreditation process to see that, given its care delivery, that those graduates will be delivering.

Nursing does see that care is very much the domain of the nursing profession and in the very least, it would provide our members with the satisfaction that they had an understanding that those programs had had that second eye of the experts in care delivery having reviewed those programs so that graduates of those programs would be felt to have a common base and an understanding them within the profession that they did have a level of guarantee in their qualification.

MR WOODS: Does that mean that the industry skills council isn't consulting with nurses in developing the content of the curriculum?

MS OSMOND (CON): It does not necessarily mean that, but when the industry is being consulted with, that isn't always a nursing professional from an educational perspective. It can be a nursing professional with a very industry-focused view, so what is considered as industry involvement in that is not what we would consider from a nursing profession and particularly an educational perspective on the quality of those programs.

MR FITZGERALD: Moving on, you have a more nuanced approach to the issue of staffing mix and levels and ratios. As you're well aware and undoubtedly right throughout these hearings we'll hear mixed views about this issue. I just really want to explore your views about this. You say in your letter and in your submission that it is really about trying to get the right staffing mix and levels rather than mathematical formula and yet obviously we're being encouraged by some parts of the workforce sector to introduce more strict ratios. We understand why that is the case. On the other hand some parts of the sector are saying, you know, this is a very poor instrument, not a good way to go. So can you just explore a little bit further how you think we should approach this issue.

MS OSMOND (CON): Yes. We're very aware of the varying views within the profession. It is our college's view, however, that it's very nice, simple and easy to say X number of staff to X number of residents. Everyone will remember it, everyone can count in. Anyone who works in nursing on a daily basis knows that

you can have four residents but the complexity of those four residents can vary significantly from low-care simple; self-caring, just a check-in on a five-minute basis on an eight-hour shift, all the way through to constant review supervision and the like. So it's a one size fits all that we caution heavily against, that there needs to be a model, and it's not easy and it takes time but the time is well spent then in ensuring, both for the residents and for the nursing staff that there is an adequately educated and qualified staff mix that meets that resident case mix care needs and what potentially could be about to transpire on any give day.

There are models and, as I say, they aren't simple but they do go a long way then to ensuring that you do get that adequate mix of staff to that particular case mix of residents that you would be caring for on a daily basis.

MS MACRI: I agree wholeheartedly. But one of the things around workforce that I am really interested in and we've done it to a degree, talked about the role of nurse practitioners which an exciting and a very good one but it's also a very difficult journey to get there.

MS OSMOND (CON): Certainly.

MS MACRI: And they're not out there in great numbers and certainly not in aged care. I'm just wondering with this emphasis on caring in the community, people staying in the community longer the potential to start looking at - whilst nurse practitioners are a vision and a very good one, I just wonder about your thoughts around clinical nurse consultants and clinical nurse specialists at varying levels which seems to not be coming through anywhere about the role. We've got the role of the workforce here and the nurse practitioner her and absolutely nothing in between. Your thoughts.

MS OSMOND (CON): Certainly and we are thinking of all of the above and in between and that is why we're particularly interested in the difference between care coordination and case management. We see that nursing can take a lead role in that case management perspective. We use the nurse practitioner because of their expanded role and capabilities, that that is in a very complex and chronic environment that they have obviously the skill sets to be able to manage those. Clinical nurse consultants, clinical nurse specialists - depending upon the organisation by which they are employed can also be provided with an expanded role to take on additional responsibilities. It's not an independent, separately accredited process that they go through.

But certainly clinical nurse consultants and clinical nurse specialists in taking on that case management and coordinating the care that that individual receives is about perhaps a weekly assessment to say that, "We need an enrolled nurse to be delivering this level of care. We need a registered nurse to be delivering this level of

care and we need these aged care workers to be providing this level of care for this particular individual." So it really is about a team approach, having the team leader as we see it as the case manager in this instance, and then that particular individual pulling together the team around them meets that particular individual's needs on any given period of time.

MR WOODS: A couple of other things: one is the degree to which residents are transferred to emergency departments particularly from residential premises but also from community care, in the sense of if the carer is uncertain and they sort of reach for the ambulance to help out. But in the case of the residential care facilities, we do get some reports from those who are either doing in-reach from hospitals or in EDs that up to 30 per cent of their workload is dealing with things that they felt a competent and confident RN in the facility should be able to do, and I stress both words importantly, that they may have had the skills at some stage but if they're not practising them sufficiently, then they lose confidence et cetera. What can be done about that, because that's quite a significant load, that if that could be retained in the facility, people aren't transferring, it's not only the resident but also the family and then suddenly your partner has been taken to X and you can't get there, all of that dislocation.

MS OSMOND (CON): Absolutely. From our members' perspective, one of the biggest barriers to that actually occurring is the funding and so facilities aren't funded adequately to provide that level or to be able to employ that level of nursing staff to deliver that care. Likewise then, dependent upon - and this can be managed - it would be through the organisation's policies and procedures, there's certainly scope within those policies and procedures to be able to allow certain practices to happen under established protocols, so there's certainly the ability for those things to happen. We constantly hear though that the funding isn't adequate or how it's structured presently to be able to establish those types of systems, and in the absence of those systems, largely the nursing staff are not empowered to make those decisions without a visit by the GP. Again, whether those people are residents in an aged care facility or whether they're in their own home, one of the significant contributing factors to them presenting in the emergency department is the inability for them to access primary care services in a timely manner and it does impact on those presentations to the acute care facility. So again, nursing certainly has the capacity and the ability to deliver those services from a professional perspective but often it's the other system that sits around those from policies and procedures, from having those things in place and having the adequate funding to support them in delivering that.

MR WOODS: That's no doubt a large part of the explanation, but some of the evidence being presented to us suggests also that there is a need to ensure that the RNs who are on duty at the time not only have the time to do it and the scopes of practice to do it but also the skills and the confidence to do it which goes directly to those individuals, not just the surrounding systems. Do you have any programs or

any thoughts in place that can ensure that if the staff are there and they do have the confidence, that they then do undertake those functions and that they get refreshed et cetera?

MS OSMOND (CON): We do, and not only do we, but we can also, from our organisation's perspective, tailor those programs to upskill. I suppose it's a little bit of chicken and egg at the moment, and we do provide these programs and there are some facilities obviously that take those up and upskill their staff. Some wait until there's a reason to do it and so there are other facilities where the other ducks aren't lined up, so to speak, in order to take that next step and provide those sort of services. So the college is ready, willing and able in terms of providing those upskill programs for registered nurses in those areas. Assessment of the older person, assessment skills absolutely come first and then the upskilling and training.

The other issue that we make about the lack of parity between acute care and aged care in terms of remuneration for the registered nurse is another big factor in terms of those nurses who have those skills and abilities and wish to deliver them in the aged care environment. There is a real barrier in terms of the remuneration because it is a decision between, "I've got that much money to pay off the mortgage as opposed to that much money."

MR WOODS: Very good. Thank you very much.

MS OSMOND (CON): Thank you.

MR WOODS: Can I call forward the Health Services Union East, please. Thank you for coming. Could you please each state your name, the organisation you represent and the position you hold.

MR BOLANO (HSUE): Thank you. I'm Marco Bolano, deputy general secretary of the Health Services Union East. I'd like to extend the apologies of the general secretary, Michael Williamson, who couldn't be here. Instead is Monique Irvine, our lead organiser for aged care.

MS IRVINE (HSUE): Monique Irvine, also from the HSU East branch. I'm the lead organiser, looking after aged care.

MR WOODS: Thank you for your detailed submission to us that no doubt you wish to take us through.

MR BOLANO (HSUE): Thanks to the commission for providing us the opportunity to speak today. The HSU East mission is to better the aged care industry to provide quality ethical care to our elders. This can be done by giving better recognition to the workers in the industry, to improve their wages, their opportunity for career paths and using these principles as a means of attracting more people to work in the industry, including the young and unemployed. We have already made a formal submission to the commission. The focus of the submission was on employment within the aged care sector. There are a number of recommendations in the submission but we would like to concentrate on only a few today.

As a fundamental principle, we believe that people who reside in an aged care facility in effect reside in their own home. They have a basic right to respect, privacy and so far as possible, the encouragement of independence. We would like to see models of aged care which support this principle. We believe it is essential that aged care facilities do not overmedicalise or overinstitutionalise residents. We strongly support the Productivity Commission's view that workforce shortages are exacerbated by uncompetitive wages and over-regulation. We would like to see the commission's final report place more emphasis on workload issues and provide stronger recommendations in this area.

We note there are currently only three specific recommendations on the workforce and these are narrow and directed primarily to nurses and tertiary matters. However, nurses constitute less than 30 per cent of the direct residential care workforce. Over 70 per cent of the direct care workforce consists of personal carers for the large majority, and allied health workers. In addition, non-direct care staff such as administrative staff, cooks, food services assistants, ground staff, cleaners, account for over 23 per cent of the total workforce and that's based on the Department of Health and Ageing data provided in its submission to this

commission.

We would like to see more emphasis and recommendations on staff in these categories who are the large majority of the workforce. In a sense, they are the backbone of the aged care workforce.

MS IRVINE (HSUE): With regards to wages in particular, it is urgent that the commission address the issue of wages for the lower-paid workers in the sector and we'll use the example today of the personal care workers. As has been indicated, these are a significant proportion of the aged care workforce. Personal care staff have complex jobs which require a great deal of skill and judgment. Attachment B to our submission actually reflects that. That was the example that has been taken from Victoria. It's not too different to the model in New South Wales but we use the Victorian example as the example to put in the submission.

Despite the importance of their role, their wages don't come close to reflecting their levels of responsibility. Members who are carers or personal carers have advised us that they receive very low wages, often only $15.95 an hour up to $17 an hour. They are the working poor. That is not much above the minimum wage of $15 per hour for an unskilled worker. Just to demonstrate this further, in New South Wales the example of a highest level cleaner, which is a hospital assistant grade 3, earns $20.48 per hour in New South Wales and in Victoria it is $18.54 an hour. These rates of pay are paid without there being the necessity to have qualifications, nor any responsibility for patient care. In addition, workers employed in the aged care sector are often employed as casuals which means, amongst other things, that they are not guaranteed any particular minimum hours of engagement, regular rosters or time of work, sick leave or annual leave.

The low wages and lack of career progression also results in a high turnover of staff, the lack of incentive to improve qualifications and often the loss of the most experienced and skilled staff in the industry. There is little attraction or incentive for younger people to work in the aged care sector because of these issues. If lower paid aged care workers see no way to progress and they are doing more difficult and more stressful work than people in other sectors, for example, retail, they will naturally tend to be attracted to more of those types of work in those industries. Those who stay in the industry, however, often do so as a sense of loyalty to the older people that they care for and their desire to care for those people and give back to them. This is an unsustainable basis on which to structure such an important, large and growing industry.

The ABS statistics data indicates that workers in mining, IT and utilities have won pay rises of up to 15 per cent since 2008. Workers employed in aged care on the award rate have seen average income rises by less than 5 per cent.

MR BOLANO (HSUE): We're concerned at the limited scope of the only draft recommendation on wages in the productivity report are 11.2. The recommendation assumes that if aged care providers receive additional funding through scheduled care prices, funding will flow through automatically to aged care staff to provide competitive wages. There are many excellent care providers who have struggled to continue to provide quality care for their clients and support for their staff in a largely underfunded system. However, not all aged care employers are good employers who value their staff, irrespective of the funding available. Delivering the largest profit possible can often be a much more powerful motivator.

There are also many other reasons why a provider may decide not to pass on money as a pay increase. Mission Australia admitted in a Fair Work Australia hearing recently that it did not use all the money it received for pay increases from the Queensland government for the handing down of the 2009 Queensland equal pay order for its Queensland workers' pay. Some of the money had instead been invested in Queensland services. The basis for their reasoning appeared to be that they did not want to pay Queensland workers more than they pay their workers in other states. We have outlined a list of recommendations in relation to wages in our written submission. If these were accepted, we believe there would be a much more direct link between increased funding and fair wages. In addition, draft recommendation 11.2, as it currently stands, emphasises nurses out of all careworkers who deserve wage increases.

We proudly include nurses amongst our members. We strongly support additional pay for nurses, let's make that clear, however, this should not be at the expense of the vast majority of workers in aged care, nor at the expense of developing a properly structured aged care workforce which incorporates a range of health workers who can deliver the best services to clients in the most efficient way possible.

MS IRVINE (HSUE): With respect to workforce structure, we would like to see a stronger focus in the commission's final report on workforce analysis and comment on the workforce structure and the development of the appropriate aged care structures and careers. Attention to this issue would be one of the most effective ways to increase the quality of aged care, as well as efficiency, effectiveness and productivity in the industry. It is important to outline the type of work performed by different workers in aged care. This provides a real picture of the diversity of the workforce and an understanding of the complex work undertaken and the heavy workloads of a number of aged care workers. It leads to a greater understanding of what work can be and is being performed at the lower paid levels. As I indicated, we have provided that in attachment B of our submission.

It would enable the skills and the capacity of lower paid workers to be recognised and encouraged. It also provides an opportunity to redesign jobs,

incorporate multiskilling and provide a career path to effectively use existing people/resources in an aged care setting. A more effective work structure would emphasise career progression for all workers in the industry and not only through the clinical path. As one example, immediate productivity gains could be made if aged care workers were able to provide prescribed medication, that is, oral medication in tablet form which is individually packaged and marked with a time and date of dispensing to residents. That would be without the supervision of a nurse. State legislation currently varies but most requires at least supervision by a nurse. In disability residences, which are not covered by the relevant Victorian legislation, disability workers dispense medication in this format to residents.

A possibility of progression for all workers through the levels of the aged care industry would encourage the development of ongoing skills development, including relational skills, a strong training and accreditation system, a sense of aged care as a specific profession and retention of skilled workers in the sector.

MR BOLANO (HSUE): We believe the commission's draft recommendation 11.3 on skills development should be considerably expanded. The draft recommendation highlights only a very narrow group of people, ie, nurse practitioners and potential managers and provides no rationale for why these groups are being singled out for special attention. It is particularly puzzling given that the nurse practitioner positions largely do not feature in aged care at the moment. As noted earlier, over 70 per cent of direct care staff are personal carers or community care workers, however, no formal qualifications are required to perform those roles.

However, in 2007 65 per cent of personal carers had certificate III in aged care. This is now generally viewed as the base qualification for personal carers. Only 13 per cent of the workforce has certificate IV. It is essentially that significantly more resources are devoted to skills development and training in the aged sector equitably applied across all segments of the workforce. Much greater emphasis should be given to the VET sector in meeting the needs of the industry in line with government policy on using VET to deal with projected skill shortages. The current rates of incentive provided for completion of certificate III and IV courses should be increased given the low rates of pay for the people who undertake these courses. We have made a number of recommendations on skill development which are also detailed in our written submission.

MR WOODS: Can I just draw your attention to the time because there are a few things that we would like to ask of you and we do have your full written submission. But if there are a couple of things that you do want to highlight just in bringing this bit to a close and then we can have a bit of discussion as well.

MS IRVINE (HSUE): I think we've just about finished.

MR BOLANO (HSUE): A few seconds, commissioner.

MR WOODS: It's just that I was conscious, looking through the submission, that there was still a fair way to go.

MR BOLANO (HSUE): Thank you. There are a number of matters in our submission including in relation to the VET system and tapping into the unemployed, a marketing campaign to encourage entry into the sector, aged CALD, migration and licensing of personal carers. We cannot cover these matters in detail but we would be happy to take questions or clarify any matters or respond to any queries about our submission. Thank you for the opportunity.

MR WOODS: My apologies. I should have tried to read to where you were at on your script.

MR BOLANO (HSUE): That's all right.

MR WOODS: Thank you, and it is a very detailed submission and you do cover a lot of additional material and we are grateful for that. In terms of wages rates - but I would like to get on to a number of things as well - you talk about the different rates, $15.95 through to $17 per hour. Presumably you also have some enterprise agreements with various facilities or providers with community based care.

MR BOLANO (HSUE): Yes.

MR WOODS: What is the top upper level in that category?

MS IRVINE (HSUE): From the New South Wales perspective with a number of the enterprise agreements that we have negotiated in the last 16 months, there has been wage increases of 3 to 3 and a half per cent on average per year, with a few being at 4 per cent for one of they years during the duration of the term of the agreement.

MR WOODS: Is that bringing you up to $19 or something an hour.

MS IRVINE (HSUE): It varies. I have done that many I have lost track as to what the final hourly rate is. It does in some situations, however, in order for there to be the compliance with the better off overall test there have been wage increases offered on one hand, however, the reverting back to the modern award clauses for shift penalties and the like and certain allowances, I should say. Whilst people are better off overall, it is not a significant - - -

MR WOODS: The headline rate doesn't show the - - -

MS IRVINE (HSUE): It doesn't demonstrate with - yes, in the contents of the agreement.

MR BOLANO (HSUE): In Victoria it ranges from low $17 per hour to low $18 per hour the majority and that's where we do have EBAs. There are some employers that are resistant to come to the table in regards to negotiating an EBA unfortunately.

MR WOODS: Okay.

MR FITZGERALD: Just following on from that, the mechanism by which you want this addressed is interesting and that is in your recommendation on page 9, that you see the regulation commission that we're proposing as being in a sense central to that (1) in terms of making sure that the financing of the sector is based on appropriate wages, but you also added an interesting component and that is that they should publish or establish general target or aspirational levels for wages. Is that correct?

MR BOLANO (HSUE): Yes.

MR FITZGERALD: So you see this commission as being, in a sense, whilst it can't dictate the rates because they will be done through enterprise bargaining agreements and what have you, as very much the scene setter for the appropriate wages, in particular, I suspect, for the personal care workers and community care worker. Is that correct?

MR BOLANO (HSUE): Yes. The funding model is changing in Victoria in regards to disability services. Under the current funding model, unfortunately, we're evolving away from it. The organisation and the service providers were funded per client per hour of service and there was a wages component in that funding block, it was, "This much you have to set aside for wages," and they factor in a wage increase. So that is where our suggestion is coming from.

MR FITZGERALD: Thank you.

MR WOODS: We do understand your argument on the wages. You talk about requirement for certification of aged care workers but then don't take that through to licensing. So you're saying that their training and skills should be at a minimum approved level but that licensing is not the next step you wish to take. In view of the importance of having a skilled and competent workforce and there is that third level that, as you say, are the majority of the workforce, what are your views then on both the content and quality of delivery of the cert III and given that there is an industry skills council? Where do you play a role there and how satisfied are you with that process?

MR BOLANO (HSUE): Our view is that - and having listened to earlier speakers - the industry should safely be able to assume that if someone has a cert III level qualification or a cert IV level qualification they are competent in certain areas and I believe that may be an issue at times with providers of training which needs to be addressed. Some employers complain to us, particularly in the disability sector, "We get someone with a certificate IV qualification and they can't do what we would expect them to be able to do with a certificate IV qualification." That I think is an issue with the providers of the training which needs to be addressed. So, yes, you should be able to safely assume if someone has certificate III, certificate IV they have these competencies. You have police checks in Victoria that are mandatory and that would go to the character of the person.

But also again I go back to Disability Services in Victoria where there is a strong code of ethics, if you will, disability service standards, there are 12 of them which are principles drawn from the legislation covering the rights of people with disabilities in Victoria and it is an inherent job requirement that you operate within those standards and if you don't, if any of your actions in the workplace are in breach of those standards, it is a serious matter. It is a matter for discipline or termination. So we believe rather than licensing which could be onerous in regards to costs and deterring people from entering the industry, certain standards have to operate within competent training and police checks should address those issues.

MS MACRI: And a good code of ethics.

MS IRVINE (HSUE): That's right. In terms of the licensing, it comes back to our initial point that we made in our discussions today that we don't want there to be the over-medicalisation or the over-institutionalisation within the industry. Now, if there was a scope of practice for personal care workers which was part of the licensing process, that would scare a significant majority of our members and it would not attract people to actually join the personal care workforce within the industry. If anything, it would be more of a deterrent than anything else. If the wages themselves is not an incentive for people to actually be part of the aged care industry at the carer level, then the licensing would only exacerbate that deterrence to join the industry.

MR FITZGERALD: I think this is where there is a fundamental distance occurring, isn't there. The ANF's submissions, as you will have seen, right throughout Australia, and we'll get more of those, in a sense are predicated on the view that personal care workers should be the next level of in effect the nursing profession so that the career path can go right through and in a sense it is predicated on the view the courses currently don't have sufficient medical or nursing components in it. Your union and a number of other unions representing personal care workers have taken a different view, that it's a much more general certificate and sits aside from that.

So I suppose in a sense we've got two very different view of where this very large group of workers, according to the figures you have given us - 170,000 workers give or take - fit within the system.

MR BOLANO (HSUE): I think the ANF's view in regards to personal carers being the assistants of the nurses is correct in regards to the clinical functions but the personal carer's role goes beyond the clinical role as well. So beyond that clinical role they are not in the tree of nurses, only when it comes to the clinical aspect of the job which is - I wouldn't say half the job but an aspect of the job.

MS IRVINE (HSUE): That is why we are seeking that there be the exploration as to a number of varied alternatives for career progression within the industry, not just the medicalised strain. So that is something that is intrinsic to the majority of our members that we have recently surveyed that they do want to see some career progression and career pathing but not necessarily down the stream of becoming a nurse.

MS MACRI: There are some thoughts too that you start to licence that third tier level which will then lead to the creation of a fourth tier careworker. So what are your thoughts around - - -

MS IRVINE (HSUE): As I have indicated today, the current wage levels - we have working poor now and so that will only exacerbated the problem if there was an additional tier within the aged care strain. We are looking for further analysis as to what opportunities there are for people working in the aged care sector and we don't have all the answers to that as yet. But I think there needs to be the exploration as to what alternatives are for people who wish to work in the sector and not necessarily through the medical strain.

MR WOODS: I am conscious we have gone over time but one brief observation, and I found your attachment B very helpful, but we had presentations yesterday from various dental specialists and I notice that oral care is the responsibility of the PCW and it doesn't appear, at least in overt terms, for either the EN or the RN and so one wonders as they are responsible for oral care whether they have sufficient training and skill to be able to then draw attention to significant issues of oral hygiene and the state of the mouth of the residents or patients. It is more an observation but it fits into a broader concern that we have. Sue, any other points?

MS MACRI: No, not really. Just to make a comment again about attachment B and I think in some respects you look at - there is an absolutely interlapping between PCWs and enrolled nurses or AINs in terms of some of those skills and I guess the really important thing in this is around that capacity to have a career path for those who want it and to be able to make sure that then if they're going to go and do a certificate IV aged work or enrolled nurse or endorsed enrolled nurse (a) that they

have access and (b) that the programs are appropriate and skill them appropriately.

MR WOODS: Thank you. Is there any concluding point you want to make?

MR BOLANO (HSUE): We have covered it.

MR WOODS: It is a very helpful submission and we have had a lot of interaction with your membership in our various visits and the like, so we are very grateful for your contribution.

MS IRVINE (HSUE): Thank you very much for the opportunity.

MR BOLANO (HSUE): Thank you for the opportunity.

MR WOODS: We will take a 15-minute break and then resume.

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

PROF MEAGHER (US): I'm Gabrielle Meagher, professor of social policy at the University of Sydney and convenor of the paid care research group which is a national network of researchers interested in paid care work, so work in child care disability and aged care.

MR FITZGERALD: You could come and join the commission.

MR DAVIDSON (US): Bob Davidson. I'm here with Gabrielle as part of the group. I have a number of hats. I'm not representing anybody but I suppose for the purposes of the record, University of New South Wales social policy research centre is probably - - -

PROF MEAGHER (US): Your affiliation, yes.

MR DAVIDSON (US): Affiliation with, yes.

MR WOODS: Thank you. You've identified a number of points that you would like to discuss.

PROF MEAGHER (US): Yes. I just start thanking you very much for the opportunity to meet with you. It is an extremely comprehensive report. It's a very large document. I can't say I'm familiar with every element of the analysis in it but I'd just like to comment today on a small number of what seemed to me to be key issues. The most important one I think is to think about how quality is ensured in the system. As I understand it, a key principle of the proposed system is one that allows people who have more resources to top up a basic level of service by paying for higher quality services should they choose to do so.

MR WOODS: Not quality; they can choose additional services but the quality of care that they are assessed as requiring is constant and common to all people in all locations. If they wish to purchase additional services, then they can do so on a market basis.

PROF MEAGHER (US): So I guess in this context, the policy decision about what's the basic level of subsidised accommodation and the universal care quality, that becomes quite critical to maintaining a humane and decent level of quality in the system as a whole. It's almost the critical decision, particularly for those that don't have significant resources. Just one small example is that I note in the draft report that it proposes a two-person room with a shared en suite as the basic standard in residential care going forward.

MR WOODS: The accommodation side.

PROF MEAGHER (US): Yes, the accommodation element. I'd be interested to hear the reasoning behind that and why single rooms weren't proposed because it does seem to me that unless an older person prefers to share a room and can have some choice over who they share the room with, it sets the bar a little low.

I guess if we think about what are the kind of drivers of quality, one is the skill of the staff and the way they're managed and the organisational culture that they work in. Things like the disability code of practice that was discussed by the previous speakers can be really important there in shaping people's sense of how they should perform their job and so on and the way the workers are managed, the amount of time they're given to do their job, how their work is organised is really what enables them to do that or not to kind of fulfil those ethical codes of practice.

Another element is the regulation and the incentives in the system, how the system is organised, and then both of those create a floor on quality; at worst they create a floor and so you have to think about what demands they make and what capacity there is in the system for them to deliver quality care. Then a third element to driving quality and one that's quite prominent in the report is market mechanisms. How to balance those three I think is a challenge and I personally think getting the floor right, the first two, the staff, their management, the quality of the organisations that they're in and the system of regulation is really critical there.

There's just two other things I want to talk about briefly. One is about the role of social professionals other than health professionals in the aged care system. In my view, aged care nursing is quite a different role from acute care nursing and that aged care as a domain of practice is more than a domain of health care practice. I'm aware of some aged care facilities that employ a number of social workers, occupational therapists and other kinds of people to provide a much richer environment for the people who live there. Just thinking about what environment older people are living in, what sorts of opportunities for enrichment of their life might be offered if there's a more diverse staff mix I think is really important and it also goes to the issue of what kinds of career paths might be created for people that go beyond becoming a nurse.

The third thing I want to talk about is the issue of what older people really want and what is the role of choice in helping them live a life where they feel like they're autonomous and so on. In this regard, I really welcome the emphasis in the report on person-centred care. I think that's really valuable, including the improved integration of the different care systems, smoother transitions and so on, and the report recognises, and I quote:

The aged care system should promote independence, wellness and

continuing contribution of older people to society.

I think that's really excellent. Choice is also one of the major ideas in the draft report and the ideas of choice of provider and the ability to change provider driving quality seemed to be quite prominent. It is clear I think that older people do value choice over key dimensions of their aged care services that they receive and enabling some key choices is crucial for getting genuinely person-centred care. But I guess the challenge is to design a system that offers people choice over the things that really mean something to them.

On page 80 of the report, it includes some quotations that give a sense of what really makes a difference to older people's quality of life, including maintaining their dignity, privacy, control, their sense of identity as their world shrinks and so on. What they talk about is things like respectful engagement from careworkers and not having a string of different people caring for them performing their work as a set of mechanical tasks and so on. Elsewhere the report cites the importance of being able to make choices over things like if you want to make a cup of tea for yourself, you should be able to take the risk of doing that. I think they're very good points.

I guess where my concern comes in is that I'm not sure that choosing a provider and changing your provider if you're not happy with the one you've got is the way that you get that sort of service, those elements. I think what enables you to get person-centred care and have a sense of control over your daily life is that the people that are caring for you know you, understand you and there's continuity of care and continuity of personnel. That sort of setting is better for working out responses to changing needs. So it seems to me that a system that's kind of flexible inside a care setting rather than putting the flexibility on to, "Well, this care setting isn't working for me any more, I don't like how they treat me, I'm going to go to a different one," is probably more likely to be able to give the genuine person-centred care.

MR WOODS: So in that respect, will you be commenting on our idea of breaking open the packages so you don't have to go from one care provider to a different care provider if your needs change?

PROF MEAGHER (US): I think that sounds excellent, yes, absolutely right, given that this kind of person-centred care is quite demanding on the staff and it does require that the staff have time to spend with people and also that they stay in an organisation for a period of time as well. So solving a lot of the challenges in the workforce that have been talked about by other speakers would improve the capacity of the system to deliver this kind of care.

Just a very final point, I would just like to say that formal aged care services are not simply a cost to the community. I think they're an important enabling service for informal carers whose labour market participation is pretty low. So if you turn

that problem around and instead of thinking, "We're losing these informal carers," actually providing high-quality formal care services opens up employment opportunities for people who are doing that care but also frees a lot of people to go into the labour market who might otherwise not be there. Younger women now might have different expectations about their future labour market participation, providing both good jobs in aged care and good services so that people can feel comfortable using them; going off to work and leaving their parents to receive some more services from the formal care system should be taken into account.

There's been some research recently about what is the impact of the gender pay gap on economic growth. I don't know if you've seen that, but NATSEM did a study recently showing that Australia's economic growth could increase by 8.5 per cent if the gender pay gap was closed. The connection with this situation is that there's a pay gap in aged care, and also it's a disincentive for women to work because their wages are low. So there's room there in the broader macro economy for aged care services to play a role in actually increasing economic growth rather than being seen as something that's, "We've just got to find this money for this expensive but necessary ultimate drag on the economy," kind of thing. I'll leave it there.

MR DAVIDSON (UNSW): Yes, I come to this with a number of backgrounds. I've worked a lot in government, designing these programs. I come as a client with a mother-in-law, an intellectually disabled child in care and I also come as a member of a management committee of a small community based NPO. The first thing is there's a lot of positive features about the draft report. You've identified the need for sufficient funds to provide for people who have got a need for care above a specified level. There's a better alignment of the various services, the rigorous consistent basis for assessing the needs and the structure of subsidies and the payment of contributions. It's good that we can enable service users and their families to have a wider range of choice and providers to be more flexible. I think that the report has actually identified most of the concerns and most of the considerations. It's not clear to me and others exactly how the conclusions were necessarily reached on the basis of some of the points that were in there, particularly in relation to choice, as Gabrielle was saying. So I think there's a lot of positive things and it's a terrific move forward.

There's just two or three things I want to talk about in the brief time we've got. One is it's very important that we align community care and residential care. I'm not sure there's necessarily sufficient recognition of the differences between residential care and community care and how that will drive the market in an open competition model. I use the term "open competition" because I think I heard you use that one day, Mike, so for the purposes of description, I will use that term. So those differences are important.

Also, I'm not sure, looking at it from the community aged care system - and

I've spoken to a lot of providers and a lot of players in the system - as to whether it's as broken as the draft report suggests. A lot of the problems about money, there's some very poor coordination and consistency of policy that needs to be sorted out and there's workforce issues. It's a bit like we don't give the car away just because we haven't put enough petrol in it. Perhaps if we put a bit of petrol in it and sorted out the road rules, the car would be much more useful. So I'm not necessarily sure that we need to quite go as far with open competition, and we probably haven't got time to talk about breaking out of the packages.

There's a few other issues that I think need to be looked at in terms of the incentives for service providers, how the co-contributions are going to be collected, who keeps them, what's the rate of return for providers that's going to be in the price that's set by the regulatory commission. As the previous group asked, the price that takes account of labour costs, will the pay and conditions be passed on?

But just very briefly on the differences between community care and residential care, the physical and financial capital requirements in community care are a lot less. That's got some good aspects and some risk aspects. It means that we see a lot of people who are not profit maximisers who are coming in, ex-nurses, ex social welfare people, and setting up some very good services. Some of the best services are actually for-profit bodies run by people who have come out of that sort of sector.

On the other hand, that easy entry or very few economic barriers to entry makes it much easier for opportunists looking for sort of quick dollars. Now, I know we're going to maintain and hopefully increase the sort of levels that are needed for accreditation of providers, but I think, as Oliver Williamson who won the Nobel Prize for economics said last year, that at the end of the day, complex contracts are by definition incomplete. You cannot chase up everything that a provider is doing. I think, Mike, yesterday you used the phrase about providers with "less trusted reputations". So I think there's a real question about the extent to which the differences between community care and residential care - there's some big implications for competition. There's also differences in workforce requirements. There's less scrutiny of people in the house. It's true that the people they're servicing generally have lower needs and are probably more capable of making decisions, but there's also less scrutiny of what they're doing. I think you will find that when they do the quality assessment monitoring of community care providers, nobody ever goes into the house or watches what's actually happening and there's very little done other than paper checks. Now, I think actually because of the way the systems work, there's not that many problems, but the potential is there if you're having much more open entry.

I guess in the time available, I'll just cut to the chase and say that there are models of approved panels - the Lifetime Care and Support Association has a panel

of approved providers. There is an accreditation system which the Attendant Care Industry Association would argue is probably more rigorous than what DoHA applies. I'm not in a position to measure that. But you have to pass that accreditation, then you have to go through another hurdle in order to be put on the panel. Again, I don't know whether you know but the ACCC has just - there was an appeal made against that being a non-competitive measure and the ACCC has just endorsed it.

So it seems to me that rather than necessarily jump to an open model of competition, I think at least as a transition phase we might go to a point where the existing providers in each region that are getting packages two things could happen - one is that you could allow them to provide any level of care that they're qualified for or accredited for. In other words, they may have been given each package and no CACP but if it's a lower level of care, let them provide it. So that actually opens it up a bit. It also allows the same situation for people to move between providers and because you've got sufficient supply of places there actually is the scope for choice. Choice is in the system, as we saw in Queensland in 2008-09. What happened there was the residential care providers felt that it wasn't worthwhile applying for the places, there was a lot of spare place. They moved them across to community care providers and suddenly there's an excess of places. We saw choice and competition working very briefly in that state for a while.

So it's not that choice isn't in the system, it's that there is not enough money and what happens is people have to queue up. So I guess my basic point is that I'm not sure the system is quite so broken, at least in community care and I don't pretend to know much about residential care except as a son-in-law. I think that at least as a transition measure, because there are a lot issues associated with the provider with provider incentives, there are lot of issues associated with the validity of choice. For example, the report refers to Dowling and Jones, there is a quote from them. If you go back to the Dowling and Jones article, what it actually says is that there is a better quality of choice from a limited number of options that are varied than there is from simply a large number.

I think that is a very important principle that needs to be applied in how we either run the system or at least introduce it. I think a transition phase over the first couple of years where people get used to a model of open competition and then we increase the places and perhaps allow some others in will be a much better way of phasing it in and I think might even be a better way in the long term of running the system. I'll stop there.

MR WOODS: Yes, we don't want over-complexity because that doesn't actually assist the process.

PROF MEAGHER (US): I guess what I was trying to say was a lot of the things

that people want to have some control over are inside a care situation and if you're choosing between care situations - sometimes that's between care at home and care in a residential facility, that's an important transition but that's something else, you're thinking of someone providing the same thing. You might want a choice of, "I'm a Macedonian and I want to have a facility where the people speak Macedonian and they understand my needs," or, "I am a gay or lesbian person." But that's the sort of variety in a sense that is more important than - especially when the needs are assessed and you've got a list of things that you can get. It's like saying we might have a hundred different supermarkets, but you're only allowed to buy from a list of things. So that choice of supermarkets isn't that meaningful.

MR DAVIDSON (UNSW):   I think people want to know that there are at least four or five choices that they know they can trust. That is what they want, rather than being confronted with 25 choices.

MR WOODS: We understand that.

PROF MEAGHER (US):   And you have to sort out the quality and decide whether you like it or not. That is just an insurmountable burden.

MR DAVIDSON (UNSW):   One thing that isn't covered in the report too is the issue of subcontracting. It should be possible for them to continue that subcontracting and brokering. But it is a major part of the industry, the community aged care industry that the ones actually get the places don't deliver the care to the - it is actually done by a private agency which isn't necessarily a bad thing but it is an important feature of the industry.

MR WOODS: You have raised a number of issues but, unfortunately, we have run out of time. We have other participants to scheduled to appear. But we will take your written material as well and pour through and as appropriate we can come back and bounce particular issues from you. Thank you very much for your presentations.

MR WOODS: Can I ask the Centre for Health Services Development at the University of Wollongong to come forward, please.

MR OWEN (UOW): Apologies from my colleague, Peter Samsa, he is off on some other business today. Not coincidentally he is busy trying to finish a report on palliative care.

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

MR OWEN (UOW): Yes, Alan Owen. I'm from the Centre for Health Service Development at the University of Wollongong. I'm a senior research fellow in the centre. I am also a policy adviser to the Australian Council of Social Service.

MR WOODS: Excellent. Please, speak to us.

MR OWEN (UOW): What I thought I would do is first of all apologise for Peter, but in doing so draw a little link across to palliative care because I think that is one of the salutary lessons that can be drawn from there. I also just want to, in the preliminaries, say thanks for the excellent quality of the work so far. It's the sort of thing we have seen quite missing within the departmental approach to aged care and that's not coincidental, I have been shackled by their programs. You are less shackled by those sorts of things which is good.

I wanted to introduce the ideas here firstly by just being a little bit provocative on the policy front. I am going to give you gratuitous policy advice which may or may not be appreciated. But I think there has been a change of game plan within the COAG arrangements for the health reforms. I am mindful of the fact that you don't want to get sucked into the insatiable more of acute health care. But there is the question of how the growth money in the health sector will be distributed and the key to that is the growth of the interface between aged care, primary care - aka the Medicare locals - and the acute care system, now known as the local hospitals network. The funding models within the local hospitals network have to be able to get beyond the walls of the hospital and we now have a situation where due to the intervention of the Prime Minister in the COAG arrangements in February, we saw the game plan change from the primary care sector being 100 per cent Commonwealth funded, and controlled to some extent, to now being a fifty-fifty arrangement in principle. But they're starting from a base that's actually 42 per cent Commonwealth and 58 per cent state.

It is that 58 per cent state that means that it's inescapable that the hospital system is part of the aged care system. It is a traditional problem that we have had in the community sector, the closer you are to a teaching hospital. If they sneeze you

have caught a very severe cold. It is the sort of problem that is familiar to most community care workers, you have HACC money, community care money coming to a planned arrangement and you find it has been used to fund a dietitian inside a hospital rather than in the community. So these are common sorts of problems and it's going to be an interesting situation where the Medicare locals, as proposed, will have to have clear arrangements with the secondary specialist care delivered through hospitals.

That is where you have the interface issues that are really interesting for the commission. You have rehabilitation, especially if you've got the guiding principle being wellness, then rehabilitation is a major factor in getting people back on their pins again after a knee operation or whatever. But increasingly it is becoming part of the preparation before acute care. If someone is going to have a knee operation, they are going to recover quicker if they have had strength training before they have it rather than pick them up as a casualty not only of their condition but of the medical treatment that they've just got.

So we've got a situation I think where the key to the future growth of the aged care sector comes in how to get some control over the growth money that goes into the bits that join the system together, the interface between acute care, community care, aged care, residential care. Those interface issues, I can appreciate you don't want to get into telling the acute care system what to do because they're very much bigger than most in any local setting, and there's also the shroud waving and other things that are part of maintaining acute care within the politicians' - yes, within what they want to attend to by way of new arrangements.

I don't want to keep talking at a fast rate, that's one other issue, but I want to look at funding and how that relates to assessment and also how to look at incentives within the different models of aged care. So if I can just briefly tie that back to the report, the report, most of what I've got to say goes to chapter 8 on the gateway issue and also the recommendations that flow from that chapter 8.

I briefly mentioned that we've got an activity based funding model within the acute care sector. That actually is a set of incentives for increasing volume in the acute care sector. Increasingly there are new models of how to do activity based funding and your recommendation - anyway, it was the one on palliative care - where it actually says it would be useful to pursue a casemix approach such that you could fund palliative care services no matter what setting they might be in. I think that's a really good example of the sorts of incentives that can be built into funding models. If the only thing that you can incentivise is more diagnosis based treatment in an acute care setting, then you're going to continue a system that's highly technically efficient, in the sense that it can churn through volume, but it's not necessarily dynamically efficient, in that it can substitute the right mix of services at the right time for the right people.

In the additional paper I presented as I came in, there's just an example there of how you can use assessment to try and look at both building wellness models into the system but also collect the right information at the entry point to aged care, such that you can measure the outcomes of care further down the line. That work that we build on in our centre is beyond acute care. That's where we've moved basically. The last 15 years, we've earned our keep by doing stuff that's not driven by diagnosis but is driven by the functional needs of the person and their carers in the community, but it's really hard to ignore that interface with acute care. You have to have tools that can go across settings and that can give you that capacity for continuity over time but also continuity across settings.

We think the role of the gateway is crucial. We liked the way that the diagram of the gateway model separated needs from financial capability. Financial capacity I think should be a separate question to levels of need, otherwise you start to get things very confused as to who deserves what. Once there's a good assessment of need - and what I've put up the front there in the hand-out is really just a model of how you can assess need, mainly with a focus on carers, there's a set of questions, not too big, although not too small either. There's a set of domains, a set of about 30 questions that can be used to separate people out into those who don't need much, people who do need quite a bit, people who need to be assessed more fully because they have got maybe minor problems that could be dealt with if they actually had a better quality and a broader type of assessment.

So I think the needs assessment issue - I guess the other bit of disagreement with the models as they're floated in the draft report - I can see financial capacity as a Centrelink-level activity through a gateway but I don't see the requirement for needs assessment to be centralised. There's already a diffuse and well-developed, although undersupported sector of assessors who are in the community and I see a distributed network of assessment using common tools, a shared language and a shared set of understanding of how you can classify the clients, patients, residents. Once you can classify them according to the goal of the care, then you've got a tool for going across settings. This person may need palliative care but they may be in a residential setting or they may actually be in a hospital setting, but they more likely will be in their own homes.

The gateway function I think becomes a contested ground. It's like when you see the Department of Health talk about gateways, you can see they've got a model of the gateway to residential care. They've got a sense of, "It's a hundred per cent or we're not really interested and we want to control the gateway." It's not a single gateway, it more resembles a porcupine with lots of spikes, lots of community care sectorism neatly arranged as a triangle. It's a bunch of people in a distributor network doing all sorts of things under a confused array of funding models. But I think there's potential; the way that funding can be redesigned, I think the potential is

there for that to be simplified. It's got to be looked at it in a complex way before it can be simplified. I might stop there in case there's questions.

MR WOODS: Thank you. Thank you for the supplementary document which you have provided today. It certainly provides some useful additional detail. On the assessment process and the role of the gateway, of course we're not assuming that the gateway employs all of the people who do all of the assessments. The assessments have got to be carried out at the local level. The gateway agency has got to be ultimately responsible for authorising care that's approved and the public expenditure of funds that is associated with that care, but they would draw on a wide range of expertise at the local level, dependent on the expected level of care assessment required and then with triggers as well if it's not what the expectation is. So they would call on further professionals if something was triggered in a preliminary assessment that suggested that something else needed exploring. Hopefully we can allay your concerns, that the gateway has the responsibility but isn't expected to be the entity who employs all of the various professionals who require to be involved in that assessment process.

MR OWEN (UOW): Yes, the key to it is that they share a common approach.

MR WOODS: Absolutely.

MR OWEN (UOW): And they are standardised to some extent with lots of boxes for people to have their narrative appreciated as well. We often get stuck in dated elements but they're only part of the story and that's our way of understanding what people are actually asking for.

MR FITZGERALD: The real challenge is I think to avoid the duplication that currently exists in the system. A person that currently accesses a multiple of HACC services gets multiply assessed. So we've actually got quite a lot of assessment going on, you're right. A lot of it is duplicated and it is all different.

MR OWEN (UOW): Yes, you know, we did some work in Victoria at one point and we started out by looking at how many forms people were using. We walked around Victoria ringing a bell saying, "Bring out your forms." We stopped counting at 352.

MR WOODS: The cart gets filled up and they start falling off. It's quite messy.

MR OWEN (UOW): Yes. No, it's messy.

MR WOODS: But also in the case of a person who then ends up entering residential care that the ACATs or ACASs in Victoria do assessment according to one instrument and then the provider goes through and does another.

MR OWEN (UOW): Yes, and also the other important bit is that there has been a really sophisticated assessment done at the hospital by the rehab people, and they don't get asked what they think would be useful either.

MR WOODS: So we want to bring all of that into a consolidated process, but with an electronic health record that then captures that and builds on it rather than keeps duplicating and replacing it.

MR OWEN (UOW): Yes, an ongoing record.

MR WOODS: Sue, have you got any - - -

MS MACRI: No, not really. I mean I think the points about that communication between the various interfaces right through caring for older Australians is just absolutely critical to the quality of care that they receive.

MR OWEN (UOW): Yes, I think the commission is in a unique position, because it's not - as I actually said earlier, it's not hamstrung by the program structure, where every program manager is going to die in a ditch over their own version of assessment.

MR WOODS: Our independence is an important part of our process.

MR FITZGERALD: I suspect they'll still die in a ditch over their programs as the reform gets rolled out. But I want to come back to your opening comment, which is in relation to what you regard as a game-changer in policy. We're very much aware that there has been a change to the health reform agreement or hospital reform agreement in relation to community-based care or community-based health care. Managers say it's now fifty-fifty. What I don't understand is what you - well, you can advise use. How do you think we should handle this interaction between the emerging health reforms and aged care? Some people are encouraged to really see it as one system. We think that is not a good thing.

MR OWEN (UOW): You can't merge everything all over the place.

MR FITZGERALD: No, and anyone who has been associated with health would know that that's not necessarily a very good outcome, because health dominates everything. On the other hand everyone says they need to be better aligned, better coordinated, better everything. But what does that mean in practice? So just given your opening comment do you have a particular view as to how we should approach the reforms in aged care given the reforms that are taking place in the health and hospital area?

MR OWEN (UOW): Well, I think there's an interesting example in Western Australia where Western Australian Health decided they were about 500 beds short of a useful system and they contracted - open contest which they gave the contract to Silver Chain.

MR FITZGERALD: Yes.

MR OWEN (UOW): So they're running a bunch of virtual beds, which gives them the flexibility to substitute different goals of care, depending on the needs as assessed of the individual; very much acute-care focused, because it's talking acute care beds as being - are where the money is coming from. That's the lever, the ability to actually pool the funds to say, "Okay, well now we've got funds pooled to the equivalent of the national average of how much those beds would cost to run. That's the pool. Now, let's distribute within that pool according to assessed need." It's not unlike what the 2000-or-so COAG Coordinated Care Trials did. We've got good models, but I think we've got a - we learnt lots of lessons in the COAG trials because we were the Illawarra evaluater of the trial there; also had in the hand Mid-North Aboriginal Trial. Increasingly people talk to us about how they think of their - what are the lessons from their trials and demonstrations.

That set up a bunch of tools for the job. That was where we then evolved out of that an approach to functional screening. One of the outcomes of that was a nine item functional screening tool that's inside the Home and Community Care Minimum Data Set. I've got a standing joke with my colleagues at work that I want on my tombstone that, "This is the man who contributed nine additional items to the HACC Minimum Data Set. What a guy."

MR WOODS: Well, thank you for coming up from The Gong to present today, and thank you for your additional written material.

MR OWEN (UOW): Yes, thanks very much.

MR WOODS: We appreciate that.

MR WOODS: Could I call forth the Quality Aged Care Action Group please. Thank you for coming. Could you please, for the record, state your names, the organisation you represent and any position you hold in it?

MS McKENNA (QACAG): I'm Lucille McKenna and I'm the president of the Quality Aged Care Action Group. I'm also a director of nursing in aged care, currently at St Mary's at Concord. The Quality Aged Care Action Group is a - - -

MR WOODS: Sorry, just before you proceed if I could invite - - -

MS McKENNA (QACAG): Oh sorry, Betty.

MS JOHNSON (QACAG): For me too?

MR WOODS: Yes.

MS JOHNSON (QACAG): I'm Betty Johnson and I'm a member of the Quality Aged Care Action Group. I represent on that the older women's network. I'm also - just seeing you've been talking about the local health networks with Alan, I'm on the Northern Sydney Local Health Network governing council and on a number of other state government, and previously Commonwealth government, committees on health and on ageing. I was for a while on the Aged Care Standards and Accreditation and also on the Commonwealth government's advisory committee. It's how I got my AO.

MR WOODS: Thank you very much. I did enjoy our earlier meeting where we went through a number of items, but please proceed.

MS McKENNA (QACAG): We've made submissions, an initial submission and then the subsequent one just in the last week, in relation to our group and their concerns about aged care. I just want to comment on a couple of areas today, particularly the gateway. We really support that idea. Through the action group and also through my work I am continually reminded of the poor understanding of the system by the aged care - the people in our community. There's a lot of confusion in knowing how to go about it, there are many avenues, and that has been fairly well covered today already, I feel. We do feel that the gateway should be a core government service, rather than run by an NGO. We think that it also should have consumer representation or consumer input.

The other area of concern to our members that I want to spend some time on is in relation to staffing and the workforce issues. We do support all of the recommendations that have been made in the interim report, but you also identify in the report all of the issues that we feel are of concern: the increased workloads, the reduced numbers of registered nurses, the increased scope of practice of the

assistants in nursing and the care workers. One of the things that concerns me as a nurse is the less opportunity for professional collaboration.

I've worked in aged care for 40 years, so I've seen a few systems come and go. I feel at the moment the staffing issues are very inconsistent between facilities and worse in - for many. I'm very lucky to work in a unique environment. It's a facility of choice and very highly regarded in the community, management is committed to care and safety of its residents and safe staff levels are maintained. Because I happen to work in that facility of choice, I'm constantly interviewing people, in large numbers, who are unhappy with the services that their family member is receiving in other facilities, and it's really quite distressing. I recently had a woman in tears, pleading with me to be able to take her father into our facility. I didn't have a bed and I couldn't help her.

The accreditation process is supposed to ensure that adequate staffing levels are maintained, but it's not a quantifiable assessment. It's not really something that the accreditation assessors in aged care are able to really do anything about: they look at rosters, but that really doesn't assist in assessing whether the care levels are adequate and there are enough people to do the work. My personal experience, talking to people and interviewing the numbers that I do, reinforces the concerns of our members; they talk about things like the need to attend the facilities at meal times to make sure that they feed their family member. They often say they want to do it to help. They're not critical of the facility, they want to be there to help, because they realise the nurses are stretched.

Residents themselves talk about and complain about the lack of interaction with staff, or extra people to be able to assist them. Just simple things like taking them outside, getting them in the sunshine, is really difficult for staff who are really stretched with the very basic needs they need to see to. One of the things that really concerns me is that there has been no benchmark of care done; we really don't know what it costs or what is really needed to do this. In most facilities, it has to be a commercial decision; the staffing levels are a commercial decision. It's about what one can afford.

There are other spin-offs as well: that insufficient registered nurses in a facility has an impact on the hospital system; poor assessments result in increased hospital presentations, which are distressing for the resident and for their family. We all know that the best way to keep old people healthy is to keep them out of hospital. Of course, ageing in place has created another issue which concerns our members, because a high number of high-care residents are in low-care facilities. In New South Wales, where we have the requirement that there's a registered nurse on duty in all nursing homes or high-care facilities at all times, of course this doesn't carry across to the low-care facilities, so you have some high-care residents having access to professional staff and other high-care residents who don't have access to

professional staff. We believe this is an anomaly that should be fixed.

The community expect it, the consumers expect it, and many are unaware of the level of training of aged care staff. Many participants assume that they have this availability and access to professional staff at all times, but they don't. We believe that there should be a way that the government can provide adequate funding, so that all facilities can have adequate staffing levels. How it's done, I don't know, but there are certainly actuaries available to our governments that should be able to work out some sort of staffing level that can be attached to the ACFI. This should be mandated and funding should be available to ensure proper staffing for all aged care residents; it's what our community expects.

Just one other thing I'd like to quickly touch on: it's the level of training of our assistants in nursing and our care workers. We've raised that in our submission, we've raised it in other areas as well. There is some excellent training that happens in places like TAFE and some of the private providers, but there's also some very, very poor training happening and this really needs to be addressed. We need to have some sort of standard, some sort of benchmark of the level of course that's being provided.

MR WOODS: I noticed your phrase there of, "Be a nurse in seven days."

MS McKENNA (QACAG): Yes, there are courses available; you see them advertised in local papers. I personally employ, because I'm in the inner west of Sydney, a lot of international students, nearly all of our staff are from non-English speaking backgrounds. These are people who have done courses, they've paid a lot of money for them, and they are very, very poor. They come to me with something that's been done in three weeks, and they have the certificate.

Because they've been exploited, I then feel compelled to try to take them on and look after them - which I do - but then I basically have to start from scratch and train them. At the other end of the spectrum, I have a connection with the TAFE here in Ultimo and we employ a lot of graduates. They are just outstanding. So you've got the two ends of the spectrum: one which is excellent; and the other end, where you've got this group of often-exploited people who have paid a lot of money and have very poor training, literally none.

MR WOODS: How can we address the systemic issue there? It's coming up time and time again, but do you have any observations?

MS McKENNA (QACAG): I think that there's an educational body that's supposed to oversee these courses.

MR WOODS: There is.

MS McKENNA (QACAG): I think there's not enough vigilance there, obviously. I've actually tried to talk to people about it; I found it very difficult. It's extremely difficult to get to VETAB to actually talk about that particular issue. I've raised it with politicians, but I haven't had a lot of success. With our international people, a lot of these courses are actually sold overseas, I think, so they actually come with that commitment to enrol in a course for something else, "But while you're doing it, you can be a nurse in aged care. If you do this course in three weeks when you arrive, you can." So it's a very complex issue and I don't know how we address it, but it's a concern for us.

MR WOODS: Sure.

MS JOHNSON (QACAG): I might just follow on from what Lucille said there and hop into the middle of what I was going to say. Many people in nursing homes, in hospitals, and in the health system in general are confused about who is looking after them, what their training is, what their background is. I think it would be very useful, in aged care facilities and also community care, if staff could be identified in the same sort of manner as has been suggested by Commissioner Garling in New South Wales and which is starting to happen in hospitals in New South Wales. I grew up in a hospital, I spent most of my childhood in the hospital, and I always new the level of training of the nurse on the basis of the marks on her cap. I think that sort of thing, particularly for older people, it's very important to them to know whether somebody is trained or not and what they could talk to them about. I just thought I'd add that to what I was going to say.

But I just wanted to say thank you and congratulations on how well you've done in this report; enormous report with an awful lot of stuff in it that is very important. I just want to add a few things, some of them from me, some of them are from the consumer members of the QACAG. There's a big concern about the implications of the shift to a user-pays system and the effects on low-income people and particularly in terms of many of them say they will avoid going into hospital because often in a hospital, they send you off to a nursing home, and people are concerned about that in terms of their financial ability to pay for it. They fear that they will be unable to get the care they need because they can't afford it. I think that it needs to be much better clarified than is certainly suggested.

MR WOODS: We certainly won't have that happen. We'll make sure that we write it clearly.

MS JOHNSON (QACAG): Yes. One of the problems about information is people don't go for information until they have a need for it, but just the same, I think there's ways that something can be done. We welcome the proposals and the fact that the report has dealt with community based care because I feel and many of us feel that

this is the sort of growth that is occurring and will occur as the population ages as far as numbers and so on is concerned and that you look at it as being more responsive and flexible, and choice available. But I think that this has got to be supported by a greater transference of accountability from providers to the funding bodies and to the older people who are receiving the care and paying for it. I will deal with that a little bit more later on too.

For people that want to remain at home and where possible to be cared for by the people who are their family or their friends, it's very important that it be properly conducted and dealt with in a way that in many cases is better than currently. One of the things that I feel too, and I have mentioned it elsewhere in a report to you, there's a group that's been functioning in New South Wales called Impact, set up to deal with - consumers and also professional providers of care have been meeting for the last three years, looking at how better to provide care for the clients of community care and there is a document which I did say I'd send to you and I haven't. I will send it to you because it deals with five principles that we believe would be better as far as clients and providers are concerned.

We're also concerned about the removal of the distinction between high and low care. At least now with the high care, there's protection in New South Wales legislation to ensure that a registered nurse is on duty at all times. As it is, the hostels are mainly filled with people who have aged in places, as I said before, to high care where there is frequently no registered nurse on duty. That's of great concern to all of us and also the Nursing and Midwifery Board and Council which is the New South Wales part of it.

MR WOODS: We're going to try and treat those as two separate issues. One is having the accommodation in which care is delivered and separately to ensure that staffing is appropriate to the care needs of the individual.

MS JOHNSON (QACAG): Right. Because one of the things that we were concerned about in our discussion at QACAG was if it changes and merges, will the people in high care be disadvantaged and will people in low care not have the independence they currently have? They're just some of the things we've discussed.

MR WOODS: Yes, absolutely.

MS JOHNSON (QACAG): Thanks. One of the things, we support the focus on care at home, including palliative care and end-of-life care. These are issues that in some parts are being dropped. I understand that within the community, palliative care coming from hospitals is being changed and I think that this could be a great disadvantage if it means people have got to go to a nursing home to get palliative care. It is not what people want, not what they expect, not what they need. In these areas, there should be proper staffing at all times with the necessary skills.

We want some sort of mandatory staffing. I know this is one thing that you've heard a lot of from nurses but we'd support that there should be mandatory staffing in terms of the numbers of staff to residents or patients. We drew attention to the fact that the accreditation standards and the aged care principles use terms such as "adequate and appropriate staffing" but the numbers and times that are available to care continues to decrease. I've told you about what older people need in terms of being able to identify, but we believe that the residents who need care are at risk by the lack of registered nurses caring for older people.

I'd just like to sort of finish by saying that I'd like to hear more about what's happening as far as any changes in the complaints system, and I hope the name gets changed from "complaints" because I think it's much better that we talk about it in a more positive way, "comments" and so on. I want to know and so does our group want to know whether the unannounced visits is going to remain. Anyway, finally - and Sue, you won't be surprised at me raising this one - aged care reform must incorporate consumer participation at all system levels; that is, the opportunity must be taken to ensure that this is built in rather than added on and that we want genuine long-term and structured involvement by consumer representatives at all levels such as the proposed gateway, which would be great, and in the Australian Aged Care Regulation Commission.

MR WOODS: Thank you very much for that. Sue?

MS MACRI: Obviously very strong within the report is around the Commonwealth government funding advocacy services and consumer participation, so that's seen as absolutely critical. In the report, we continue to hear about the RTOs and the problems associated with that and I guess that's something that we'll have to go back and have a look at, but it is a major issue for the AIN personal care worker level and the quality and the end product coming out of that. That obviously impacts on the quality of care, both in community and residential.

MS JOHNSON (QACAG): Yes.

MS MACRI: So they're major issues that currently are coming through. I think, Lucille, just in terms of the benchmark of care again, ACSA and ACAA at the moment are doing some work around that and we look forward to eventually getting - that true cost of care is another issue that's come up, the skill mix.

MS JOHNSON (QACAG): Could I just make an addition?

MR WOODS: Please.

MS JOHNSON (QACAG): You were talking about the local health networks. In

New South Wales Health, one of the things that will be worked on by these networks and others is the unnecessary admission to hospital which sometimes does happen with older people and the unnecessary readmission because of lack of proper care in the community. I think that these are things that we ought to note should happen and I believe in New South Wales, there's a real attempt being made for it to happen. But it's very important in terms of older people because we are the ones who are more likely to have the problems there. I'd also like to finish by saying thank you for what you've been referring to as far as dignity and respect for older people. Sorry.

MR FITZGERALD: I just have one issue, and that's transparency. You've mentioned about providers being more transparent.

MS JOHNSON (QACAG): Yes.

MR FITZGERALD: We think the system needs to be more transparent and - - -

MS JOHNSON (QACAG): Yes, absolutely.

MR FITZGERALD: - - - we've made comments about that. But when you get to the individual provider, we need some guidance as to what you mean by transparency. As a concept it's fine, but what does it actually mean? In one sense people might say all the resident needs to know or the consumer needs to know is that they're getting good quality care for the fee they're paying or for what the government contribution is. So what is it that you think needs to be made transparent from the provider's point of view that is currently not available to you, if anything?

MS JOHNSON (QACAG): I think in many cases they don't really know what to expect; that just the fact that they're in there for care very often they don't get the sort of care that is appropriate to their personal needs. I think that talking about nursing homes as being your home means that - but doesn't necessarily deliver it - that care is not delivered in a way that you would expect if you were at home. I don't know whether - I think Lucille might be able to better say this, because of her experience.

MS McKENNA (QACAG): Well, I think that we hear the arguments all the time that consumer says, "We're not getting enough care," or, you know, "there should be more staff." The provider says, "We're spending all we" - you know, "We can't afford any more. The government needs to pay more money." The government says, "Well, we've given the proprietors money to spend on staffing levels." This sort of goes around in circles and at the end of the day nobody really knows what is really happening.

I think that we have such a variety of residential-type facilities. We have the not-for-profit places and the for-profit places. I think some have big mortgages, some don't. I think it's such a - but I think that there should be some pool of money.

We had it in years ago in the CAM funding.

MR WOODS: I noticed you referred to CAM and SAM.

MS McKENNA (QACAG): Well, you can't help it, because I'm just - - -

MR WOODS: I was showing my age.

MS McKENNA (QACAG): - - - old enough to show my age, but I can go back before that. I can even tell you what happened before that, before CAM and SAM. But even back in that system you had specified numbers of staff. I think - that's, I think - the sort of transparency they're talking about is, "How do we know what we're supposed to get?" People actually come to me and say, "How many nurses should they have on duty?" There is no number. It's about the adequate care and it's up to the individual, the management of that facility. So it's that sort of area.

MS MACRI: Just a very quick comment around the CAM and SAM. I guess one of the things to remember that that did not deliver the best efficiencies either in terms of people having their budget and not being able to spend - smaller facilities did very poorly under CAM. Larger facilities had so much money that they didn't know what to do with it, so rather than return it to the government they created places. You'd have to question whether that, at the end of the day, delivered quality care. So I think we need to be careful when we're looking at some of the older systems that are painted as - - -

MS McKENNA (QACAG): I understand that. But there still needs to be, I believe, some sort of basic - - -

MS MACRI: Absolutely.

MS McKENNA (QACAG): Some benchmark, some bottom line that you have to have. I think somehow we have to get around it.

MS MACRI: Yes.

MR WOODS: Thank you very much for coming.

MS McKENNA (QACAG): Can I just say thank you for having us.

MS MACRI: No, thanks very much.

MS McKENNA (QACAG): Thank you for the report and thanks for the opportunities.

MR WOODS: Can I ask Henry Cutler to come forward, please? Thank you. Can you please, for the record, state your name and the organisation you are representing and any position you hold in it?

DR CUTLER (DAE): It's Henry Cutler and it's Deloitte Access Economics. I'm a director of our health economics and social policy section there.

MR WOODS: Please proceed.

DR CUTLER (DAE): The purpose of me being here today - and first of all, let me say thanks for having me and allowing me to express some of my views. I suppose what I'm really here for today is to gain some sort of clarity from within some of the recommendations in the report and also offer suggestions as to some areas where the report may want to focus on, or at least the commission may want to focus on.

My particular area of focus today is really in regards to the impact of regulation on providers and the recommendations surrounding the aged care financing. I applaud the Productivity Commission for moving towards a more market-oriented approach, removing some of the regulations around the supply side of residential aged care facilities, therefore allowing greater choice within the market and greater flexibility for providers. I'm just wondering in terms of the impact of removing bed licences - sorry, bed licence supply-side limits on some residential care facilities. Some of the different competitive outcomes that could result within Australia and also particularly within particular regions, rural and remote regions - we're moving towards a more competitive market.

Not all markets within each region are the same. So I'm just wondering whether the Productivity Commission has thought about some of the impacts in areas where there may be just one or two residential care facilities within a particular region, some of the competitive outcomes that may result there, particularly the issues surrounding local monopolies and the possibility that one may be a lot stronger than the other. Even though regulation or the change in recommendations and removing regulation inherently will see some inefficient providers being removed from the market, you can imagine a situation where within a particular region one provider may have some sort of market power and therefore in the long term result in reduced choice for people in residential care facilities.

I also wanted to mention some of the impacts or the expected impacts of removing - or focusing on, I suppose, a greater reliance of facilities to provide a price based on the cost of care. So in the current situation we have lots of cross-subsidisation going on. So we have, for example, payers of high-care bonds in low care cross-subsidising those who can't afford high-care bonds. We have payers of high-care bonds cross-subsidising the care component. We also have some of the

revenue from the care being cross-subsidised into accommodation as well. I'm just wondering as people adjust their prices and as people move towards a more costs-orientated pricing regime, especially in accommodation, how that is going to impact maybe the price of care.

So, for example, if there is some money that is being used from income earned from accommodation to fund care will that mean an increase in the price of the care component? Therefore what does that mean for the federal government in terms of having to cover those costs through subsidies provided for care and also paying for any additional amount over the recommended cap for care?

MR WOODS: We'll come back to that.

DR CUTLER (DAE): Yes. I also wanted to talk about - well, I also wanted to just sort of discuss some of the reasoning behind some of the price control recommendations within the Productivity Commission's report, especially in terms of calculating the price of aged care services and what those factors should include. If you're looking at the calculation of price it should not only include the cost of providing that care but it also should include the individual characteristics of the person receiving that care.

In terms of government support to assist the aged care market to transition to a new model, if there is a big shift in aged care providers who no longer receive bonds to an accommodation charge, what will that mean for some of the aged care providers who are currently relying on typically an interest-free loan and how will that impact their cost of financing that debt in the future and will they be able to access that debt to cover any shortfall in the amount of bonds if people switch from bonds to accommodation charges.

In terms of providing people with better information, the Productivity Commission recommends publishing information on the quality of care and also prices, but I would go a little bit further than that to say that the aged care must be also required to provide a much broader range of indicators, not only based on quality but looking at satisfaction. We can go towards a national health performance framework that's currently being used by the Department of Health and Ageing and look at different factors associated with aged care so the appropriate service is being delivered, the satisfaction of people within aged care facilities, the responsiveness of care and a whole series of other performance dimensions that probably should be included in any information given to someone in determining whether the quality of care is appropriate for the price that's being charged.

Also, finally, I just wanted to mention the debt equity release product in shifting financing to more an accommodation charge. You can imagine the situation where maybe people who no longer have to pay bonds can release equity in their

house, receive that money, transfer that money, or at least start within a residential care facility, transfer some of that money to their children and be left with just paying the accommodation charge. What would be the situation where an individual decides not to pay the accommodation charge any more but yet has no more assets because they have transferred those assets to siblings? To me, it seems as though some of the risk is being shifted on to providers; prior, when they have bonds, it's more like an up-front payment for rent. Now, if they shift to an accommodation charge, they lose control of that money and being able to access that money and therefore it's sort of like a rent charge on a per week or a permanent basis and therefore they're faced with a greater risk of people not being able to pay that rent. To me, it doesn't seem as though there are great avenues for providers to start receiving money through other means, especially if someone is going to be within their facility for another six to 12 months. It's not as though they can go down a legal proceeding, for example.

MR WOODS: Okay. You've raised a number of issues. I assume under the new combined Deloitte Access that people like Henry Ergas and the like, you're now all part of the one family and that you've been talking to each other and sorting out your respective views because I know Henry, for one, amongst others, has also been heavily involved in looking through the draft report.

DR CUTLER (DAE): Yes. I should probably also mention that these are more my personal views rather than the Deloitte views as well.

MR WOODS: Okay, thank you. That's helpful. One of the ones that you raised earlier on, the cross-subsidising, in fact we've had providers come to us saying that under current arrangements, they just treat all money in as money in and then they pay their bills. What we're trying to do under this arrangement is very clearly separate out the issue of accommodation payments and care payments. We don't envisage any cross-subsidising from one to the other at all. All providers would be paid equally for the care delivered if it's a common level of care, and if a person has been approved to receive a level of care, there's a price set for that care and all providers would get that funding.

The only issue there is what proportion of that funding constitutes the care co-contribution by the individual depending on their circumstances and therefore the balance of it which constitutes the government subsidy, which is by far the largest amount, anything between 75 and 95, up to a hundred per cent of the cost. But that is a very separate question to paying accommodation which you would pay either by a periodic charge or a bond or some combination of the two. So our reforms are in fact about removing the opportunities for cross-subsidisation which the current arrangement, because it's a bit of a blended system, can promote.

DR CUTLER (DAE): Yes. Just on that, I understand that that's what the

Productivity Commission report is all about and I congratulate that situation, but that's quite different from what the current situation is - - -

MR WOODS: Absolutely.

DR CUTLER (DAE): - - - where people are cross-subsidising, and that's the whole point of what the Productivity Commission recommendations are.

MR WOODS: Yes.

DR CUTLER (DAE): But my point was more about what are going to be the changes in how these providers operate? Have you thought about that? Now we'll see, you would expect, a reduction in the cost of accommodation, for example, but an increase in the cost of care because you have stopped really cross-subsidising from accommodation to care in some situations.

MR WOODS: What we anticipate is that, for instance, on the supported residents that the price paid to operators for the accommodation component would more properly reflect the actual cost of providing accommodation at whatever proves to be the agreed standard. Beyond that, it's up to them - if you're not a supported resident, then the provider can offer accommodation at a whole range of standards. Clearly they would charge accordingly but they would have regard to the market they're drawing on. Most providers know very well what the median house price is or the median dwelling price is in their local regions, what people can afford, what quality of accommodation they want to buy into, so all of those normal market operations would occur.

In rural and remote areas, we haven't given a lot of thought to that. Clearly, there are additional costs of supplying not only care services but in some cases accommodation, although sometimes land can be cheaper but construction costs higher and there are balances. But the current arrangements under the ACAR rounds don't dictate that there are different providers providing competitive and alternative services, other than to the extent of restricting the bed licence for some operators who could otherwise expand and delivering bed licences to others but who may not be providing good quality care or are struggling to keep beds open. So the current arrangement doesn't sort of create the perfect model in rural areas.

You mentioned about care needs and focusing on the individual needs and the cost of care. Again, under our reforms, we're not proposing that people try and fit into current packages and look like this because that's what the package is, that by breaking open all of those constraints that the care assessed as being needed and then delivered much more reflects the individual circumstances of the individuals and reflects the cost of delivering that care in a transparent manner. So we're trying to focus on those. We would appreciate your further advice on when you talk about

publication of quality indicators and you did mention the national health performance framework, but if you've got further thoughts on that, we do see it as important that consumers be informed and that they therefore have access to information on the full range of experience that they're likely to receive in various facilities or from community care providers. That's just as important as the resi care environment. We would welcome your further thoughts on what would be an appropriate transition mechanism, given that it is likely that a number of potential residents will seek to take up the option of a daily or weekly rental charge, rather than a bond, but not everybody. There may be blended options. This is yet to play out in the market, but if you have further thoughts on what would constitute an orderly transition in that process, that would be helpful to us as well.

DR CUTLER (DAE): That's really all I wanted to mention and discuss.

MR FITZGERALD: You raise the issue Mark just touched on, about the situation where you really have only two providers within a close geographic vicinity, and what do our proposals do. In a sense it's uncertain what they do; Mark will have to work this through. But recognising that, yes, you could have a dominant player and a less robust player, what is your concern and what is your response to that concern in this? Given that we recognise that in some rural and remote communities, clearly, a different funding model needs to be put in place and a different model will be put in place. But in regional centres more generally?

DR CUTLER (DAE): Yes, I suppose my real concern is that within this new marketing environment there will be a dominant player who will be able to charge over and above what the normal market rate would be, for example, if it was a competitive market. So if you have a particular region where people don't have the capacity to move to another region or they're really only faced with one of two choices, then they don't really have a choice and so therefore they can't exercise their power to express that they're not happy with the price; they basically just need to accept the price. Some providers you could expect, maybe, earning supernormal profits, because they're not faced with this competitive market.

MR FITZGERALD: This is really only in relation to the accommodation charge.

DR CUTLER (DAE): Yes, exactly.

MR FITZGERALD: Because the rest of it is capped in some way. Have you got a response to that; but what would be the mechanisms? We can have monitoring mechanisms and those sorts of processes, but have you got any other particular mechanism you think we should explore?

DR CUTLER (DAE): There's nothing, I suppose, that jumps out to me at the moment. You can either monitor or you can regulate, and you don't want to go down

a regulation path.

MR FITZGERALD: Not particularly.

DR CUTLER (DAE): No, exactly. I suppose it is more about, "Has the Productivity Commission thought about these implications," because there was nothing mentioned within the report as to these perverse outcomes that could occur.

MR FITZGERALD: That's good; thanks for raising that. Sue?

MS MACRI: Just the death equity release product and the transfer of assets to siblings. Again, that's been raised a number of times and we are looking at a deeming process to have a look at that.

MR WOODS: That's standard in a lot of other government programs; that any transfers that take place within five years of needing access to a particular program are seen as to whether they're a way of avoiding obligations and therefore the intent of the transaction is unwound even though the actual dollars have flowed. So if somebody has handed over a large sum of money within a period of years prior to or even during their stay then they're still deemed to be able to meet that payment and where the money has flowed is where the obligation flows.

DR CUTLER (DAE): Yes, okay.

MR WOODS: Thank you very much.

DR CUTLER (DAE): Thank you for your time.

MR WOODS: We will adjourn for lunch and resume at 1 o'clock. Thank you.

MR FITZGERALD: Yes, thanks.

(Luncheon adjournment)

MR WOODS: Cameron Way, isn't it?

MR WAY: Yes, that's correct.

MR WOODS: If you could, please, for the record, identify your name and if you are representing any organisation.

MR WAY: Yes. Cameron Way, citizen and guardian under the New South Wales Guardianship Act to a resident of an aged care facility in New South Wales.

MR WOODS: Thank you and thank you for providing us with some background information. Please, do you have a statement you wish to make?

MR WAY: Yes, I've got a number of points, if I may. Are there two or three people?

MR WOODS: It's all right, please proceed.

MR WAY: Okay. First, in terms of our role in the aged care sector for the last 10 or 11 years, we've made an effort to make evidence based submissions and be quite professional in all that we've done in exercising the - - -

MR WOODS: Sorry, when you talk about "we", who do you mean?

MR WAY: I'm referring to myself, my mother, and her husband as the three key family members, guardians and case managers for my sister. I'll outline her situation in a tick. Just being evidence based, I would like to verify our credentials by experience of commenting on the aged care sector. When my sister had a car accident I began keeping a diary within a month. If the commission would like to have a look, they are all my journals, and the latest one, for our journey in the aged care sector in the last 11 years. I just wanted to offer that transparency.

As I said, I'm representing my sister and our journey in the aged care. I just wanted to say congratulations to the Productivity Commission on a different front; that is, with its review of disability services. The position that funding needs to go with the person with disability, so that they can compete and service providers have an incentive to meet their expectations, is absolutely critical and I want to really complement the commission on that point.

In my case, we've been in the aged care sector for 10 of the last 11 years. In our case it was a young person, my sister, who had a car accident, a brain injury, and I'll give you a very brief outline of that situation, because it's relevant to what comes next. But I want to say that even though she's a young person, it has given us a

window on what's happening in the aged care sector generally. The comments I make are not individual for our case; I want to make that quite clear. In the process of the last 10 years, we have often travelled on public transport, trains to the country and so forth, and I've raised mention of the aged care sector and I'll have two or three members of the public who want to tell me their horror stories. So I've had a chance to verify the key points I'm making here as valid for outside our individual case.

In our families case, my sister had a car accident in her early 30s. Her flatmates were fine, but unfortunately she had an acquired brain injury as a consequence. There was no compensation in New South Wales, even though there's a compulsory Green Slip scheme, because trees don't have green slips. So she had all normal five to 15 million dollars of lifetime care, that would have been recognised for her injuries, disappear like that, and we didn't have much money. So it was a very difficult situation and we had no money and she had no recognition.

She went into the public health system, which we found as stressed in terms of staffing as the aged care sector, and after 12 months she still needed high-level care. But we observed a capacity for her recovery to maybe a semi-independent level of independent living. So we had to find a place of high-care and, as young people did back then in the early 2000s, she had to go to an aged care facility. We were very fortunate in that we had a young, progressive DON at a nursing home near where her friends live, in that region of Sydney, who wanted to have a young person in the nursing home because there were staff-morale issues in her aged care facility. She understood the issue of young people and was hoping that if her staff had someone who was young and who could recover, that would help their morale. So we also had a room on her own, which is a rare thing in the aged care sector, which was absolutely critical, because we needed to provide in-reach rehabilitation as a family, without interfering with another resident; a wonderful situation.

We moved her there and I noticed that in the first couple of weeks, when my sister Fiona was very welcomed and was positive - for example, even though she hadn't been speaking, began to speak; have a full, intelligent conversation with all her friends in the room, in a normal adult intelligence - which is the demonstration that her injuries did not make her intellectually disabled; so she's fully aware. What emerged in our case was that the deputy DON, with staff coming forward to us indicating that they had a workplace bully in that place, and that deputy DON preceded to keep the staff captive to how they were imposed with a young person inappropriately and ran a campaign of victimisation of myself, my family, and my sister that, indeed, actually threatened my sister's life, I think, in several respects. That emerged over the first 12 months.

They were the circumstances we were led to need to exercise, as a last resort, complaint processes in the aged care system. We did so. I'd like to put on record that we had support from a unit called the Private Guardianship Support Unit within

the office of the Public Guardian of New South Wales and within the Attorney-General's Department. After three years of three family members exercising all possible complaint processes of a severe abusive situation in an aged care facility, that unit was saying our family was professional, thorough, had exhausted possibilities they hadn't even considered, and had acted more thoroughly than any family they'd met in 20 years. The reason why I think it was relevant to my story for the Productivity Commission is: we are the test case, as a family, of whether there is appropriate scrutiny of care and abuse and adequate care in aged care.

I can say that, after 10 years, we are hoping to get my sister out this year; I'm very excited about this, it's been a long battle. I believe her case has played a part in the recognition of young people in nursing homes and the national changes there, and the Lifetime Care scheme in New South Wales. I have to say, having begun with the cracks in the system, where my sister ended up in an aged care facility, three dedicated family members who wanted to rehabilitate that person, we have spent over the last 10 years somewhere between 100,000 and 500,000 dollars of staff, personnel, and government resources to make sure that effort failed to produce the worst possible outcome, and I think that level of cost and failure should be noteworthy and significant to the Productivity Commission.

There's also been the cost, separate to that, of the five lives, separate to my sister: there's my mother, who was a psychologist, counsellor, had her own business, she recognised attention deficit in children long before drug companies discovered they can make a lot of money out of it, was a pioneer of peer support in Australia - she invented peer support but was never able to follow through. Her husband has been on the board of an aged care nursing home, is an architect in the aged care sector - is a renowned architect for the Australia Club, for example. Myself; unfortunately my life isn't as productive, I've had chronic fatigue syndrome since I was at school, but I'm making a slow, gradual recovery from that, but I was considered to have pretty good science skills by CSIRO when I had a job there and so forth. So we have three people, who are very competent people, to advocate on behalf of my sister and exercise the system. Also my son - my partner left halfway through - then he was at high risk, running away from the other household to me, and I had to then fight that in court as well. So there was a period of time in view of raising complaint that I had all three members of my family at life risk as a consequence, including my sister.

In terms of complaint processes, there are a number of points I would like to make - and I'm still on my major points here and I'll try to keep this tight. From our on-the-ground perspective, there is much complaint in the aged care sector of the immense burden of paperwork with complaint processes, but I want to say that the industry has put itself in that position quite consciously, in preference to genuine random, no-warning inspection, on the ground directly, in aged care. So why they

complain to much: it's an avoidance tactic to be really accountable.

So I can say, after the last 10 years, while my sister and the circumstance have improved slightly when the workplace bully was eventually recognised and the facility quietly removed her and retired her. But really nothing has changed in 10 years and the Aged Care Standards and Accreditation Agency, despite all our engagements, has still given, other than a few slight taps on the wrist, full accreditation of this facility, and we speak to other residents of aged care facilities and they have, not only concern for my sister, but also concern for the realities of the same factors and that nothing has changed.

I can give you an example of how serious it is. In my sister's case she has lost some of her swallowing reflex. If she is fed lying down she can choke and die. No matter how much you - after nearly 10 years it's still happening. She has requested not to be showered by male staff. There was a period where we learnt from staff that she'd been heard screaming and could be heard below the reinforced concrete floor downstairs when two or three males who had rostered themselves onto her roster would shower her at 6 o'clock in the morning. No-one had even told us and we were actively involved guardians. So these are the kind of levels. In fact, our family has described her targeted psychological abuse by the workplace bully holding the staff captive, who were innocent parties - we can see no difference to the way that process sought to destroy my sister as a human soul as what you see on the public media with Abu Ghraib. There was no difference. The props are different but the quality of abuse was orchestrated, determined and relentless. Basically there has never been any recognition there was a problem. Aged care standard accreditation all ticked after 10 years, no problems. That's the level of credibility of the complaint system at this stage.

Now, in terms of - and one of the things I want to make a point here: if you want an effective complaints system it has to focus on the final synapse connection in the system, the hands-on carers with the residents. When you have a paper process all places simply can document - as the workplace bully had a sign in her office, "If it's not recorded, it didn't happen." I realised after that what she was saying is, "Whatever happens that's wrong, don't record it because there's no evidence." That's where all the complaint processes fall down. The evidence is the paperwork and the people who are abusers in the system control the paperwork. So even when it comes to legal options you've got no evidence.

Now, equal accountability, random reviews. I remember engaging, after six months' work, the then state-based - what was it called, PDSU? I've forgotten the name at the moment, it's probably in my list there, but anyway, they were a unit that could come in and do random inspection. I clarified with them that when it came to that body there was genuine random inspection. In a situation where my sister was left covered in faeces for three days, was dehydrated, hadn't had water et cetera I

organised them to come in for the first time to try and catch some evidence that there was real abuse in the nursing home. That was the one day in that whole year that when we turned up that morning after he had been, the whole place was spotless. They found nothing. When I pressed them, "Yes, of course, there is this courtesy 24-hour warning call before a random inspection," off the record.

I noticed that having had chronic fatigue syndrome and having to be on unemployment for a while because I really wasn't capable of working, that I can get six random inspections on social security because I'm using $12,000 of public money. Here is a public system that handles hundreds of millions of dollars of public money and hundreds of millions of dollars of private citizens' money, hard earned, and a random inspection is quite fine for a social security recipient to give accountability for 10,000 or 12,000 dollars but there is this, "Oh, we can't do that for poor corporate organisations managing aged care." I find that difference in accountability really offensive.

Now, past government policy. I don't have a political view one way or the other when it comes to Liberal or Labor, but I do want to make this point, because I think it's relevant to the Productivity Commission: under the previous Liberal government one of their strategies to present as good economic managers was they forced people on welfare into the low-paid jobs in the aged care sector and they cut funding and then gave a little bit back near the end. What this did was it brought an influx of a lot of workers who were by the time they travelled, did their job and went home were the working poor and weren't much better off than if they were on Centrelink. They weren't the caring type. They were resentful at their position. Their quality of care to aged care residents was so poor that a lot of the good caring workers become so distressed - and I've spoken to many who have ended up leaving the aged care sector because they could not continue to bear the emotional trauma of seeing the way aged people were being cared for, and so they streamed out. So that policy produced a process where they streamed out the good workers in the aged care sector. I believe just - I've got no qualifications but I would say it's going to cost about 500 million a year for the next 10 years to get those caring people back. You can't teach caring attitudes at TAFE. You've either got it or you don't.

So that was one of the ways that fundamentally failed the aged care system. At the same time you've got a government that presents, "We're good economic managers," but that cost and that saving was transferred to the real suffering of hundreds of thousands of people in aged care. I find that view reinforced with many people who are hands-on workers whenever I travel. So I check this out with other people, make sure it's not just our story. I think that needs to be highlighted. I also found during that period of the last 10 years that in all the processes if you're actually in it - not what's on paper - that the primary citizen is the corporate body, not the resident. That's a culture that has to change.

On to some other issues. They're my main points, on to some other issues. Rate of staff turnover. Because of the strapped system most nursing homes have to hire a lot of agency staff who come in short term. I've been a residential care worker working with children with disabilities as a casual. You can't come in and read 25 case management plans; carers for aged care residents. So when you have 30 or 40 per cent of your staff, which some nursing homes are forced to, with that kind of walk-in, walk-out workers you are not getting quality care. It's not possible to get quality care. There is suffering in the aged as a consequence. So this is where the aged care workforce is so critical to improving the quality of aged care. You've got to have stable staff. That also applies to the public health system, as far as I'm concerned.

Also too there's a tendency of agencies to hire people from a diverse range of cultural values and experience. That's fine, but you do need to recognise that different people from overseas from different cultures have different values around ageing and dying. Language is also another major issue. I know if someone came in here and was suddenly speaking Spanish and waving their hands in the air and then walked out again we'd go, "What was that about?" Maybe if you understood Spanish they were saying, "There's a fire three floors up and the fire system isn't working, you need to get out," and we would be none the wiser, in the same way that we have people who can't speak English who cannot transfer essential daily information to enable effective care.

For example, in my sister's case you must not feed her lying down otherwise you will kill her. Just to explain that, think what happens to my sister who is intelligently aware. She is faced with the threat of choking, which is a very horrible sensation, with the possibility of being hungry and starving. This went on for eight years. I mean the problem we have with my sister now is she has become so intelligently aware and withdrawn in herself that we've had to argue at state government to have a transition stage where you can get her out feeling safe in order to get her back to be available to be engaged to rehabilitate her. Thankfully I've won that argument, with a lot of work, last year. Very excited about that change. If you have a Greek-speaking nursing home with Greek residents, the staff need to be able to speak that language. So language is important. It's not a discrimination issue, it's an essential.

Also nursing homes - people need to be where their families are. Some nursing homes are in wealthy areas. Unfortunately when you have low-paid workers they can't afford to live in that area, they have to travel a long distance. They're suffering as workers. You do need to make some accommodation of supporting, for example, travel costs for people so you can have equitable levels of care in all aged care facilities irrespective of socioeconomic background.

Workplace sociopaths. I think sociopaths unfortunately in the

workplace -3 per cent of the population - is a national issue in its own right. I'm tired of the poor schizophrenics getting the blame for all the behaviours that actually belong to an entirely different psychiatric category. But I just refer to David Williamson's play and Monsters in the Workplace by Dr Clarke at Sydney University, they're very good books. These are very toxic people. They're often highly skilled. When you have a stressed workforce the nursing homes won't remove those people even if they recognise they're undesirable because they're afraid of failing accreditation because they're not sure they can replace them. The damage that does - not only to residents but to workers and the whole costs structures. We found out with our particular workplace bully, with a bit of background work, there were serious questions over their performance at a previous nursing home. We had workers coming and tracking us down and speaking to us confidentially. Of course everybody is afraid to speak on record, so we again have no evidence to act.

Now, I've produced a funding graph. I'd like to explain that briefly. This applies to the aged care sector. It also applies to public health systems. For those in here what I'm pointing out is that there has been a tendency in policy in the last 10, 15, 20 years to keep shaving down the funding for public hospitals and aged care. There is a point where, as we found in the public health sector, you've got a system so stripped down and so tight that you've got everything in place like a cardboard cut-out but because it's so stressed the availability for professionals - take, for example, the rehabilitation doctor for my sister. They have the skills, they have the capacity but they are so stressed they haven't got the time to competently apply their skills to any one person. So you get a system that's basically just like a fibrillating heart. It's all funded but it's minimised and it's like a cardboard cut-out and you're not getting productive outcomes. So I'm saying that in terms of funding you'd look at what is the sustainable level of funding to get good productive outcome for the dollar.

Euthanasia is a controversial issue, and I'm not very much involved in anything about euthanasia. I know with my sister the first question I asked is, "Should we switch off the machine?" when she's in intensive care, and we were told she was one level above that, and I have checked with my sister, despite all her suffering, "Are you glad you're alive?" and she says, "Yes." So I'm very pleased with that. But there's one point I want to make that's relevant to looking at aged care and the future euthanasia debate.

As a human species we have developed - and I'm very thankful for this - a capacity to intervene and put off death. That's great. But one thing that is wrong is if we fund a system such as intensive care that puts off death but then doesn't have the capacity to ensure that that person's future ends up being a fate worse than death, then I think that is one area where there is no moral quibble that that's wrong. So in terms of the enormous costs and the capacities, you know, you can't keep someone alive and then leave them in a situation where death would be a gift, whether it's a

young injured person or an older person.

That's what would potentially have happened with my sister, if it wasn't for our actions. By the way, the outcome of the workplace bully in the end - which I'd like to come back to - was that, having presented that Fiona had challenging behaviour that was extreme - it was confirmed by many as not - the final step of her rule was to try to remove us as her legal guardians so that they could sedate her for the rest of her natural life, removing any chance of recovery for life. I see that as criminal intent; no-one is interested. Further, in terms of going to the Guardianship Tribunal hearing, which is a court, in three years we were never allowed to know what the outcome of our complaint processes were, because it's all commercial-in-confidence, and nothing changed.

But what I did offer - this is the test of whether there it is just self-interest or it's genuine - I said, "Okay, we're going to the Guardianship Tribunal. This is a court. This court needs to have access to appropriate information to make a good determination of whether we are negligent guardians or we're fit guardians. Part of that is the quality and character of the nursing home and the outcomes of our complaint processes." So I said to the compliance section of the Commonwealth government Department of Ageing, "We think it's reasonable - since you can't let us know, because it's confidential, fair enough - for you to provide that to this court, so the court has all the information for it to make a fair determination." The answer, "No." So we went to defend and stop my sister from being inappropriately sedated for life with no evidence.

If I went round drugging women's drinks at the local nightclub and had sex with them, that would be seen as quite serious. I don't know how it's any different. I'm sorry for my emotion, but it has been a long ordeal and I'm determined to make sure the truth on the ground gets known, because I want the aged care sector to change, and if there's one thing that helps our trauma it is to see positive change come out of our experience, and that's why I'm speaking now here. We're into our 11th year.

Medical costs too, which is part of the aged care, we have got a limited budget as a government and as a people, I think we have to look at the cultural thinking around that. Also as part of our efforts one of the things we did was we ended up actually going and designing - we have an architect in the family - an appropriate aged care facility for high care. When we looked at all this, thinking of what needs to change in the system, we found facilities in the community that support high-level respite care - support, come in, rehabilitate to maximum independence, go back in the community - works as much for non aged disabled as it does for aged. So there's common ground there, because, if you can maximise people's independence, you save our long-term cost.

Lastly, I have mentioned "Aged care, an Anglo-Saxon issue," one of the comments I heard on the radio, which I thought was very good. A woman rang up when they were talking about the cost of aged care and said, "It's an Anglo-Saxon sort of issue really, because, you know, in our cultural background we all look after our aged." I thought that was a very good criticism and a very good point. Therefore I think, in terms of the huge costs that we're facing over the next 40 or 50 years, we do need to look at the level of excessive nuclear family and isolation - I think we're all suffering from it - and therefore we need to look at some cultural change as part of the solution of meeting this cost. They're my points. Thank you.

MR WOODS: Excellent. Thank you for coming. I think we can fully accept your background and bona fides, so we won't need to dip into the individual diaries. But thank you for bringing them to our attention.

MR WAY: Any further questions too, feel free to follow up with me.

MR FITZGERALD: Yes, I do, a couple of things. I should just preface that I used to be the Community and Disability Services in New South Wales, which was the ombudsman for oversighting those services. It didn't include aged care. One of the schemes that was operating in New South Wales and has operated in a number of states in relation to children's services and disability residential services is the notion of the community visitors. These are not the inspectors, but they are visitors that visit residential services - - -

MR WAY: To reduce social isolation?

MR FITZGERALD: No, to in fact monitor whether or not the standards are broadly being maintained, and an access point for people who have grievances. It is that third party randomly turning up, but not being the regulator. I'm just wondering whether you have given any thought as to whether or not that sort of system would have had any benefits in your case. The reason disability is so important is because for so long it was a closed system, and it has gradually opened up. I'm just wondering whether you have given thought to what would be the practical ways to improve the system, in terms of those random visits. You have got the random visits by accreditors and/or the regulator, but what would have made an additional difference?

MR WAY: I think in our situation that could have been of some assistance, in that when we raise a complaint it's so easy to alienate our presentations as exaggerated perceptions, a grief-stricken family inappropriately blaming a nursing home, out of the trauma of the situation and so forth. I think if you had some other people coming in and a less threatening way, in terms of the facility, and able to talk and engage with the residents there's more opportunity to have an independent second person go, "Look, there are issues." Just simply having another set of eyes go "Look, it's not

just family with distorted perception; there are serious issues" would have gone a long way to enabling formal complaint processes and more attention to be paid. Is that helpful?

MR FITZGERALD: It is. The second thing is, what do you actually think went fundamentally wrong with the complaint-handling system itself? I understand clearly you were very dissatisfied with the process, but what went wrong? Some people think complaint-handling systems by nature work well and some people think they work very badly, often depending on whether their grievance was dealt with in the way they wanted it or otherwise. But in your case you're talking about a very long period of time. You have indicated that there was evidence of individual and systemic abuse taking place. Even the worst complaint-handling processes normally picks up on those sorts of issues and deals with them in some way. So what do you think went fundamentally wrong?

MR WAY: That's a very good question. In terms of the complaints resolution scheme - I actually felt that was a very good scheme, even though in our case it took a long time - because you've got such a massive number of broad-ranged complaints. It starts with, "Have you talked with the nursing home itself directly?" and that's negotiation. Then there's a mediation, where it's a process where you attempt to work out between the two parties. Then there's the termination, which is more a review of the committee. We thought that three-stage process - even though for a serious complaint it takes a long time - was very good; we couldn't see a better way to do it really. It wasn't actually that process that failed, it was actually the big stick people to follow up once we got resounding decisions in our favour, then a review, then yet a stronger decision, that's when everything failed, nothing happened.

MR FITZGERALD: Can I just ask this question, without going into the detail?

MR WAY: To get back to your point, the way to improve it is this. I believe you need people who can come in and talk directly, fearlessly and without intimidating the staff, with the hands-on carers and the residents. That's the level you have to access. In our situation the evidence was with a witness, and there was no-one who'd come in and gather the evidence of a witness, and that's where it failed, in a nutshell, and I have held that view since we did that. Does that answer your question?

MR FITZGERALD: Yes.

MR WOODS: Thank you very much. We appreciate the time you have taken to come and provide the evidence.

MR WOODS: Can I ask John Trounce from Maranatha House to come forward, please. Thank you for your cooperation in the rearranged schedule.

MR TROUNCE (MH): That's fine. No worries.

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

MR TROUNCE (MH): My name is John Trounce. I'm the chairman of Maranatha House of Wellington. It is a not-for-profit retirement and respite facility that started off as a low-care facility and has moved, with ageing in place, into supplying higher care accommodation.

MR WOODS: Thank you.

MR TROUNCE (MH): Can I just make one other statement?

MR WOODS: Please.

MR TROUNCE (MH): I feel like a bit of a foil about the last speaker. In some of the points I'm going to bring up, I would think he would like to challenge me and I would like to take it up with him later because there is some difficulties in that complaints area on both sides of the argument.

MR WOODS: Please, have the conversation. Yes, please.

MR TROUNCE (MH): Right. First of all, thank you for the opportunity here. I feel like a minnow here today but after listening to the speaker before me, I feel that you have a very open door to all of us. There's much in this report that gives us hope for the future of the industry. I've only been involved in it for five years. The first year I came in knowing nothing about it and for the last four years I've been chairman. So it's been a dramatic learning curve for us, but we do see some failings that we need to get on top of.

The first failing or the big problem we have in a rural area with a low socioeconomic group and with retired rural people is the raising of bonds in our rural community poses a major challenge for many reasons. We have a significantly low socioeconomic demographic. Older members of our rural families often reside on properties under the care of their children. The difficulty of substituting a bond holder that passes away with an equivalent bond holding is a major problem to us compared to what I would think would be the eastern coast experience. There is often a lack of consistency in audit recommendations from one auditor to the next. It leads to confusion with the floor staff and causes difficulty with staff respecting

management who are constantly trying to comply with audit requests so to optimise the funding received from the government.

Condoning - this is where we're going to have an interesting exercise - anonymous - and I will emphasise "anonymous" - complaints to the complaints department of Health and Ageing can create operational problems. For example, Maranatha House has suffered a number of vicious, spiteful, personal and completely without foundation complaints after repeated visits from the complaints department. They have never been able to find any reason for the justification of these complaints and I take note of what was said before about if it's not written, it doesn't exist. We have had written diaries - as you know under the ACFI and the operational exercises you have to do - and we have had interviews with residents from these people to try and verify it. So if we were trying to hide something, it would have been found.

This is all brought about by the bullies within the staffing systems we have. When you start to get on top of them, they use this as a weapon over your head as far as management and the board is concerned and it's used repeatedly. Over 11 years, one person - we were getting complaints to us and we couldn't base where they were coming from. 11 years later we found out where it was. Unfortunately that person has moved off and now we probably have a legal case on our hands but that will be much nicer than having the constant complaints. It is very, very concerning.

I believe a complaints committee is essential for the ongoing protection of our residents and particularly our residents. But I'm bewildered by the fact that it has to be anonymous always. My own personal opinion on anonymous complaints is I have great doubt about the validity of it. But I do understand the need for anonymous people who feel they have nowhere else to go and they need to be protected. I do fully understand that. What our board has instructed me to say to you is we would like to be notified of a complaint - not the person who made the complaint, be notified of the complaint - and be a joint partner with the complaints commission to rectify this problem. We can't be constantly getting complaints and be not part of the loop. We need to be part of the loop to be able to rectify the problem.

With the possible deregulation of the industry, a number of issues occur to us. We need to do away with the different awards for employees between not-for-profit and for profit. Now, I understand on the modern award and the different agreements that have been made in the industry, that is inevitable, but we have a major problem, where in a small unit like that, we work on an award basis and we've accidentally been given the wrong award. It's cost us $25,000 over a three-month period purely and simply because we were given the wrong advice on what award we were running under at the time. I don't understand why the not-for-profit people have to pay more than the for-profit people. I just do not understand it.

The deregulation of the residential places will possibly cause a blow-out in the demand for government support for these new residents and make it even harder to attract funding for supplier-required services for established day care facilities, a major concern to me. The ability to attract government funding to assist communities to expand their residential position will be greatly diminished. We see in a small rural area, where a community puts its resources together with a dollar-for-dollar type arrangement is the only way we've been able to put these nuclear bodies together that satisfy - if I may use the colloquial term, the "village ownership" concept of a facility within its community can do it. Unless we become part of the large bodies of retirement industry players, we have very little chance of surviving in this world of very low returns or very low income. We have to stand alone in all the facilities. We cannot share our overhead costs in any way, so we have to stand alone and our costs are prohibitive to produce a profit that will allow us to sink into future development.

The expansion of funding of new residential facilities will only be granted to those facilities providing residential services on site for other disadvantaged members of our community detracts from the prime function of facilities such as Maranatha House. That was touched on earlier today with the early onset of dementia. We have been compelled to take some on. That's fine. Our staff will do the best they can but they're not trained for those people. The comment about the physical strength of these people is very real. We have had people knocked over and it's not intentional, it's just purely and simply the nature of the people.

Our whole ethos within the community is that this is an aged care facility. We've got people who have been there up to 18 years. They are so distressed by having people being cared for who are not part of their normal social set in which they live in. We have said under the licensing agreement, we do have to take these people. There's no argument about that and we do it the best way we can, but I don't think it's fair. It's even affected our ability to attract capital funding in our last round because we did not say we were going to do more beds and places for these type of people. I think it's a mistake. I know there's probably good examples why it should be there, but really for a small stand-alone unit, you're asking too much of us.

The concept of resources to support a person in their pre-dependent life or support them in a care position is an ideal situation, I say ideal, but there are many factors that could preclude this from happening and they are in the rural sector and all small businesses in the rural area, the ability of those businesses to continue on is that those businesses over a period of time are transferred to the next generation. So the equity that the person who's retiring has in that is zilch. They are there as a guest of their children. This just leaves us no ability to attract a bond. Now, I know there's an option that we can gain from the government a supporting contribution. It is nowhere near strong enough to be able to do the work we need to do.

We have taken the attitude with bonds that anyone over $200,000 who will deposit with us, we don't do the monthly drawdown because the interest rate we can attract on that $200,000 or better is far better than the drawdown plus the interest on less than $200,000 and it's also an encouragement to the family to use their asset to raise the funds to keep mum and dad there. So it has worked well, but there is only a small percentage of our community that's in a position to do that. So we don't have the opportunity to raise those funds for our maintenance, do our capital depreciation expenses and those sorts of things. That's where we're running into trouble. We can cover our cash expenses, our running costs, but to cover our depreciation and our maintenance costs, we are just being left - blown out of the water.

The need for a full-time RN who is responsible for the health matters of our residents though desirable is a financial cost that is difficult to support with the present funding arrangement. Maranatha House has a general manager who is an RN and who is currently covering this responsibility as well as that of managing the facility. Our board considers that the industry can only remain viable through multi-skilling of its senior staff. We were pinged last time with an unannounced visit. I must say we didn't get 24-hours phone call before the visit, they just walked through the door, which is excellent. I have no complaint about that because the way our system is working we have no fear of anyone walking through our door. But we were pinged because the person we were sharing with another facility in Dubbo said she just couldn't keep the work up any longer. So she was doing two days a week with us overseeing the medication. She had to pull the pin.

There is just no resources left in our area to be able to put another RN in. We just don't have them. They don't exist. They're like hen's teeth. We just said to our general manager - she offered to us, "Look, I will look after both those facilities. I'm available 24 hours on my phone." Even when she goes away - she will always go away, she loves camping - she will not go anywhere she hasn't got mobile coverage. So she is on call 24 hours a day, 365. So that's how we cover that. We have an EN, who is very efficient, and we have a couple of grade 4s and the rest are 3. We believe that regulators determining accreditation standards expect industry best practice, and who wouldn't? But that's a high cost, and the funding is gauged by the lowest-cost operators within the system. It's a minus. We are being wedged out of the system or sandwiched right out of the system.   I'd like to talk about some other things too if I could. Have I got them?

MR WOODS: Please.

MR TROUNCE (MH):   This whole business of staffing has been a nightmare for us for the last five years. We had a very dominant manager who had no qualifications in the industry except she was an extremely good financial manager. The new board and she clashed and she left. We have had four years of hell by bringing people in who had no understanding of the industry, by people who are in

there already who were already very strong-willed people who had been educated by this manager to be strong-willed people to get exactly what they want. We had a Catholic nun who was very used to being in a cell and thought everyone else had to live in a cell, which made life extremely difficult. We are winning. We've got a lovely lady who came in from the industry who has had 20 years' experience. We are still whittling out people and we are still getting complaints because these people believe they have the right to cripple us.

Staffing is a desperately hard thing to get - good staff are the most valuable people you can have. We would love - and I was talking to my manager the other day. We would love to get to the situation where we can say, "Look, there's about 12 of you people who are fantastic staff. We'd like to be able to put you on as full-time permanent people" - not just permanent casuals - "put you on as full-time permanent." We may have five or six other people we can pull in when we need to because our activities go up and down as our demand is required. We'd love to do that, but the way the funding is done we cannot afford to do this because we have to be able to cut people's time back according to the cloth we've been served with. It's a major, major problem. I believe if we could have full-time staff who could develop a collegiate attitude towards their workplace it would be a far better way to work. I think that the Productivity Commission would see a great deal more return - social return and financial return to the age industry.

It's most important for us to survive in our town - and I am saying survive, because we're employing at the moment on a casual basis about 50 people, at times we're up to 60 people, which covers the cleaners, the cooks and everything else. That's a big input. We're putting a massive amount of money into our community. We buy as locally as we can. So therefore we've got penalties on our costs overheads. I heard earlier that - you mentioned the fact that the rural area does need a different formula. I'm pleased to hear you say that, but please have a very long hard look at what the formula is going to be so there's equity for the residents, primarily, in what they get but there's also an ability for the community to give their residents a fair go; good job.

MR FITZGERALD: Can I just clarify, we're talking about rural areas though. We are interested in rural areas - except to say that 57 resident beds is quite a substantial service, it's not the 10 or 15 that are struggling to survive.

MR TROUNCE (MH): No.

MR FITZGERALD: So can I just ask a question before Mike - I just want to clarify - this is a low-care facility?

MR TROUNCE (MH): It started off as a low-care.

MR FITZGERALD: And it has some high-care residents?

MR TROUNCE (MH): We have ageing in place. We also have in town a nursing home, which is part of an association from Dubbo that our - it's a very good place. I've got no argument it's top grade, but our residents live in fear of being transferred there. So that's why the board previous to ours adopted the ageing in place. When they adopted that they put another wing on that allowed them to do higher care.

MS MACRI: So sorry, that wing is specifically high-care beds or were they low-care beds?

MR TROUNCE (MH): They started off being under the heading of dementia beds.

MS MACRI: Right.

MR TROUNCE (MH): Now, as time goes on we've found the population of our high-care people - dementia is probably about 30 per cent.

MS MACRI: Yes.

MR TROUNCE (MH): They're just highly-dependent people who have gone into that wing.

MS MACRI: Okay. What size - - -

MR WOODS: But it's not a high-care as such?

MS MACRI: It's not a high-care - - -

MR TROUNCE (MH): It was never designed as a high-care unit.

MR WOODS: Yes, sure.

MR TROUNCE (MH): It was just an extension of the low-care into a higher care area. But as far as the auditors are concerned when they come, it's classified as high care. They are constantly changing the posts which we've got to meet. We had one one day - and I don't - I probably shouldn't say, but I'm going to say. We were pinged purely and simply because one lass had put a piece of paper in a plastic file around the wrong way. We were made, for that particular section, non-compliant. We then also had recently our three-year accreditation done. We came through with flying colours. Within three months we had a different person come and completely interpreted the medication form that we were working on - jointly worked out with the doctors and the chemist - said, "No, this is no good. You're non-compliant." When one auditor says one thing and one auditor says another, we are just

undermining our management and our staff morale tremendously.

I would like to refer one little comment to you. There's a book written - I forget the lady's name now but it's Why Do Nurses Eat Their Young? If any of you have not read it I strongly recommend you to have a good look at it.

MR WOODS: Just to answer Sue's question, the number of people who - or the number of beds in that - - -

MR TROUNCE (MH): 57 units.

MR WOODS: In total, but in that separate - - -

MR TROUNCE (MH): There's 15 in one and 40 - - -

MR WOODS: Sure. You've raised a number of issues, and we understand where you come from on those. If I can ask a slightly more generic question - - -

MR TROUNCE (MH): Please.

MR WOODS: - - - because you mentioned that you've been on the board for five years and become the chair for the last four. Now, that's - again, particularly in community areas that's not an uncommon event and you, suddenly, as you say, enter into a very steep learning curve. What is the quality of support that you receive (a) coming onto the board, and (b) becoming the chairman? I don't mean from your colleagues on the board or in the community but more broadly from the peak groups and the like. Do you find that stepping into this role has been a transition that you're able to reasonably accommodate because you were given support and assistance and have reference points that you can go to?

MR TROUNCE (MH): Well, I can say the first thing is we're very well serviced by the association we belong to who gave us a lot of legal advice and advice as far as - well, it was basically legal advice we used for drawing up contracts of agreements with managers and all this sort of thing and legal advice as far as when we had difficulties with staff and how we managed staff out and things like that. As far as getting to understand the industry, two or three of us went around other areas and we used other establishments to educate us. We were very, very lucky that the lady who ran an organisation in Mudgee came over and spent time, three times she came over, and actually sat down and educated the new board on how the aged care industry worked. That was a wonderful framework for us to develop an understanding under. But the other side of things is, it's reading, trying to keep in touch with things; it's just simply that if you take on a responsibility, you've got the responsibility of educating yourself to a fair degree, and bringing commonsense that you've learnt from other areas of life to it.

MR WOODS: Yes, and you're not alone in that steep learning curve. But in terms of the actual operational issues, I think you've explained them sufficiently to me; I don't have any further questions. Robert?

MR FITZGERALD: Just this issue about the bond. As you know, our proposal doesn't require bonds.

MR TROUNCE (MH): That's right.

MR FITZGERALD: We accept that in some areas bonds are more readily available, in other areas they're not. In order for you to be able to refurbish and reinvest in your capital, your buildings and that, I presume you're going to rely fairly heavily on supported residents contribution from the government.

MR TROUNCE (MH): Yes.

MR FITZGERALD: And to some degree the equivalent of that being paid by individuals. Is that going to be sufficient? We agree, and our report indicates that the government's contribution needs to increase, so in a sense we would say that needs to be costed, taking account of the capital needs. But over and above that, what are you recommending or what do you think we should recommend in relation to the capital costs, both in terms of refurbishment and expansion, if that was necessary?

MR TROUNCE (MH): Right, there's a number of issues for me in that. First of all, I believe we should maintain the bond. The bonds, to us at the moment, we are not using them as security; they are purely and simply interest-earning deposits, because - if we can just deviate a little bit from your question for a moment - the reason we are not prepared to put them in as security for any loans is the fact that we may lose someone who has got a $300,000 and therefore we are left in a situation we cannot function without going into a further loan, so we're not going to do that. But it does contribute towards, as I said earlier, an overall pool of money which allows us to meet our commitments. Technically, on our books, the bond money is being used for maintenance and reserves for our depreciation. We're physically doing our maintenance, but we're not meeting our depreciation which would allow us to generate an income to be able to invest in the future.

What we did last year with our application was, we asked for a capital grant and we would match it three to one; in other words, the government put in two and we put in one. It was a three and a half million dollar exercise. We were knocked back purely and simply on the basis that we were not going to cater for other people in the community. I also think the long history of these anonymous complaints worked against us; they felt we hadn't got on top of our management, because they

were still getting these complaints, and who would want to invest in an organisation that was getting these anonymous complaints. So I think that was a factor.

The other option we had was, what was called, a no-interest loan; in other words, whatever the inflation rate is at the day you're paying for it. No matter how we sat down and looked at it, if we used our bonds as security and then we had to pay it back to the bank on a commercial basis, there was no way, ever, that what we received from the government and what we were receiving for our bond investment was ever going to allow us to do a building.

MR WOODS: Thank you. Sue?

MS MACRI: Just in terms of the residents, what proportion of your 57 residents are high care?

MR TROUNCE (MH): We've got 15 in one wing, but we are now also having to start catering for them in our low-care facility, with extra work and extra staff. There is probably about 30 per cent of them, so we're looking at, in a round figure, of getting close to 30. As they age, because they've been long-term residents there, their demands just go up and up and up.

MR WOODS: Again, you're not alone in that particular issue.

MR TROUNCE (MH): No, we don't see ourselves as a unique case at all.

MR WOODS: But it's a very instructive case. Do you provide any community based care?

MR TROUNCE (MH): No, we don't. The previous board was discouraged from doing it and, ever since we've been there, we've been putting out bushfires and getting our management under control. We have questioned our manager, who has had experience in this area before, "Why don't we do it?" She's looking into it. We do have some people already providing in our area. We were also asked the other day whether we would supply food to the Meals on Wheels, because the system that's happening in New South Wales at the moment, it seems to be that the hospitals are not interested in doing it, and it's just frozen food coming up and being thawed out. Unfortunately we can't compete with that on price; we just cannot supply that service at a cost-effective price.

MR WOODS: With the opening up of supply constraints and not having packages and the like, is that an area that you think you may look into?

MR TROUNCE (MH): We will be looking into it. When the offer comes out again for packages to be taken up, we'll certainly be applying for it. But we don't see

that's going to be a panacea change, and all that we say that's going to do is possibly employ one or two more people, put a bigger, heavier load on our management structure, but it will give us a feed in-type opportunity, we think.

MR WOODS: And if our reforms proceed then you won't need to apply for packages, you'd just offer services.

MR TROUNCE (MH): That's exactly right, yes.

MR WOODS: Thank you for making the time available to come down and present to us. It is instructive to have these cases that are focused on areas, and particularly in rural areas. So we appreciate it.

MR TROUNCE (MH): Thank you very much for your time.

MR FITZGERALD: Thank you very much.

MR WOODS: If I could ask Aged and Community Services Association of New South Wales and the ACT to come forward, please.

MS PRETTY (ACSA): Jill Pretty. I'm the chief executive officer of Aged and Community Services New South Wales and the ACT.

MR WOODS: Can I thank you for your on-going contributions to this inquiry. We've had submissions, we've had visits, we've had presentations, and we know that behind the scenes you are also organising for us to be able to access individual providers and the like, so we're very grateful for your contribution, and hopefully some of it shows in the report.

MS PRETTY (ACSA): I'd like to just thank you all for your interest and making yourselves available to our members; I know they very much appreciated it. What I'd like to do today is, I'm referring to our national submission that was lodged with you on Friday, I believe.

MR WOODS: Yes, we've been busy.

MS PRETTY (ACSA): Yes, I can imagine. I'll just highlight some key issues that our members in New South Wales and the ACT have raised. 70 per cent of ACS members are based in regional, rural and remote New South Wales, so I'd like to focus on some of those issues.

MR WOODS: That would be excellent, thank you.

MS PRETTY (ACSA): ACS would like to congratulate the commission on a very comprehensive draft report, because we see that it outlines a new direction for aged and community services and you certainly haven't put bandaids on our existing structure, so we really appreciate that. In looking at the cost of care, ACS supports the commission's recommendations of splitting accommodation, everyday living expenses, and care costs, with the main responsibility of payment of accommodation and everyday living costs being the responsibility of the consumer.

Just one of the questions or concerns that have been raised by our members, and particularly by the ACS board, is that from a past history we believe it's important that any new funding system does not lead the industry and government to debating which bucket the item relates to, so it's important that funding remains flexible in order to meet the needs of individual older people.

We recognise in the report and support that there needs to be a strong safety net in place to ensure that there is sufficient funding for accommodation and care for the financially disadvantaged. A key purpose for the delivery of aged care services for

our sector is to service the marginalised and most disadvantaged in the community and our current system - I think, internationally, Australia has a very equitable service that services those marginalised people and is probably one of the best in western society, so we'd certainly support recommendations in the final report that strongly support equitable funding for that group of people.

We certainly believe the subsidies for care must also reflect the real cost of care and we strongly support the recommendation that a cost of care study be conducted in stage 1 of the reforms. One of the discussion points that have come up, especially from our regional members, is the supported resident ratio. The trading and tendering of supported places in the draft report we believe is unclear and the points that have been raised is that the trading and tendering of places needs to be more clearly defined with cost implications these would have on the industry; that supported places are available in all regions, especially in rural areas which will ensure that older people who are financially disadvantaged will not have to move from their community in order to receive care; that any tendering process is equitable, both for provider and consumer, and one of the recommendations that ACSA would like to put forward is that if a tender is won by a provider, it should be for the life of that allocation, provided the provider meets all the legislative standards and requirements.

Under the regional, rural and remote areas that have been raised, I will touch on several parts of the report but these are things that have been raised by our members. Certainly there is very strong support for your recommendation of the varying of the supported residents' supplements based on regional costs of the provision of accommodation. In some rural and remote areas, there's certainly concern about opening the supply up to market forces because of concerns that it could disadvantage older people and their communities. I think one of the things for our smaller providers out in those remote areas is that the aged care provider (1) is the major employer and they also support the local business. I think we'd want to see continuing support for that, that the aged care provider is a key provider in order that those communities remain.

So certainly we'd support capital grants and block funding in certain areas but I think what we were looking at is that the rural and regional communities need to be taken on an individual basis, that block funding across the board may not be appropriate for some areas. I will just raise this issue - and I know it's been debated quite strongly with you - but in rural areas, most of the accommodation has been low care which has now moved to ageing in place, but the requirement from those communities and also from the Commonwealth government when they were built was that they were single rooms. Certainly the concern has been raised around the two-room and shared en suite which I know you're aware of. People have a choice of what accommodation they want and how they want to build it. I think ACS's position is that the funding that's attached to that is adequate and certainly we would

support more of a focus on the single room.

ACS is supportive of the integrated model of health and aged care. We're looking at the MPS and certainly in the ACSA submission, they're strongly supportive of a like MPS model. Certainly there's some evidence in New South Wales that the MPS has certainly maintained services for the community in both health and aged care. The concern that is raised in New South Wales is the control of the MPS by the New South Wales Health Department and they are extremely medically focused. The aged care and older people, their social needs are often overlooked. I have visited most of the MPSs in New South Wales and certainly the clinical care component is extremely strong but the social and the homelike environment is often overlooked. The engagement of staff to provide activities and things I think is something that needs to be addressed. There are some very good models, as I'm sure you're aware, in Tasmania which I have visited and are very strongly supported.

There is also a model, although New South Wales Health is still the provider, out at Portland, just outside Lithgow, and we work very closely with the Health Department when that became an MPS. But what they have done is the existing hostel have built the clinical and hospital side of the subacute and emergency room but that hostel still operates under the Aged Care Act and still has the classification scale and also has to meet the accreditation standards. I think looking at that sort of model, it has certainly focused on the broader needs of the older people in that area, rather than perhaps some of the other MPSs which are very clinically focused. So I think there are some examples of good MPSs; whether they're run by a health department or, as in Tasmania, there's more control by the aged care providers.

One of the issues that has been raised, especially by our rural members - that's what the ACSA submission is calling an unaddressed issue - is that the accommodation arrangements certainly will work for those who are without financial means, the financially disadvantaged; however, it is not quite clear for the current assisted resident or individuals with limited means but high enough to fall outside of the "supported resident" definition and certainly a request would be that that's addressed in the final report.

The other concern is certainly the farm property, which at the moment is protected; if there is evidence that that farm is the ongoing income for subsequent generations, that any debt that may be incurred by the original owners, the older people having to go into care, is not going to disadvantage ongoing generations over a long period of time. I think that has also been raised with older people who have a younger person with a disability living in the home; again, there's protections in place that any access to the income, the asset from the house, won't disadvantage long term those people.

Just moving on to the gateway, the establishment of the gateway is supported and if it's adequately resourced with skilled staff, we believe it certainly could simplify a very complex system for both consumers and providers but in New South Wales I think there are some ongoing issues with concerns with the ACAT and we would need to have to move past the current culture in order to be convinced that the gateway is the way to go.

Key issues that our members have raised is around how would the gateway handle emergency admissions, especially around assessment of care and their financial status. That is often a delay at the moment. I know it's done by Centrelink but there would need to be some processes in place that deal with those emergency admissions fairly efficiently. One of the things that's been raised by our community care providers is it appears unclear that if a consumer has an entitlement for community care, would that entitle them to be moved into residential care and is there a seamless process for the funding entitlement to care or would you have to be reassessed if you needed to move into residential care.

In meeting the increasing needs of consumers, the layered idea of funding is positive but this does not recognise how improvement of care will be addressed, allowing the client to move in and out of care. I think one of the things certainly looking at the HACC model, certainly in New South Wales, is the re-enabled model, that people could actually improve and not have a service for life which tends to happen at the moment.

We believe there needs to be a clear relationship between Medicare, locals and the local health networks to ensure that older people receiving aged care services are not disadvantaged from other health provisions. One of the key services that our members are very interested and do provide very well is respite. We believe this is not addressed in your draft report. In home, daycare and residential respite are vital services in supporting carers and assisting to keep older frail people at home. So in the gateway model we are unclear at the moment how respite would be addressed.

One of the comments that you asked for was around veterans. We have several members that provide services to veterans. I have also had talks with our veteran community in New South Wales, both the DVA departments here in Sydney. There certainly is support that veterans and other special needs groups could certainly be assessed by the gateway, but I think one of the things we've raised is that there would need to be the resources or access to resources for specific health issues. For veterans that's certainly - the mental health issues that often identified in veterans and the complex behaviours that are often identified in the homeless and the cultural needs of other minority groups. So I think it would be the gateway having access to those resources as needed.

In the introduction of a new system it needs to recognise that older people are

familiar with other agencies that distribute information. Although we have a complex system, older people especially based in the community are very familiar with going to their local government shop-front things - that there is a connection between what is a new gateway and existing systems so that transition is smooth for older people.

The last point that I wanted to raise is just reducing the extent of regulation and certainly the strong support to easing regulation. We certainly were very pleased to see the commission refer to our think tank paper which ACS commissioned and involved providers, consumer groups and both the peak bodies.

Mandatory reporting has been in place for some time and has never been reviewed. We think this is well overdue. But one of the things I wanted to raise was from our rural members, certainly from small communities, that if there is suspicion or allegation of reportable offence that the expectation of the department is that that staff person will be stood down. We believe there should be more time to investigate whether the allegation is actually substantiated. We certainly would support that the staff member may need to work under closer supervision. But in smaller towns if you stand someone down the whole town knows why, however hard you try to keep confidentiality. We have certainly had reports around staff members who actually have been exonerated, there has been no issue to answer for, but they have actually attempted suicide. I think the mental health pressure on those staff members is something that has been ignored in the legislation and the impact of the legislation.

We also, I think, are concerned about older people's choices in whether they actually want it referred to the poverty. We did have an incident in Sydney where a married couple married for 60 years, yes, there had been some domestic abuse but without - but both residents were mentally alert and they had no say in the fact that it was reported and those two people ended up in different facilities. So their choice and their human rights, we believe, were actually invaded. I think we have to be careful that we don't put community standards on people who perhaps for 60 years have managed their situation quite adequately.

So ACS recommends that the final report does contain a strong recommendation to have this legislation reviewed, also including the department's process in dealing with these issues. That is the end of my presentation. I certainly haven't covered all of the areas in the Access submission but would be happy to take questions on my presentation on other areas that are in the submission, if I can.

MR WOODS: Thank you, Jill, as always, very comprehensive. Couple of things from me to start with. One is just a note of information. Yes, we are watching closely the development of Medicare Locals and local hospital networks and the like. In reforming the aged care sector we've tried to make sure that should these other initiatives blossom and prove to be viable and highly efficient then there could be

some merging or relationship between what we're proposing and those, but we certainly don't want to assume that they're both (a) up and running, and (b) proven to be highly effective in designing our scheme.

MS PRETTY (ACSA): We would support that, because I think our concern at the moment is that aged care has been sidelined in both at the moment. So we certainly are working very hard to see that they get a - - -

MR FITZGERALD: One of the issues that we are asking participants to comment on, maybe they can't, that is, what would be the principles in the design of a region that the government should take into account? At the end of the day this will be a regional-based aged care system - - -

MS PRETTY (ACSA): Yes.

MR FITZGERALD: - - - both in terms of the gateway and a number of other elements. So Mike is right. At the moment some people are encouraging us to align to these health ones. Superficially that's attractive but it's way too early to do that. But on the other hand we absolutely know from the comments that people have been making unless we get the regions right there are all sorts of perverse outcomes as well, not only in terms of information but absolutely in terms of equity. So there are issues around that.

MR WOODS: The next issue is in relation to a rehabilitative restorative model. It may not have come through sufficiently clearly in the draft, in which case we'll go back and do some redrafting, but the whole intention is to allow people to be assessed for their needs as they are and as they are perceived for a period into the future, but including investment, where appropriate, in assisting them to regain a higher measure of independence or to retain their current functionality as the minimum. The layered model is not intended as a linear model. What the building blocks are trying to do is to say you may need to draw some services from different levels for the one person, and then in some cases you may feel satisfied that that could continue on for a year and be re-assessed unless there's a material change of circumstance, but in other cases it might be a 12 week investment in physio or OT or something to help a person regain a previous measure of independence. So we see it very much as a flexible approach. If some impression has been gained that we had a sort of linear model and were working down the tiers, that's not as we intended it.

MS PRETTY (ACSA): I accept that. I think one of the issues would be the resources and the ability for the gateway to manage that sort of process. We believe that the gateway is an absolute key function in order that people have access to the services they need but also the knowledge that, "Yes, I've got them for 12 weeks but if I get worse or I get better and I need them I can get back in there." So it's about, I guess, the availability of services which up to now hasn't been available to older

people and to providers.

MR WOODS: Again, the concept of moving to an entitlement with a number of providers and without the caps and constraints on supply - our intention is that this would lead to an arrangement where people weren't holding on to, "I'm in HACC now and I don't want to give it up even though I'm a bit better at the moment or my daughter has come for awhile," you know, whatever the situation.

MS PRETTY (ACSA): Yes.

MR WOODS: That they feel that they could draw on the services when they need and relinquish them when they don't need them. Then should their circumstances change again that they receive an entitlement and can go to a provider and have the services, because otherwise you get very perverse behaviours - - -

MS PRETTY (ACSA): You do.

MR WOODS: - - - and lock-ins and rigidities in the system. Also, the providers would play a key role in re-assessing a person's situation once the provider gets to know the individual, they're best placed to monitor changes in need and in most cases, they would then just notify the gateway that there's been a change in circumstances and a different level of care is required. The gateway would have an audit process that would check on a risk-managed basis but the provider would be integral in that process.

Your mention of MPSs was interesting. You drew the distinction between the Tasmanian and New South Wales models and we've certainly also seen both of those and I think we probably tend to agree with you in terms of the assessment of the relative merits of the two different models, although we will chase up this Portland model and see what - - -

MR FITZGERALD: My father has a farm in Portland, so I'm very familiar with that particular service. But I think your point is, and we've heard it, "We support the MPS model but the models are so variable and different across Australia." The question is whether we should be more prescriptive or not. In other words, because it's an experimentation taking place, what's very clear is if it starts as an aged care facility to which the health care is attached, it has one flavour; if it starts as a health care facility to which aged beds are attached, it has a very different one, and then the issue of ownership or management is the other determinant.

But one of the issues for me is should we just simply say these are good models but let the industry and government work out what's the best model or should we be more prescriptive? That's just a question.

MS PRETTY (ACSA): I think there would be dangers in being more prescriptive; I think acknowledging that there are a variety of ways that this could be done and then perhaps there is some encouragement for providers and health services to get together, because (1) it's not only about having them on one site, it's also about sharing resources. There are some models now in New South Wales - and Port Macquarie being the one that I'm very familiar with - where the Health Department actually funds the nurse practitioner. I know Sue has, and I have personal connections with Port Macquarie - - -

MS MACRI: Yes.

MS PRETTY (ACSA): - - - where they have funded a nurse practitioner who's attached to their emergency department to actually service older people in the community and in residential care and it has saved the hospital a considerable amount of money. I think it's about trying to get that flexibility into health services around the nation. I think if we could really open up that discussion, that it isn't about cost shifting, it's about cost sharing, that we could really have some good models out there, especially in smaller areas.

MR WOODS: It is a feature of the sector that when you go to individual facilities or providers of community care, and I'd have to say particularly in rural areas, that you find innovation and you find people bending the rules to adjust to providing the care that is required and they're very good at it, both sides. But the industry as a rule doesn't develop a lot of innovation that then spreads broadly across the sector and I'm wondering if it's because the administration of the act, the rigidities, the packages, you have to meet all the rules or else you may not get the next allocation et cetera, whether that's some of the constraint in the system and whether there's some purpose for and actionable recommendation that we could take that would help sort of reveal and test and then allow development of these various innovations. It's not an industry that spreads the innovation very rapidly across.

MS PRETTY (ACSA): No. I think the restrictions by the legislation and some of the department's interpretation of the legislation has restricted innovation. I think that's become very obvious since 1997. I saw a lot more innovation before the act, where people were prepared to trial it. There are still some providers who are prepared to push the boundaries. One of the examples we have had is that high-care facilities have actually challenged the need to have handrails along corridors because everybody is either in a wheelchair or has a walking frame and they have been successful in those sorts of areas.

I think one of the things that would be really useful - and I don't know the timing of this - is actually whether the consumer directed care pilots are prepared to push the boundaries. We have divided views on that, that they will be contained and we'll just have community care packages with another name, but I believe there will

be some innovation by some providers. I think with changing the system, it's going to require a lot of cultural change from both providers and from governments and a lot of education and understanding. I think one of the challenges for providers in moving to a new system is being assured that their financial viability isn't threatened during that transition, that they can see that their funds will flow. I can understand, you know, if I'm going to send someone home, who's going to fill that bed? It's about getting a lot more short-term people, understanding that they will come and ago.

MR WOODS: Subacute and transition care and respite.

MS PRETTY (ACSA): Yes.

MR WOODS: It's a facility that has a number of potential uses for the community, including individual rural communities.

MR FITZGERALD: Assisted residents, that group that are not low income, low wealth, and those with wealth, we are looking at that right at the moment. We've become very aware since the draft that we need to do more work around this group. It used to, in the early days, be called the taper group, but it's this group of modest means.

MS PRETTY (ACSA): Yes.

MR FITZGERALD: I noticed in your written proposal you don't have any particular view as to how they might be dealt with and I didn't expect there would be, but again it would be an area that if you could give any advice or guidance to us or your association, that would be helpful because we're aware of this group.

MS PRETTY (ACSA): Okay, yes.

MR FITZGERALD: I suppose the starting point is does the current system deal well with that group - - -

MS PRETTY (ACSA): No.

MR FITZGERALD: - - - and if not, how do we improve it going forward? It is of particular interest to us. We didn't cover it very much in the draft and we certainly will in the final, but it's quite a tricky group, as you know - - -

MS PRETTY (ACSA): It is.

MR FITZGERALD: - - - yet it's a very important group.

MS PRETTY (ACSA): Yes. They sort of fall - their assets aren't sufficient. I don't think the current system deals with them well and we certainly hear of low-care facilities getting bonds of 32,000 which really aren't particularly helpful for them. The supplement is certainly helpful but it would be again - yes, I'll take that back to the national organisation and we might do some brainstorming to try and come up with some solutions for that.

MR FITZGERALD: Thank you.

MS MACRI: Just around technology, Robert and I were talking about this at lunchtime, and we talk about the importance of the integration in the health care system and we talk about the importance of the electronic record, but it still seems to be within the industry there are those that are out there really getting the IT clinical record systems in place and medication management, but it still seems to be a minority rather than the majority and I just wonder what your thoughts are around it. To take all of this forward and to go into the recommendations is going to require organisations to be a little bit more IT savvy than they currently are.

MS PRETTY (ACSA): Yes.

MS MACRI: What are your thoughts around how we get the industry to better start to embrace and understand the need for technology?

MS PRETTY (ACSA): My community care providers would say they have never been given any financial assistance from the government, which residential has, so I think certainly some support from government for community care providers. I think one of the concerns is that there are a lot of systems out there and I think it's confusing for providers to know which one to access. One of the things that I think would be helpful is if there was - I mean, certainly a health record nationally, of how providers could access that. I think one of the concerns is, "If I purchase this system," which is quite expensive, "will it be there tomorrow or will they go broke?" The other one is, "Will it meet the demands or the requirements of the legislation?" So I think there perhaps needs - and I don't know whether it's an endorsement by the department on certain systems, some support of systems, because certainly I've been to IT conferences and at the end of it, you're no wiser than when you started. So I think it's really about sitting down and looking at what are the key issues or the key components that people need to have in place and how can we get some support, you know, that this system is supported by the department and aligns to it.

MS MACRI: The industry seems to have embraced it in terms of monitoring if people get out of bed, on toilets and all of that sort of thing, but on the other side of care, clinical care, records, it's incredibly slow.

MS PRETTY (ACSA): I think one of the downsides, which I think is improving, is

actually there has been a strong demand - Sue, you're probably aware that if you've got an IT paperless system, then you are required by the department to print everything out when they come. So I think it's about how we skill up the monitoring system by the department electronically as well as skilling up the industry.

MS MACRI: Certainly another criticism is where there's an organisation that is IT savvy, and in fact if the department comes in or the accreditation agency, they're not, so there's a gap between the departmental agency side and the industry side.

MS PRETTY (ACSA): Yes.

MR WOODS: Thank you, Jill, for your ongoing contributions.

MS PRETTY (ACSA): Thank you.

MR WOODS: It sounds like we should resume at Port Macquarie.

MS PRETTY (ACSA): We'd be very happy with that.

MR WOODS: We'll take a 10-minute break.

MR WOODS: Thank you very much for coming. For the record, if you could please give your name and if you are representing any organisations.

MR WHITEHEAD (VCL): Thank you, and thank for the opportunity.
Merill Whitehead is my name. I'm here as the founder of Genera Gardens, which is a concept, within the 12 to 18 months, is ready to be undertaken as a major project for the aged, for the disadvantaged, disabled, carers and volunteers. We have formed a public company called VolDis Care Ltd, of which I'm a director and co-chairman of that particular organisation. We have not commenced trading, we have spent the last three years investigating the fields that were of interest to us in wishing to set up a not-for-profit organisation, which needed to have a thrust and needed to be able to do something for the benefit of the aged and the disabled, and their carers and volunteers, in a way that hadn't been done before.

We note that governments of all persuasions have attempted over a long period of time to provide necessary fundings for various projects and they carry a fairly heavy burden of what needs to be done. We decided to look at it in a manner and a thrust which was different. Our premise is eventually to circumnavigate the need for exclusive government funding and to create the opportunity for a substantial income scheme through the private sector. It has long been our contention that the current form of funding through taxational levies for the care of the aged will not be sustainable during the foreseeable future. It's time to start thinking laterally and to begin to create developments that will provide all forms of specialised accommodation, medical, nursing, therapeutic, and diagnostic facilities, with opportunities for social interaction and all situated in a location that allows the creation of an income stream and, thereby, the opportunity to become self-sufficient. This is a fairly important thrust, from our perspective.

The commission, of course, has just finished an inquiry into the disabled, and currently the aged is under consideration. Having regard to the submission outline, it may be worth giving consideration to treating the aged and the disabled in a contiguous sense as our thrust is to create a village-style atmosphere. We see the need for not only the care to be for the aged and the disabled; we think they need to be treated in a contiguous sense. For example, in New South Wales they have a state environmental planning policy in relation to housing, including residential care facilities, diversity of housing, and wishes to make efficient use of infrastructure and services. It's a combined policy document designed to meet the needs of seniors and people with a disability, including a section for vertical villages. It's our belief that the current policy document doesn't fully address the issues that we wish to outline here.

We propose to build or to create the first income-producing development solely for the benefit of the aged and the disabled, and we recognise that even its concept is

a very ambitious undertaking. During the initial conceptual stages we spoke with many community providers in our research and wanting to understand what their thrust was and what they were looking to provide. In the very general sense, they expressed their opinion that a single location would be construed as being institutional in form. We believe that their opinions could represent, perhaps down the track, a conflict of interest as they have based their operations on reliance of substantial government funding, and there is the thrust of what we're all about.

It is proposed, in the practical sense, to construct a unique type of development for the aged, the disadvantaged, the disabled, and their carers, who will live, work, and play in their own village. They will share with others in an integrated and inclusive way the facilities that have immense therapeutic value and make an important contribution to early intervention programs as well as being a magnet to the general population as the village will be a meeting place, offering major, in this instance, tourist, convention, and medical facilities. This will also address the need for ease of access to these medical, therapeutic, social and transport requirements at the one location and would yield obvious economic advantages.

By way of example, our first stage is plans to construct specialised residential accommodation, as a commercial venture, to be sold off the plan to investors under a community strata title. The appeal for such an investment would be the highly competitive purchase price, achievable through technical advanced construction methods, density ratio and guarantee favourable percentage return on their investment. This will be achieved by offering the government the opportunity to lease or provide a guarantee for affordable housing - and that applies both to state and federal government - on a permanent basis, rather than the current expensive method of construction and ownership by government.

In the process of doing our due diligence for this project we have repeatedly come across financial institutions showing a growing wariness to providing funding for community providers relying heavily on government funding. As economic professionals, they too concede that the current method of funding does not have sustainable economic viability on a continuing basis. As a charitable organisation and a not-for-profit concern, the proceeds from the first stage will be reinvested into the second stage and will provide a mixture of commercial premises, tourist attractions, creating an income stream for the wellbeing of this village community. This will be done in stages; it may end up being five, six, seven or eight stages over a period of time.

Our chosen location in this instance is Castle Hill, and in our concept we have integrated the essential need for easy access to a transport hub. In fact we believe it is quintessential to any proposed project. I spent three and a half years looking for what could be done. I have no immediate family who are aged or disabled. I'm probably old enough myself, being 74. But I realise that we really need to look at

something that creates a village atmosphere. For those of us who have been fortunate enough to travel, you visit Europe, you visit these countries, and you see that the older people are mixing with the younger people.

We don't seem to have that any more, unless we're from particular ethnic groups that espouse that sort of contact. It really is important that people of all ages and all persuasions and all walks of life are able to be integrated and be inclusive and be able to understand the needs of others. I think if we look at more understanding of what is needed we'll come to a conclusion that maybe these two separate streams with the Productivity Commission, both for the disabled and for the aged, should really be in a contiguous sense, they should really come together with the points of all so that people can mix in that way.

I was alarmed recently to continued discussions with banks. My background has been in development projects. My own personal background is in the field of architecture, town planning and structural engineering. I have a small modicum of understanding of these things, and it was important to look at different forms of construction which are affordable. I'm absolutely flabbergasted with our local council, who doesn't want to see affordable housing in this particular shire at Castle Hill, and in the hills district they probably want to have the elitist view perhaps. I live in Castle Hill. I've been there most of my life. I have looked around for a location which would meet all this criteria and I have actually found something which needs to be developed on a very major scale, and over a period of seven to 10 years it will be in the order of half a billion dollars.

You say to yourself, "Well, how is someone going to go out there and do all of this and put all this together?" So I started with talking to the banks and I realised that the banks - and they referred to it as the GFC - have gone through a difficult period and that money is not that easy to procure. Indeed if you want money, if you come along to them and say, "Look, I've got a set of deeds that are unencumbered and I want to do some construction," "Providing you've sold everything off the plan, we'll be delighted to lend you the money." That sort of irks people particularly when you know that governments have given them some financial backing. So there needs to be a new approach to it.

I happen to live directly opposite one of the largest Anglicare villages in Australia, known as Mowll Village. I walk and run through there on a daily basis. I try and talk to someone in there, I can't really find them. The people seem to be closeted, they seem to be locked away. They haven't even got a post office. They have a Penny Lane type thing that is open on two days of the week. They have got community areas to meet, but there doesn't seem to be a place where the older people mix with a whole generational level, and I think this is sad and I think this is what is lacking.

If you're going to develop something you need to develop something that has the ability to offer other things. For example, what we're looking at is that the whole of the ground level of the development will be a Grevillea garden, it will have the largest type of Grevillea garden in the world hopefully and that will be of therapeutic benefit, particularly for people that need to have some wellness care and need to get themselves back into society, they can go out there and help and work and do these things that are needed. We are in an area that has a large drawcard of volunteers and we have a situation where we really do need, in my belief, and from the research that we have done, to mix with these people.

When I first started this concept some three years ago the first thing that I did was make contact with other who were going to be providers and people in associations and groups. I wrote to many of them; I got no response. One gentleman who wrote back, who is well known in the actual field of the disabled, and said, "Look, what you're doing is institutional reform, and, with the way that the legislation is in New South Wales, we don't see that you're achieving something that is going to be worthwhile." They refer to it as a six-pack, which might be for aged or might be for disabled. You can go into a neighbourhood area and you can put up some accommodation with carers and people in the need; providing you don't build one next door - you can build one around the corner - then that's okay, that meets the criteria.

What they're forgetting about is that aged people, as well as disabled people, need to have access to transport. So to make these projects viable, they need to be bigger in essence than just trying to do something small. Those small things can come later, or in areas where it's not possible to provide those needs. So access to medical needs, therapeutic needs, recreation facilities and things of that nature; areas where they can walk, areas that they can easily travel on. In this particular instance we have a fall on land, which is about 60 metres overall, and people say, "Why would you try and attempt to put something on there?" Well, we tried to apply some lateral thinking about it, and that is you can have people movers, you can move around the contours on level areas. So there's all sorts of ways to overcome these problems.

MR WOODS: Merrill, I'm conscious of the time. If you want to focus in on your key points towards that end, that would be helpful.

MR WHITEHEAD (VCL): Thank you. I could talk for hours on this. In essence, what I'm saying is that we need to develop the villages or places for people to live that have an integrated and inclusive manner about them, and we need to be able to mix old people with other generations and younger people. There are some people that aren't well, that won't want that situation. But a lot of the elderly are starved for conversation and starved for the opportunity to mix with people. So you need meeting places and you need activities that can involve people in these things on a

wider scale. I do urge the commission to seriously look at bringing both those spheres together - your disabled and your aged - in a contiguous sense. I thank you for your time.

MR WOODS: That's fine. Thank you for coming. We're certainly very interested in having a whole range of accommodation options developed for people, so that they can choose to live in an environment that best suits their needs and their aspirations as well as the delivery of quality care. So to the extent that your concept can add to the variety of accommodation options for people so that they live in a village environment, that there's social interaction as well as supporting care, I think that has considerable potential.

MR WHITEHEAD (VDC): Well, not everyone wants to live in a village, and I understand that, but there will be many that won't have the funding to do otherwise.

MR WOODS: Yes.

MR FITZGERALD: Can I just ask one question?

MR WHITEHEAD (VDC): Yes.

MR FITZGERALD: Will any part of the village be a retirement village under the act?

MR WHITEHEAD (VDC): Yes. We want to be able to provide for that 10 per cent affordable housing in that form and to also meet those needs. It's quintessential that it happens that way. The interesting thing about it is that we will be looking for people to have ownership. I mentioned in my delivery to you that there are - it's community title. What is important now, community title opens the door to many forms of approach. Indeed, in a few short years you'll be able to own a property here and another one over there and they will be under the one title. That's a white paper that is under consideration at the moment, and has been for several years.

MR FITZGERALD: Good, thank you, Mr Whitehead. Sue?

MS MACRI: Just in terms of the first stage where you talk about residential accommodation. I presume that's also accommodation where you talk about aged and disabled?

MR WHITEHEAD (VDC): Yes.

MS MACRI: So are you talking about a residential aged care facility or are you talking about smaller group homes or what - - -

MR WHITEHEAD (VDC): Stage one in this particular instance will be just under 300 homes in unit form. They will all be elevated above ground level, so the gardens are continuous throughout the development. Each of those community titles will be 140 metres square, which is made up of a 50 metre square - or the old five-square unit style, motel style, and a nine-square unit style, so that if a family wants to live and they have one aged parent or two, they can either have the choice of renting out that space or having one of their family members live in that space and they will have ownership and community title.

I think what's important is that people, if they can, have ownership so they can pass that on to other generations. You go, for example - and this is not a criticism of the Anglicare approach, but if you take a property now which is only two kilometres from where I am, just down from the village, you can go in and get a two bedroom box, as I describe it, pay six or seven hundred thousand dollars, up to $850,000. After the first three years you lose 30 per cent, you don't get your money back, after 10 years you've exhausted your money. Well, there's no incentive for people to have ownership. What I think is wrong with that is that they are reliant upon subsidies from government. I do believe that the banks are going to move and cut that out because they have too many community providers on their books. They told me that point blank and said that, "We're nervous about having so many community providers on our books when the economic situation is hard, because they're looking to government to take care of that." So we think we've got to move in a different way.

MS MACRI: Okay, thank you.

MR WOODS: Thank you very much - - -

MR WHITEHEAD: Thank you.

MR WOODS: - - - for your presentation.

MR WOODS: Can I ask Community Transport to come forward, please? Thank you.

MS BATTALINO (CTO): Thank you.

MR WOODS: Thank you for being available to move timing if needed. We appreciated that.

MR ALLEN (CTO): No worries.

MR WOODS: Could you please, for the record, state your names and the organisation you represent and any position you hold in it?

MS BATTALINO (CTO): Thank you. My name is Helen Battalino. I'm the manager of the regional coordination office for Community Transport in northern Sydney. I'm officially today representing the Community Transport Organisation of New South Wales.

MR ALLEN: I'm Kain Allen, and I represent the CTO, Community Transport Organisation New South Wales. I currently hold the position of vice-president of that body.

MR WOODS: Excellent, thank you. Thank you for providing commentary on our draft and please - - -

MS BATTALINO (CTO): Thank you. Yes, as you've noted we have provided written reports and we thank you for you the opportunity to speak to those comments. We really just wanted to focus on three main issues here today, that is, the funding, the gateway access to aged care services but also raise or highlight the special nature of transport services. As I said, we represent Community Transport in New South Wales, which is 130 organisations which are specifically funded under the current HACC program to provide transport for the frail, aged and people with a disability and their carers.

You might forgive me if I labour the point just a little but community transport, when that term is used, is often confused with a whole range of vehicles that are out there in the community - in small C community - but Community Transport, as we see it, is the organisations and the services which provide a specialised service. Community Transport has grown from a few small community services to a state-wide network or operation in New South Wales. We are only a small player in terms of the New South Wales HACC budget, we recognise that, but I'm sure you would all recognise how important transport is and how important transport is to everybody in the community. Without transport we can't access services, we can't

stay connected with our community.

Our concern, I feel, is that transport is part of this aged care review because it is a HACC service, but because it is a minor player we're concerned that the particular significance of the way transport is delivered may be overlooked and we can - - -

MR WOODS: Can I just clarify on that. You talk about 34 million of HACC funding for - - -

MS BATTALINO (CTO): Yes.

MR WOODS: - - - you say "for community transport". Do you mean for the members of your organisation or do you mean for all of community transport in its generic sense for HACC funding?

MS BATTALINO (CTO): No, that is my point. The Community Transport Organisation represents community transport services which are particularly defined and funded under the Home and Community Care program, and that's that $34 million.

MR WOODS: Sure, thank you.

MS BATTALINO (CTO): That's what we see as the community transport industry. As we said, we know how important that industry is. Just to give you a little bit of data we provide something of the order of 35 million kilometres of service a year, that's three million trips to 200,000 HACC clients. We have considerable investment in infrastructure in that we own upwards of 1000 vehicles. We also use many more vehicles provided by volunteers. We employ something of the order of 1000 drivers plus office staff and somewhere of the order of 3000 plus volunteers across the state to be able to provide that service.

We know that transport was acknowledged as being very important in a lot of the submissions to this inquiry. We also acknowledge and thank you for your acknowledgment of the importance of transport. We did note and certainly appreciate that you recommended that we continue block funding for our sector, I hope in recognition of the investment that we have. So we thank you for that. We are a little concerned though however that the funding is not large. Everybody will always say that it is not great in comparison with the demand but one of our main concerns is that there is not a systematic or an equitable allocation of funding across the state. We have members who have different levels of funding, and without any apparent reason. It's not allocated on a client basis, a kilometre basis, a trip basis. So we would like to see some consideration of how the funding is actually allocated to the services so that we can look at having a much more equitable distribution of

service opportunity.

MR WOODS: Sorry, again if I could just clarify, it just helps in understanding your presentation, that the current amount that is devoted to community transport in any one region is a decision at that regional level by the HACC budget holders rather than a central allocation across regions?

MS BATTALINO (CTO): I'm not terribly clear on that.

MR ALLEN (CTO): Neither am I.

MS BATTALINO (CTO): In the industry we're not clear and I think that might answer it. There are models of population projections and population numbers and population growth which are used and that may have formed a basis for initial funding allocations, but then funding is also distributed through tender systems.

MR WOODS: Exactly my point.

MR ALLEN (CTO): And CT sort of started at different times too in different areas.

MS BATTALINO (CTO): That's right. It's hard to see what the rationale is behind the funding model which is actually being used.

MR WOODS: Probably history.

MS BATTALINO (CTO): Yes, absolutely. We'd also like to make the point that we are somewhat different from the other HACC services in that our funding is actually administered and monitored through the State Transport Authority, so there are times when we actually feel as though we have split personalities because we report to the two departments and we are concerned as to what the future of our funding arrangements are going to be with the changes in the aged care funding allocations going back to the Commonwealth. What will then be the relationship between State Transport and the Commonwealth is a major question in our minds.

We're also concerned about the gateway and we know that that has been raised by a number of submissions. We do acknowledge and we agree that there does need to be a streamlining and there needs to be more clarity and it needs to be easier for people to find their way into the aged care system. We'd just like to make the point though that from our experience and certainly under the current system, transport is often the first entry point to needing any services. People will need transport when they've just lost their driver's licence or when they just can't walk up the hill to the bus or when their partner has passed away and they were the one that used to do the driving. You can be transport disadvantaged and you can be in danger of becoming

dependent on a community care or an aged care system just because you can't access a transport system, and that may be just within four or five hundred metres of a bus stop in the middle of Sydney, the same as it may be out in remote rural and regional areas. So being able to get past a gateway and a gateway that is sensitive enough to pick up the low-level clients so that they actually get the type of service that they need is of considerable concern to us.

We're also concerned that if you just need transport, you just need to go to the doctor's, why do you have to answer all those questions about, "Can I go to the toilet?" or, "How much money do I have?" or whatever.

MR FITZGERALD: Can you just tell me how that works now? If somebody wants to access a community transport organisation or service, what happens?

MS BATTALINO (CTO): They have to be assessed for HACC eligibility, home and community care eligibility for a HACC provider which can be the Community Transport Organisation itself.

MR FITZGERALD: Say I or my carer believes that I have a need for transport. I can access a particular community transport service in my local area to which I've been advised to go and you will then do the assessment as to whether or not that person can or cannot access your service. Is that correct?

MS BATTALINO (CTO): That's correct.

MR ALLEN (CTO): That's correct. Also outside of HACC funding, there's also CTP funding which comes through the Ministry of Transport and that's the transport disadvantage, so it falls outside of the HACC criteria, for those people who might be 400 metres from a bus stop and the bus doesn't run up to their place.

MR FITZGERALD: But again, you do that assessment?

MR ALLEN (CTO): We do that assessment, yes.

MS BATTALINO (CTO): Yes. The client could have been referred from another HACC service to our service, but if transport is the first point, we do the assessment, yes.

MR FITZGERALD: Sure.

MS BATTALINO (CTO): We also find, as probably other providers, there are communities who have difficulty accessing a gateway, and I think your report acknowledged that. The ATSI communities, the CALD communities, they find it very difficult understanding why they have to undergo that process and being able to

access services that way. We have some examples from our Northern Rivers area where we particularly have Aboriginal transport workers working with those communities to help them access services. So any gateway needs to be particularly culturally sensitive to be able to ensure that those people get the services that they need.

MR FITZGERALD: That raises the question of whether or not you need to go through the gateway.

MS BATTALINO (CTO): This is our point with transport, and I think it gives us the opportunity to think about transport. As I said, we are a small player but we are caught up in this aged care inquiry and also the reforms of the health system, but we are a fundamental and vital service. But there is an opportunity here we believe to see us as a transport system. We provide a specialised service providing transport. While we are extremely mindful of the need to provide a specialised service to our clients who are elderly and frail and have a disability, we also bring to the delivery of this service specific transport skills, skills in fleet management, skills in scheduling, skills in vehicle maintenance and those sorts of things.

MS MACRI: Can I just ask you then, in terms of your clientele, what proportion, percentage, would be just utilising transport services and no other HACC services?

MS BATTALINO (CTO): I don't know that I can tell you that off the top of my head.

MS MACRI: Would it be a high proportion or most would be having some HACC services and transport is a part of it?

MR ALLEN (CTO): I manage Manly Warringah Pittwater Community Transport and there are a lot of people, a high percentage, that just use the transport service. They have no in-home care or anything like that, just transport to get to the doctor's and whatnot.

MS MACRI: Okay.

MS BATTALINO (CTO): So as I was saying, we bring this specialised knowledge and I think transport economics and transport efficiency tells you that efficiencies can be achieved in transport if you can increase your patronage. If you can get more people on the bus, it's obviously cheaper per trip than it is if you're running around on an empty bus. We believe that one of the weaknesses of the current HACC model has been that not only is there funding through the Community Transport Organisations but, as your question reflected earlier, there has been transport tacked on to a whole range of other types of service so that money is given for a bus or money is given for this. So the end result is that there are a lot of

underutilised or poorly managed vehicles out there, but there is also a fragmented and disaggregated market, if we can call our clients that in this sense.

So if we can think of the aged care system and the health system and the transport-disadvantaged market as needing a transport service - because this is the gap that community transport is actually trying to provide at the moment, community transport is the only transport service providing the gap between the 400 metres of the mainstream public transport system and the ambulance system - and within that system, we have those types of clients. We have the transport disadvantaged and we have that increasingly growing health market. The health transport that we are providing at the moment, on average across the state is 30 per cent of our trips, so for health reasons. In some areas it's much bigger than that and in terms of budget, it would be higher than that because they're very expensive transport. We transport people regularly for dialysis, for chemo, for hospital discharges and admissions and we're picking up people for whom you could say need higher care than we as community transport providers can provide.

MR WOODS: Can I just ask - and sorry to keep interrupting your presentation, but it just helps us on the way - what would you anticipate the level of unmet demand for your service?

MS BATTALINO (CTO): This is the $60,000 question.

MR WOODS: Yes, it's just that you talk about economies of scale and that's indeed true; that if you increase patronage in some areas, the per-unit cost will go down, but in fact the total public cost will go up. There's a balance there, so it's not as if it's saving money in a very narrow sense. It might be saving money in a broad system sense, which is of interest to us, but we do need to be aware of both impacts.

MS BATTALINO (CTO): Yes. There have been a number of studies which have attempted to quantify demand or unmet need and we attempt to do that. We have one service in the Lower North Shore of Sydney which reports saying, "No," to 2000 trips a year that they can't fulfil.

MR ALLEN (CTO): That's right. There was also a report commissioned by the Cancer Council, No Transport, No Treatment, where it was estimated 90,000 are unmet for medical purposes over the course of one year.

MR WOODS: Would they then be picked up in part through taxi vouchers and other things?

MR ALLEN (CTO): Quite possibly.

MS BATTALINO (CTO): I think that number was meant to be "unmet"; not able

to be met by the Community Transport Organisation in any way. But it is a difficult question to know.

MR FITZGERALD: Looking at that client group that you have, it seems to me that a fairly substantial portion of the client group, going forward, would be coming from the health system or state based systems. In a sense, whilst your services deal with aged care, they also deal with people with disabilities, health care recipients, and other groups. Would it be fair to say that, going forward, you'd expect that a major portion of the funding to come from the state government agencies? It doesn't matter which one, but is that the general trend?

MS BATTALINO (CTO): Would we expect that? We're not sure where our funding is going to come from in the future. We would like to think that we were getting funding from the state health department for the amount of transport we provide, but at the moment we get a very, very small proportion from them in relation to what we actually provide, and that also is not distributed in any way that makes very much sense.

MR ALLEN (CTO): There's a lot of disparity between areas.

MS BATTALINO (CTO): We find it quite difficult to just understand where we actually do fit, which I suppose is why we are trying to raise the profile to this inquiry. We see that here is an opportunity to recognise that transport is vital across all of these sectors and if we are lost in the HACC box or the aged care box only, we are concerned that will not bring efficiencies across the community which could be realised.

MR FITZGERALD: You're right to raise it. Basically, both our report and the National Disability Insurance Scheme report, HACC program disappears, effectively, but the services that are currently within that program don't. You're absolutely right: the future of where all these services fit is an issue which will take some time to work through. So your submission is very valuable, both to this inquiry and to the disability. Hopefully we come up with the same answer, rather than two different answers. I am intrigued that whilst you have a large number of your clients being supported in their health care needs, the state government health department's contribution is not matching that usage.

MS BATTALINO (CTO): Absolutely not.

MR ALLEN (CTO): Nowhere near.

MS BATTALINO (CTO): Okay.

MR WOODS: Are there any other points that you want to raise?

MS BATTALINO (CTO): They were the main points we wanted to raise.

MR WOODS: There is one other that I'd just like briefly to touch on. You have a three to one ratio of volunteers to paid - although paid would be on a very casual and intermittent basis for some and permanent for others.

MS BATTALINO (CTO): Yes, it's a mix.

MR WOODS: But what do you find is the general trend in recruiting and retaining volunteers into your service?

MS BATTALINO (CTO): It depends on where you are and it varies greatly from area to area. There are some regions in Sydney which are still a good source of volunteers: areas where active retirees go when they retire. There are other areas of Sydney where you just can't get volunteers in the service at all. The rural and regional areas rely very heavily on volunteers and they put in an incredible amount of not only their time, but also using their vehicles. We provide training to our volunteers, but the increase in frailty of our clients and their increasing health and medical needs is an added stress and an added concern for us to be putting that pressure on volunteers as well.

MR ALLEN (CTO): And the increasing age of volunteers as well. Volunteers tend to be 65 and over.

MR WOODS: Yes, my parents, as volunteers, were often transporting people a lot younger than them.

MS BATTALINO (CTO): Exactly. To be HACC eligible, it's over 65, but we find our volunteers are 65 to 85 and then our clients are 85 plus.

MR WOODS: Anything else?

MS MACRI: I am just a little intrigued in terms of, in your submission you talk about more appropriate CALD transport services, and I'm just wondering what the difference is around those communities as opposed to the non-CALD communities or CALD people.

MR ALLEN (CTO): Yes, I think access to service.

MS MACRI: So it's more access than delivery?

MR ALLEN (CTO): Than delivery, yes.

MS BATTALINO (CTO): It's often that they prefer to go with their community or only in their community.

MR WOODS: For language and cultural respect.

MS BATTALINO (CTO): We find we do provide group services for CALD communities going to activities, but they won't know or won't use us for that one on one when they need a medical transport or something like that.

MR WOODS: Do you do much in the space of emergency transport? I know you do the planned "go to the doctor because the appointment is scheduled for X", but if there's a need to get to the doctor in a hurry for a particular thing, where do you fit in?

MR ALLEN (CTO): I suppose emergency is different to everybody, but we take people last minute.

MR WOODS: At short notice?

MR ALLEN (CTO): At short notice. At Manly Warringah Pittwater Community Transport we do. That would vary from organisation to organisation, but emergency, that would be - - -

MR WOODS: No. Yes. Thank you very much, that was excellent.

MS BATTALINO (CTO): Thank you.

MR ALLEN (CTO): Thank you very much.

MR WOODS: The Association of Independent Retirees, please.

MR CURLEY (AIR): My name is Robert Curley. I'm with the Australian Independent Retiree or AIR, as we refer to it, and I'm a director of that organisation.

MR GOULD (AIR): I'm Richard Gould and I'm with the association and chair the New South Wales committee on health and ageing, but was the coordinator for our submission.

MR WOODS: Excellent. Thank you and thank you for your contributions to this inquiry. You have a presentation?

MR CURLEY (AIR): Yes, I just want to say thank you very much for the opportunity. I think it's an excellent report, but we've had some concerns for our members, of course, which vary quite dramatically. That's our issue; that they go from part pensioners through to people on Commonwealth Senior Health Cards, some above that. But the greater majority of our members - whilst we use the word "independent" - are not what one would class as in the wealthy class, and we really want to make that point. But over to you, Richard.

MR GOULD (AIR): Thanks very much. Thanks, commissioner, and just to reiterate what Robert said about our appreciation for the opportunity to be here. I'd like to read this, but please interrupt at any time.

MR WOODS: We have that habit.

MR GOULD (AIR): Our submission acknowledges up-front the many positive and strongly supported proposals in the report. The specific points we raise in our submission are split into a few that deal with consumer service issues, which have our strong support, and a number that deal with funding issues. In the time available today we'd like to deal with the latter, as we know that other groups will be pursuing the consumer service issues. With regard to funding matters, we realise that our submission raises more questions than it provides firm responses, but there are matters where we don't feel we're in a position to make specific comments at this stage and this is where we would seek the commission's consideration.

Our association fully appreciates all the detailed work done by the commission on the matter of funding the aged care system into the future. It's incredibly detailed. However, our difficulty is that we can't adequately assess from the draft report the extent to which aged people of various financial situations will be affected in terms of how much they might pay for aged care services based on the proposals in the report compared to what they're paying now for such services.

We fully understand the proposal that government would set prices for services based on advice and recommendations from an independent regulatory authority, so we wouldn't be expecting full price lists to be included in the report, but some indicative numbers by way of case studies would certainly help us to more adequately understand the likely impact on consumers of the draft proposals.

We took the liberty of providing the commission with a number of scenarios of some typical aged persons, single and couples, with varying financial situations and sought advice on what fees they might be expected to pay under the current arrangements and the proposed arrangements for the same services, both residential and community, and a combination of both. Hopefully that sort of information, with whatever qualifications have to be made by the commission, might be available in the near future or at least when the commission's final report is released. We do fully appreciate that such information would have to be indicative at this stage.

If I can just give an example of the sort of points that we're coming to and perhaps comment a little bit on residential care and the proposed funding arrangements. There are three components of funding. Looking at each of them, it certainly seems to us that the proposed basic components of residential care costs on the face of it are very reasonable, but again we find it hard to get a clear picture on how the details might work. For example, bonds certainly look to be more controlled under the proposals and we think that's a good thing, but we can't really assess what their range might be at this stage, nor what might be the range of accommodation charges.

Secondly, the cost of everyday living expenses will, as we understand it, be contained at 85 per cent of the pension for all consumers, which seems very fair, but it's not entirely clear as yet, at least not to us, what services will be included in that category and what related services may be necessary for the consumer to purchase as extras.

Thirdly, care contributions are to be capped at a maximum of 25 per cent. My view would be that that's eminently reasonable. For people at the higher end, 25 per cent of their actual costs sounds very reasonable, but 25 per cent of what? This is where we're not clear as to what constitutes care services as will be approved based on the individual's assessed needs and at what point will the consumer have to purchase extra aged care services and what extra costs might be involved.

Can I give a very simple example to perhaps help explain how we see this difficulty. Given that I'm dealing with a very strong economic body, I hope I've got my calculations right, and I believe I have. They're very simple. A single person who owns their own modest home in Sydney and has total income-bearing assets of, say, $400,000, would, if my calculations are correct - I will take responsibility - be likely to pay around $25,800 per annum now for normal nursing home care. That

would comprise the various fee components with in fact no cost for income assessment, but $25,800 now for that person in a nursing home. If that person asked us, "What will I pay for the same services and care under the new arrangements?" we wouldn't be able, I don't believe, to give a real answer. We could talk about formulas but I don't believe we could give even an indicative dollar amount.

Whilst on this theme, community services are even more intriguing for us, given the apparent lower level of consumer contribution to these services now, particularly in the area of extended aged care at home packages, EACH, and dementia packages, and again what we're asking for is some comparative scenarios which would be of great assistance.

Our submission sought clarification on several issues which I'd like to touch on very briefly and I may have already covered one or two of them. But we particularly would love to get a bit more clarification on the indicative prices for the various care services. As I said before, at the present, we know that the proposed range of co-contributions is between 5 to 25 per cent, but really I don't think we know at this stage 5 to 25 per cent of what level of total cost for each service, and I realise that's a whole other dimension.

What will comprise care services and everyday living expenses and what might constitute any extra services to be paid by the consumers in these areas? Will providers be able to increase the prices set for care services in the same way as the schedule fee works so that a price is set but a provider can charge more in certain circumstances? The relationship between accommodation charges and bonds, we don't fully understand it. We think the concept is great and it really does add some controls and transparency and things which we thoroughly identify with. How will the stop-loss limits and safety nets work in practical terms? Will the amount designated for the stop-loss, the $60,000, take into account all services received by an individual or will it only included approved care services? I'd like at the end, if I may, to comment just on one small point that wasn't in our submission, if I could come back to that.

On the question of means testing, our association does have a concern re the proposed new means testing formula which would include the family home as an asset. The tradition of not including the family home in such arrangements is a strong and longstanding one. For some aged persons of quite modest means, inclusion of the home in this formula will not only significantly increase their co-contribution payment but pose the need for them to consider the other options proposed in the report to release the value in the home when they would never have contemplated that. For the single person whose level of income and income-bearing assets would see him or her at the low end of the proposed co-contribution scale, the addition of a modest family home in Sydney, worth say $550,000, less than what we're told is the average, would, if my calculations are correct, on its own add

8.5 per cent to that person's co-contribution fee for care services. But, if I can say, we're still exploring this matter as we try to fully understand its likely impact on aged persons in various situations and what would really help us in coming to a stronger conclusion would be some information based on the scenarios of the kind we've provided to the commission. That would be very helpful.

So in conclusion, our concern is and has been in both our submissions that as a result of this review, aged persons and our member group of fully and partly self-funded retirees should not be asked to pay unreasonable amounts of fees and charges for services. To help us form a clear view on the likely financial impact on these consumers, we're seeking some additional information which would assist us in making indicative comparisons between costs for services now and under these proposals.

I'd like to conclude by saying the draft report provides a host of useful information that underpins the basis of the formulas. What we are seeking, respectfully, is just a little more so that we can perhaps talk bottom lines more than we can now.

MR WOODS: You said that there was some other point you wanted to add.

MR GOULD (AIR): Thank you for that. The other point I'd like to raise, it was to point out our Queensland division did a separate submission and there was a compatibility with the submissions. They perhaps came at things a little more strongly than the national submission but we worked largely together. They raised a point which we didn't put in our submission but on reflection I would like to suggest is really worth looking at and that is, with the stop-loss limit of 60,000, there is another proposal that the tax offsets for aged care services be deleted. I guess the more I thought about that the more I worried about it because I just feel, having been involved from a personal point of view in looking after the affairs of two relatives, I just know when - and looking after their money, because they were very conscious of their money - that it was a real plus to be able to tell them at the end of a given year that there was significant tax benefits based on a formula that not many of us get too much advantage when we talk about just day-to-day doctors' accounts, but when you look at the costs involved in someone paying 45, 50 thousand dollars to be in a nursing home.

So my concern is that if what happens is as clear-cut as that then that might be something that could be substantiated for people who benefit from the stop-loss arrangement. But for those who stop short of the stop-loss arrangement and don't benefit, then they have lost what I think is a very significant tax offset. So I would just want to - Robert would agree with this. We haven't had time to put this through our national body but I'm sure they would agree that that is something we would support more strongly. It wasn't an issue we put in our submission.

MR CURLEY (AIR): I think the whole concept of - the tax part of it is another part that we didn't really consider at that stage but it can form a significant part of it when people in different conditions - you know, there are some that have no superannuation that are having to fund their own income. They're looking for tax offsets - and this wasn't due to their fault. Many of those are 70 years old and never had superannuation. They get disadvantaged. What we're trying to do is just make sure that everything is on an even playing field at the end of the day.

MR WOODS: Yes. No, we're very happy to have that included in your list. If you like, the transcript can form that or if you want to send us an additional note - - -

MR GOULD (AIR): I'd love to do that if we could.

MR WOODS: Yes, that's fine. We recognise that issue. I guess one response at a broad level, but then I will go back through some of the detail, is that we were concerned in putting out the draft report that we gauge reaction to the broad architecture of our report in the first instance, that there was no point doing detailed matrices of case studies and the like if in fact the architecture, the framework that we were proposing was in dispute in itself. So we were reluctant to have people have in their minds, "Yes, you know, my actual position will be this number of dollars in this event," if there was discussion and debate that we hadn't actually constructed the scheme in the right way.

MR CURLEY (AIR): We do understand, and we have exactly the opposite concern, but the same concern really, because the whole thing was thrown out with the press. What they did - and they talked about losing your home and the user pays and, "Oh, my goodness," we have an association with the name "independent". That means they think it's going to - "We're going to be the ones who are going to be paying for everyone else." So then to try and get meaningful discussion with our own membership and calming everybody back to rational we felt we needed more to do that. So it became a - - -

MR WOODS: I understand your situation. That's the explanation for why we did what we did.

MR CURLEY (AIR): Sure.

MR WOODS: Let me then clarify a couple of the specific points, one being the care co-contributions up to 25 per cent. If you take an average, each package at the moment, you're talking in the order of say $50,000. For somebody with the highest income wealth end and paying up to 25 per cent of that then they're paying in the order of 12 and a half thousand dollars a year for the care component of their approved services.

So a CACP package, just for round numbers so that we can do the sums quickly, if it was $16,000 then somebody at that level would be paying $4000. Most people won't be at that 25 per cent level, they'll be less. We think that up to two-thirds will be no more than 15 per cent, 12 to 15 per cent, which is the sort of percentage contribution to care packages that a lot of people are paying now. Of course it would go down to 5 per cent in the community. There would still be the hardship provisions so those who come from homeless backgrounds or other particularly severe disadvantage wouldn't be paying anything. In residential care if you're a basic pensioner and you're currently paying your 84 per cent for your everyday living costs, which is your linen and laundry and food and cleaning and all related functions you wouldn't be paying anything for care; because you've paid 84 per cent of your pension basically you don't have too much else that you can contribute.

MR CURLEY (AIR): But of course then people who have misinterpreted what has taken place and suddenly said, "Oh, I'm going to have to sell my house," or, "I'm going to - - -"

MR WOODS: Yes.

MR CURLEY (AIR): "That's going to be classed in my assets."

MR WOODS: Yes. No, I understand. We're in this sort of difficult transition phase. When we produce our final report we will be producing detailed checklists and schedules and people can go across the matrix and find where they are and what it would be. But that's how that - the sort of parameters that would be involved in that. Additional services - there wouldn't be different prices and different levels of care depending on your financial situation. Your approved care needs are irrespective of your financial situation. So the only thing that changes there in fact is your co-contribution relative to the subsidy, but the total price paid to providers is the same irrespective of your financial circumstances and you don't have a change in your care delivered according to your financial situation.

MR GOULD (AIR): It may be a redundant question but there's still the question of definition of what "service" is.

MR WOODS: Yes. No, understand that. It's not a redundant question. It's relevant. To illustrate what might constitute an additional service, if somebody for personal hygiene reasons and support is assessed as requiring a daily shower and dressing, then that would be an approved service. If for their own comfort and lifestyle they also like to have a shower at night-time but it's not deemed as necessary in terms of providing personal care, then they would contract that with their provider on a purely market basis and they would pay whatever is the rate that was agreed

between them and the provider or a different provider or however else they wanted that achieved.

MR GOULD (AIR): Can I ask - and you may have this - you may want to raise this but just following that through then, would those services as you envisage it, be included in the calculation of amounts spent for the stop-loss?

MR WOODS: Okay, no, that's - - -

MR GOULD (AIR): Sorry - - -

MR WOODS: That's my next bit, but you're quite right. The stop-loss is your co-contributions for your approved care. That's important, because beyond your approved care people consume all sorts of different things that could be construed as care and support. They may not have approved care for extensive landscaping but they want that to happen. They either get the home handyman up the road who - they slip a bit of cash to a retiree, not that we're supporting tax evasion - or they might go through a provider who is in the open market. We're not proposing to capture all of those into the stop-loss.

MR GOULD (AIR): Sure.

MR WOODS: But also for clarity the stop-loss - and we have, in the draft, suggested 60,000 and we're seeking comment and reaction as to whether that's an appropriate level or not. But that would constitute a lifetime stop-loss. So all of your co-contributions over time would be added into that and as soon as you reach that then from then on all of your approved care would be 100 per cent funded by government. You would make no further co-contribution.

Now, very few people are actually going to reach that limit. Most people, if you're paying 5, 10 per cent for your care and even if you're on say the equivalent of what is currently a CACP package - if you're on 10 per cent, you know, 1600 a year, well, you're just never going to get near 60,000. You'd have to be on the most intensive care packages and you'd have to be on it for five or so years before you actually hit that stop-loss. So very few people are actually ever going to incur that sort of cost for their care.

MR CURLEY (AIR): But in terms of - as the community ages there may very well be a longevity in that occurring and some people may be - - -

MR WOODS: Exactly, and that's why it's there, for those people who require high-intensity care of long duration. That's there to protect them, but most people are not going to get anywhere near those sums of money of their own personal expense, $10,000, $12,000 over their aged care experience, the much more than normal sort of

expenditure that many people are going to incur in terms of their own contributions. For those who have limited means and wealth, it would be even less than that. They're the sorts of parameters that hopefully we've spelt out at least in the broad. I do understand your point then of responding to externally generated fears by some other parties that haven't been overly helpful.

MR GOULD (AIR): And indeed responding to people who just ask the simple question. They want to understand it and they say, "What's the bottom line for me?"

MR WOODS: "What does it mean for me?" Certainly in the final report we will be able to spell all that out once we have agreed with all the parameters. To the extent that some certainty evolves around those beforehand, then we'll stay in communication with you and work our way through with you on that.

MR GOULD (AIR): Thank you.

MS MACRI: And probably just to say there is some grandfathering for people existing in the system at the moment.

MR CURLEY (AIR): And on that one point then, you are still firm on the idea that the benefit will be the same and the costs will be the same no matter where the location of the person is?

MR WOODS: Yes.

MR CURLEY (AIR): Even though it might cost a lot more in some remote locations?

MR WOODS: The government would need to pay providers a higher cost; to what extent some part of that gets transmitted back to the individual, we're still seeking submissions on. But certainly from the provider's point of view, if it's a very high-cost location, they're going to need additional funding in rural and remote areas to deal with that. How that then translates back for individuals is something that we are seeking comment on, but we're conscious that in fact in many of those areas, people are of lower income and assets anyway. Even house prices of $100,000, $120,000 is more your house price in a lot of communities that I've been to, rather than the 550 in middle Sydney.

MR CURLEY (AIR): The other fear of course is that with the health service, the way it's changed over the times and the way that people in not so much the remote locations but the centralised areas, people, say, a hundred miles from Dubbo or something like that, they have major concerns of how this will impact on them because they have seen such a disappearance of services over the years and they're sort of saying this is just another way of chopping into those again.

MR FITZGERALD: I think we can be absolutely certain that this will increase the level of service provision substantially. One of the things we're very conscious of is that this has to be a regionally designed scheme. So one of the things we'll make clear is that the aged care system, we're envisaging, is a regional based aged care system and that's reflected in the gateway operating regionally, costings being regionally based, transferability of quotas for supported residents. So we do see it as actually being regional and taking into account those regional areas. But I think one thing we can be absolutely confident on is that services will increase. Who provides those, that will no doubt change, but I think we can be absolutely certain it's the reverse of what people might fear.

MR WOODS: Can I also just put on record that we've been interacting with you and watching your response to our draft and you've always been driven by the evidence. Your analyses are always fair and objective. Where you have doubts you raise them; where you find issues that you support, you say so, and we've been constantly impressed at the way you challenge us on the data but you then give a very objective analysis of the consequences, so that's been very helpful.

MR GOULD (AIR): Thank you. We certainly have tried to do that.

MR WOODS: It comes through loud and clear.

MR GOULD (AIR): Thank you.

MR WOODS: Thank you very much.

MR CURLEY (AIR): Thank you for your time.

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

DR SPIES-BUTCHER: My name is Dr Ben Spies-Butcher and I'm from Macquarie University but I'm not representing any organisation.

MR WOODS: You have provided written input to us for which we're grateful but please take us through your views.

DR SPIES-BUTCHER: Thanks very much. I should say at the outset I'm not an expert on the provision of aged care and my comments will be confined to talking about the financing arrangements rather than talking about provision per se.

The main point that I wanted to raise was the interaction of the proposals in the draft report with the existing arrangements in social policy, particularly within the tax system, and to raise the question of how this interacts with tax expenditures which are very sizeable, particularly in the argument put out in chapter 6 which argues against a universally public and subsidised scheme which is based on increasing taxation along the Medicare levy lines, partly because of the dead weight cost that that involves.

The alternative scheme which is to effectively tap into the savings of older people in Australia mainly held in the form of housing and superannuation - mainly housing now but increasingly superannuation over time - is outlined in the report as if that is a not publicly funded or publicly subsidised, so there's an option of public subsidisation which is direct funding from the state and an option which is private funding which is funding from the individual. What my submission raises is that those accrued savings are partly the result of very large public subsidies, about $70 billion per annum at the moment, which well and truly eclipse the direct public funding of aged care, both the individual subsidy to superannuation and to owner-occupied housing, each individually will eclipse that.

So what we should be doing is looking at the most effective way of spending public money, either through direct provision or through the subsidisation of savings which are then used to fund the same services. So what I'm saying is that the private funding model that's proposed by the report does not properly take account of the public funding which goes to creating those savings.

Now, the basis of this, which is to say the tax expenditures, that is, the tax subsidies of saving in the form of owner-occupied housing and superannuation, are reasonably well accepted now by treasuries, tax expenditure statements, by the Henry tax review, by IPART here in New South Wales. All those government agencies suggest that we need greater transparency and a greater integration between

subsidising services through the tax system and subsidising them directly through government spending. So the suggestion I'm making here is that we should count both of those. We should just integrate the analysis to say to what extent are we subsidising systems through public tax expenditures, but also to raise the possibility that because these policies all direct at the same purpose, that is, to protect people from both their loss of income and higher potential costs in old age, that we should treat them together.

When we do treat them together, we might see that the best or most efficient way to fund the extension of public provision is not through the extension of new taxes or raising existing taxes but through reorganising tax expenditures and more efficiently provide money through both the tax and spending systems and that there's ample room there to be able to much more fully subsidise directly, while instead of going and having dead-weight losses, I would argue actually promoting dynamic gains because those tax expenditures currently themselves, I would argue, have dead-weight losses which could be corrected through a restructuring. I can go through the specifics of individual - - -

MR FITZGERALD: No, you've got the paper; Mike has just had to step out for a second. We looked at a lot of this stuff obviously and we are still contemplating the financing section. A couple of things: one has got to be very careful about how one uses the terms of reference for an inquiry and how far one goes. So one of the things we determined was it was not appropriate for us to use this inquiry to be a lever for tax reform per se, nor for a redesign of superannuation and/or aged pension. Some might say it's a perfect opportunity to do that, but we decided it was not a perfect opportunity to do that.

But we did look at the issue of whether or not we could in fact use some of the superannuation benefits that individuals have received to help finance the aged care, and, as you right say, a large percentage of the superannuation benefits for the individual are subsidised by the government, public funded. That is absolutely true. One of the difficulties with that was that often the aged care costs come very late in life, potentially 20 years after; if we're talking about residential aged care, at 85, 20 years after people have ceased to work. In a public policy sense, it's a very hard ask to be able to say, "Well, let's quarantine a portion of that," for example, "for that period of time."

So one of the issues that we struggled with was, if you wanted to use the superannuation, how would you do it. Would it be appropriate or would it be acceptable? I must say that is a big ask, to ask the Australian worker to quarantine a portion of their income for a long period of time, and at the end of the day we felt that wasn't necessarily the most appropriate way to go. That is not redesigning the superannuation scheme or the public contribution in the way that you may want, but at least we did have a look at that. I don't know whether you have a view about that.

DR SPIES-BUTCHER: I certainly understand and take the point of the constraints under which you're operating. I suppose I would see, in terms of promoting private insurance vehicles, that there is an opportunity here for a public insurance vehicle, which simply takes a levy on the existing superannuation contributions and could do that without actually touching any of the money that workers themselves put in, by just touching the tax contributions - and that's perfectly consistent with, for example, the disability and death insurance that currently is integrated into superannuation.

That could also be done in a way that was more equitable, by in some way replacing some form of tax subsidy which disproportionately favours those on very high incomes with something that provides some form of basic insurance for all people, and lowers the limit at which personal contributions stop and the government replaces them in personal care, for example. So I think there are some options which are not the complete redesign of the system but simply acknowledge that one of the purposes of superannuation is to protect people from these kinds of expenses.

The most effective way of doing that is through direct insurance arrangements which are linked to superannuation and that that would be a better use of the tax dollars which go towards superannuation, not the worker dollars that go towards superannuation, about which I completely acknowledge workers should have some direct control over and make some of those decisions themselves. The other issue that I would raise though is that some of the report as currently written seems to almost deny the existence of these subsidies.

For example, in discussing accommodation costs, there's an acceptance that accommodation costs are borne by the individual, where there is currently 40 plus billion dollars worth of public subsidy of those accommodation costs already. At least highlighting that within the report and acknowledging that there are substantial public subsidies of accommodation and that it might be more logical, and for you in the future to look at how the government can subsidise accommodation across the board in more efficient and equitable ways, which certainly is possible, rather than to accept that that's not currently the case, when it seems to be that it is.

MR FITZGERALD: Your written submission is valuable in making that point. Can I just bring up this more fundamental issue? Notwithstanding there is public subsidisation of private housing, as there is in relation to private superannuation and compulsory superannuation, given those points, and given the system we have currently got, what is unreasonable? You say it's unreasonable.

What is unreasonable about seeking to access the equity in the housing that people have, if they need to be able to access it for either care or accommodation costs? I don't quite see it as unreasonable in the way that you do. Given the current systems that we have and given the current tax arrangements that the community,

through their governments, have endorsed for a long period of time, rightfully or wrongfully, what is so unreasonable about this proposition that we're putting forward, with a lot of safety nets in place and lifetime caps and so on, the accessing of the equity in the house?

DR SPIES-BUTCHER: There are two points particularly in terms of the bonds which I outline in the report: pre-supposes a reasonably efficient market, and reasonable fungibility between housing assets and other forms of assets, and I don't think that either of those assumptions holds very well in reality, in that the home ownership in Australia is clearly not only a response to incentives - that is, economic incentives, it clearly also has a range of social, cultural and intellectual relationships as well.

Encouraging people to access that form of financing has a range of costs that other forms of financing probably don't, and also I suppose if you accept the proposition that most of aged care is a necessary right then it does seem to suggest that those who people happen to incur that, which is somewhat random but is not entirely random, in that we know that certain groups are much more likely to be exposed to those costs, are those groups tend to be the opposite groups in many ways to the groups that receive the tax financing.

So in that sense, while it's better than just having an open slather market, I'll completely grant you that, it does seem to be walking away from the principle that says that people are entitled to some form of care and therefore it should be publicly provisioned in that sense. The other notion that says that it's not just accommodation that is provided by the family home, and therefore there are problems in being able to create the two as completely fungible.

There are considerable, I would argue, regulatory and transaction costs involved in establishing those safety nets, particularly in being able to ensure that people who, for example, are about to be admitted with late stage dementia are capable of making the kind of informed financial judgment that this presupposes they can make and that those costs should be taken into account - I don't believe they're properly taken into account now - in being able to weigh up the productivity gains from either option. If we take into account all of those regulatory and transaction costs apparatus, I would argue that in fact this is not the most efficient way to be able to provide those services. In the absence of that, as you rightfully point out, there are considerable equity and other concerns that would arise if they weren't properly regulated.

MR FITZGERALD: Although it is true to say that since they have had this extra service high-care category - which is an artificial means of funding the system - there doesn't seem to be a shortage of people willing to in fact sell their home and put in accommodation bonds, largely driven by the fact that they can also retain their age

pension, as irrational as that sometimes seems to be when you look at the actual dollars and cents. But nevertheless that's the case. So in one sense, since we have had the extra services market, it demonstrates, at least for a fair portion of the population, that they are in fact actually willing to sell their house and put in accommodation bonds well in excess of anything that approximates the cost of the provision of care.

MS MACRI: The same with low care. It's not just extra service. I mean, the precedent is there, in terms of the model, to a large degree.

DR SPIES-BUTCHER: I do accept that. I still would submit that there are more efficient ways of being able to manage that and that the way in which we currently understand the efficiency of services - which is primarily through dollars spent by governments, not by total dollars spent in the economy, nor even by total fiscal impact on the budget - artificially biases recommendations towards those that minimise government spending in ways that sometimes actually maximise or increase, more so than the savings, private expenditures. I do think that there are some elements of the report that are likely to lead to that outcome.

MR FITZGERALD: Can I just tease you out a little bit on your issue about the care co-contributions, where the houses could be used as a means of financing that, if you so needed it; your general view about co-contributions for care services.

DR SPIES-BUTCHER: I think where the care services are recommended by somebody who is a professional the risks of people not taking care which would be preventative in nature and prevent further costs is greater than any benefit that comes from encouraging a co-contribution. So I don't think that there's a strong argument there for an efficiency dividend from encouraging co-contributions. I think the only real justifications are either a budget constraint rather than an efficiency constraint on the part of the government, or a moral desire to want people to assume individual responsibility in a way that doesn't actually maximise efficiency.

MR FITZGERALD: It could be a combination of both of those.

DR SPIES-BUTCHER: It could indeed.

MR FITZGERALD: A moral desire but also a fiscal desire. But having said that, I mean, again just taking the co-contributions that we're talking about of somewhere between 5 to 25 per cent, zero in the case of hardship, your general view is that it's not the quantum of those co-contributions, it's really the notion of the co-contribution itself that's the problem.

DR SPIES-BUTCHER: Certainly it's a combination of the two things; that is, if the co-contribution was 100 per cent, that's certainly very different from it being

10 per cent and I would have very different views on the two. But I think here there's already an acknowledgment partly in the report about the preventative nature of this sort of care and I would suggest that the literature in health care, where co-contributions have been flagged for a long time - and I don't think there's very strong evidence that they enhance dynamic efficiency at the market much at all - that is, that the activities that they discourage are not the activities which have the lowest marginal utility, they're often activities which just happen to be undertaken by the people who have the least resources. In that sense, there's no dynamic gain from them. So it's not so much that there's in-principle moral opposition to co-contributions so much as I think there's no reasonable argument for why co-contributions enhance efficiency, and as soon as you have co-contributions, you have a range of other problems which happen in terms of perverse incentives, boundary problems and other things which seem to have direct dead-weight cost in the system. So it seems that you're increasing inefficiencies by introducing co-contributions in this particular instance.

MR WOODS: I've read through the submission and happy that I understand the views. Thank you very much.

MR WOODS: Can I ask Aged Care Association Australia New South Wales to come forward. Could you please for the record state your name, the organisation you represent and the position you hold.

MR WURF (ACAA): Charles Wurf is my name from the Aged Care Association in New South Wales and I hold the position of chief executive officer.

MR WOODS: We are now in possession of, but only recently, the response by the national office, but I understand you want to draw on some of those elements in your presentation, so please proceed.

MR WURF (ACAA): Thank you, commissioners. I thought I'd make a relatively short statement and then I'm happy to discuss any questions that may come, and follow the format for the last two days.

Firstly, just for the record, can I say that as the CEO of the state of New South Wales, I will be relying on a common and uniform national submission. There's been an extraordinary amount of work done from the provider site to try and engage with the totality of the draft report and all of its recommendations and that's led to that submission that's just come into your possession now.

Firstly, in making some opening remarks, can I just endorse what we've put to you in writing which is that as a representative of the provider base, we welcome the four major recommendations and philosophical approach of the report which is to look at the four major cost components of personal care, health, living expenses and accommodation. I think it's important for me as a provider representative to accept and endorse the philosophical underpinnings of the report.

I think, and the providers I represent, after grappling with this for some considerable time believe that the balance represented across those four major cost components in the broad framework is sound. I think that's also important to endorse. So in making that, it's been a little bit of a theme over the last two days but as a public policy piece of work from the commission, you're to be congratulated for the sheer depth and breadth of it, the willingness to engage with an enormously complex system and to seek to try and create a framework for the future where there is some simplification of that while still ensuring service delivery.

I will, at the risk of sounding trite, just endorse the fact that the commission is looking at the care of older Australians in its broad context and in doing that, is focusing on all of older Australians. I will then, at the risk of seeming trite again, focus on that part that my members are involved with which is the relatively minor percentage of older Australians who do in fact require formal care, both community and more specifically residential. So that's where I'll come from in these opening

remarks.

There is a detailed engagement around all of the recommendations but I want to focus today on three of those issues and unashamedly come from the funding side of it, from a provider base. The first of those issues, whilst we accept the focus on the daily charge for residential care, I think it is very important for there to be a sound transition arrangement and an ongoing acceptance that lump sums have an important part in the residential landscape that we have now and have been an important source of capital funding to create the service capacity that we're delivering.

I think the next lot of published figures will indicate there's around $10 billion being held in the bond pool for residential care and whilst that can be viewed in isolation as a terribly scary number from the public policy point of view, I would also say that without that bond pool of capital, probably the capacity that we're currently delivering in residential aged care may not and probably would not have advanced to where it is today. So I think it's really important for the commission to keep grappling with the structure of a daily charge. I think that's the important public policy approach, particularly in seeking a reform of this magnitude, where there is a recommendation that individuals accept the accommodation charges and seek to make an ongoing contribution to that, but to ensure that that bond pool, that available capital, is not rapidly diminished in terms of viability.

I think as commissioners you're aware that nationally we've commissioned a piece of research around that financial viability and we will look forward to sharing that with you once it's done. So I guess the point I would leave you with there is not to create a set of institutional biases against a lump sum, that they are useful and can be an enduring feature of the system. I think, if I can just pick up on the commentary from the presentation before mine, there is an increasing number of people willing to have lump sums and to utilise lump sums as a part of their changing accommodation and that can be both at and indeed before reaching residential accommodation stages. Lump sums around transitioning from family homes have been a feature of planning for retirement and care needs for a decade or more. So that would be the first point I'd like to leave you with.

The second is to focus just briefly on the overall gateway proposal. We accept the whole gateway concept as again sound and a good and appropriate way for consumers to access the variety of care into the future. I guess bitter experience would lead me to categorise it, and just to take care that a gateway doesn't become yet another form of a gatekeeping exercise which would be fundamentally opposed to the overall philosophy which the broad spread of recommendations seeks to move to, which is care as a right, and funding, following care needs. We do have some specific commentary in our response around allowing providers to be involved in the reassessment.

MR WOODS: We discussed a bit of that today but I noticed that you had it in there.

MR WURF (ACAA): Yes. I would rely there on the workforce that we currently have in both residential and community care spaces which can and should be viewed as a very professional and competent group in the main, currently engaged in assessment processes that do drive funding and resources to care need, and I think keeping the provider base both at community and residential engaged in that reassessment can ensure that resources continue to follow changing need over time.

The last point I just touch on very briefly is the workforce issues. I have read the recommendations from the commission around workforce. There are a range of submissions to the commission that probably more appropriately belong in an industrial relations context than a workforce context, those two things are in fact different. But I would again indicate that we have commissioned a piece of research around the current cost of care because wages on the philosophical model proposed in the recommendations will continue to be the relevant state or public subsidy and therefore the level of that subsidy will inevitably any wage outcomes that can be applied to care staff.

So if care funding is independently valued in accordance with the recommendations and proposed structure through the report, then there will be a response available from wages and how that care funding flows to wages but if that part of the recommendation is not picked up and delivered then, in an industrial relations context the same old arguments about wage outcomes will continue to endure into the future. Commissioners, they are basic points I would like to leverage off the written document and happy to have a discussion or questions from there.

MR WOODS: Thank you. Can I put on record our appreciation for cooperation of your association, not only directly with the association executive but also individual members who have welcomed us to their facilities or their operations and shared their various issues with us. It has been very helpful. Perhaps taking them through in the order that you presented, we are very conscious of the need for appropriate transition arrangements. The care providers are the backbone of the paid component of care delivery and, in association with the informal carers, provide services to older Australians. We certainly see an imperative in having an orderly transition. It is not in our interests for significant disruption of the industry as such. That does go so far as to protect each and every individual provider. Some of them have adopted riskier business models than others, some of them have taken different positions in how they operate their business. It is not for the commission to ensure that all of them have an easy transition. Certainly we wish to ensure that the residents or recipients of care are properly looked after.

MR WURF (ACAA): If I can just pick that point up. I would not be sitting here advocating for every individual current provider to endure or be protected in that sense but I would make a general comment that the system within which the provider base operates needs to be both robust and viable well into the future to allow that market approach to be sound so that services can continued to be delivered.

MR WOODS: Yes. I think we have common agreement on that. The commission doesn't have or propose to implement any institutional biases toward or away from lump sums. In fact what we are trying to do is to create a level playing field so that individuals can make a choice that will not impact on their other entitlements such as their aged pension, will allow them to assess their individual circumstances and for those who may be uncertain as to how they require residential care or may prefer to retain the family home for whatever reason or all sorts of different circumstances choose to pay by way of daily charges, that's fine; if they choose to pay it by way of a bond, then that's again an individual decision. We're just trying to take away any current biases from the perspective of the individuals that may encourage them one way or the other.

MR WURF (ACAA): Indeed. Again, if I can offer the view at that point that already the thinking that the Productivity Commission has promoted through this draft is releasing some innovative thought around how alternative accommodation models can be scoped and then delivered and already I think we have seen through the course of today some insight to that but I have already been exposed to folk considering using group home planning, retirement village planning, strata planning, all of those options around freeing up accommodation is what we should in fact be encouraging. But at all times - and I should have made this quite clear in my opening address as well - I just work on the assumption it's a safety net that permeates the whole thinking through the draft report and is something our members are completely focused on as well.

MR FITZGERALD: Just on that, we had providers present - I must say we have had more providers present in Melbourne than we have had in Sydney but most of them seem to be unsure but not perturbed by the fact of the proposal in relation to the bonds, that is, in this context. Most of the providers have said to us that they would believe that still a fair percentage of people would elect to pay a bond once it comes closer to the actual cost of delivering that service. Nobody can predict with certainty what that will be. One of the issues that has arisen and I am sure it is in your submission is the issue about transitioning, given that uncertainty, particularly those that almost rely on a bond coming in to pay a bond out, so there is a transitional issue.

But we have been intrigued by the variety of providers from entirely different backgrounds all of whom have basically said the same thing. Now, I am sure there are some providers that have a very different view to that. But is that the view of

your members generally?

MR WURF (ACAA): Generally that's right. It's around the transition because there are unknown factors at play. In one sense there may very well be an adjustment downwards around some level of bonds but there is an opening up to a potentially wider group of people who may contribute a bond. So that is an unknown variable. There may in fact be a lowering of the average amount but applied to wider number of people. There is also without doubt different providers operating with different legacy stock off their residential or their physical properties, so that is also going to have a key component in that.

In my submission to you I think it is quite clear that lump sum accommodation refundable deposits have driven most of the building capacity of the last half decade and most of the planning for residential services that are being built now all have a component of lump sum refundable accommodation deposits, be they low care or what we currently know as extra service. So at that tend of the market we have driven without doubt an overall improvement in the physical building stock. The other part of the physical buildings that do exist are the multi-bed wards in the older buildings and at the moment they would tend to be standard high care, at least in a large part of the Sydney metropolitan market and they have never had access to bond on the current framework of the Aged Care Act. So how that plays out is an unknown proposition but the market will respond to that.

In some cases some of those buildings may not go forward as capacity, in other cases they may be redeveloped to allow either a daily charge on a different model or positioned in to supply this assisted resident market and/or to look at some modest forms of refundable accommodation deposits. None of us can actually forecast what will happen in that because there will be legitimate market responses to it.

MR WOODS: Sue, did you want to comment on that bit?

MS MACRI: No, not really. I guess it's going to be interesting in that in terms of those facilities that have sat back and haven't upgraded and where they fit into the marketplace in the future but I guess that's - - -

MR WURF (ACAA): Indeed. That is a very important part of the transition.

MS MACRI: That is actually quite a high proportion of the industry.

MR WURF (ACAA): Indeed, and it's important for me to reiterate that from a residential point of view there is significant lead time in terms of making capacity operational, ie, from concept to planning to design to construction to commissioning currently probably averages around about the four to five-year mark in New South Wales so there are significant lead times in that. I think it is also worth me stating,

without wanting to be overly dramatic about this, that most project development is pausing in the New South Wales market at the moment obviously whilst services digest what is in the draft report, where the recommendations may go. I think it is fair for me to also observe that the current allocation round for both community and residential places for the current financial year has not seen the light day and we are effectively at the end of March. It's quite possible that that may not see the light of day for this financial year. That is one of a range of possibilities. Even if it was to be released tomorrow it's unlikely that there would be a response in turnaround time.

I think it's just important for me to just state that there are lead times around service capacity that are being impacted by the good work that is in the draft report which is more probably for the next stage of what happens in response to the recommendations from government.

MR WOODS: Just on this issue to conclude it, I was heartened by your introductory comments that in fact a number of providers of accommodation are looking to the variety of accommodation settings, whether they be some forms of congregate living, of retirement villages, of cluster housing, a whole variety of accommodation and if that were to come to pass and individuals had a much wider selection of accommodation rather than the home of many years versus an ILU versus an residential aged care facility but could in fact choose an accommodation option that suited their needs for a period of time, that in itself would be a very worthwhile achievement with the knowledge that care would be delivered to them according to their need for care.

MR WURF (ACAA): I think I need to be realistic in that and state that obviously it will operate at the margins for the foreseeable future just because of the lead time that we discussed to get projects of that nature up and the fact that we currently have a residential system of 175,000 places today means that there is obviously lead time in that. But for me I would see significant hope for the five to 20-year time frame for there to be a variety of perfectly sound and perfectly responsible market-driven solutions operating around that margin.

MR WOODS: That is certainly the time frame that - well, certainly the five to 10 plus years time frame that we are hoping that this report will be effective from.

MR WURF (ACAA): Indeed, and without going into the detail of the transitions we have actually tried to come to grips with the timing around the freeing up of community places and what that does to residential - - -

MR WOODS: Bringing that forward.

MR WURF (ACAA): Whilst I unashamedly come from the providers' financial balance sheet position here today, if we don't have those sound - provide balance

sheets then we have no service capacity into the future because one thing I am convinced of is that government cannot and will not be able to provide these services. So unless we get the policy framework sound where government continues to set policy regulation funding but a non-government and private market response takes place, then we're not going to have service delivery.

MR WOODS: We agree.

MS MACRI: Can I just - which is unique to this state but no doubt there will be other idiosyncrasies with other states around the merging of high care/low care and in particular to this state in requirements under the Public Health Care Act - I mean, the biggest issue that comes up constantly over the two days here and even when we have met with providers is around those requirements under the Public Health Act and I'm just wondering whether yourself and ACSAA have started to have any dialogue with New South Wales Health in relation to those requirements.

MR WURF (ACAA): I'll say tongue-in-cheek firstly we're not quite sure who to talk to in the state of New South Wales prior to last Saturday so I suspect we will re-engage quite seriously on that issue. But it's also worth having a longer-term view of what that provision ion the Public Health Act and, for the record, it's worth me stating that it is about the only residual piece from the old Private Hospital and Nursing Homes Regulation which goes way back into about the 40s and 50s and carried well forward. The Nursing Homes Act, as it then was, was repealed close to a decade ago or might as well call it a decade ago but that one provision remains within a state-specific piece of legislation. In my view it's perfectly and eminently repealable and should in fact be covered by a combination of standards and accreditation monitoring well into the future around appropriate skills mix.

No matter what is written into either nursing homes legislation and/or accreditation standards, fundamental duty of care obligations reside with an approved provider to have the appropriate skilled staff for the care levels being provided and, in my view, that fundamental legal obligation can be driven in combination with standards and accreditation outcomes.

MR FITZGERALD: Just two questions. This is in the Australian peak bodies submission but I just want to clarify. In relation to this contentious issue where we indicated that the government's contribution for supported residents should be at two rather the current 1.5, I just want to be very clear, it says here, "The Productivity Commission should make single-person rooms with shared en suites the main funding." I'm reading that correctly, that is, you would have two single rooms with one share en suite as the funding formula.

MR WURF (ACAA): Yes.

MR FITZGERALD: So it's one point something.

MR WURF (ACAA): It's worth me noting this has been one of the most contentious issues for us to contemplate on a provider basis.

MR FITZGERALD: It seems an eminently sensible recommendation.

MR WURF (ACAA): I will make this point before I come to the direct answer. There are buildings standards and then there is funding models for the safety net part of our resident population. What we have deliberately gone to is the funding model for the safety net. For the reasons articulated in the submission and I think you have been exposed to those in your consultations, there is a firm position adopted by the representative associations that a single room with shared en suite in our particular view is the appropriate minimum standard for that. There is an unresolved point in our submission which you will need to grapple with which is legacy stock and how that is dealt with. But in terms of looking to the future funding models we believe that community had well and truly reached the position where that single room is the appropriate standard for a whole range of reasons, both in terms of resident population - it goes a long way to dealing with, firstly, simple privacy and dignity issues that all older Australians are entitled to but, in my view, it also goes a long way to some of our special needs and special interest groups where you can have care being provided in a single room. So there are a whole range of underlying reasons as to why we have reached that conclusion.

MR FITZGERALD: The second is just in relation to capital stock for rural and regional facilities. We have heard a lot - quite rightfully so - that people want to make sure that we have given due consideration to the special circumstances of more marginal operations in regional and remote communities. But I was just wondering whether you have a particular view about what the right government approach is in relation to money availability for capital in fact in your extended facilities.

MR WURF (ACAA): I think where possible a market solution should be encouraged but in saying that there will be pockets of Australian community where there will be potential market failure unless there is a direct response. There are probably going to be two types of responses there, either block funding for service delivery, as was canvassed in some earlier presentations and, quite frankly, some capital grant may be needed across combinations of services for probably the more rural and remote. You have already had canvassed the intersections across health delivery versus residential delivery and I would say that one of the attractions of this model for the general aged care provision but particularly in rural and remotes is the capacity to hub out community-delivered services from a piece of infrastructure, a piece of physical infrastructure.

All that does is deal with your capital issue and, in my view, that is easily

fixed. If we broadly move to this system and allow the market and us as individuals to deal with a growing percentage of aged care delivery, that allows government the capacity to fix some of these capital issues in rural and remote but that is an easier solve than health and medical workforce and aged care workforce issues for some of those communities because we do simply run into the position where the physical bodies are just not available, just not available full stop to actually deliver the services.

MR WOODS: That's very helpful, particularly your point about using some physical infrastructure as a hub to then distribute community based care and whether that's an MPS model or a stand-alone facility that does a bit of subacute and transition care, respite and - - -

MR WURF (ACAA): Yes. Probably a gratuitous comment but I think one worth making is the journey that residential aged care has had for probably 25 years as we have slowly become more centralised to your Commonwealth funding is ahead on a far shorter time scale for the home and community environment. I think that as that policy and funding apparatus is centralised to the Commonwealth there will be in-built drivers for scale and efficiency and I think that is going to see consolidation around the providers of those services and I guess the trick for both the commission in its recommendations and then government in its responses is not to lose the local delivery component where there is consolidation and scale because without doubt the local delivery component of particularly that current HACC end of what we do in community and residential aged care is going to be important.

MR WOODS: I did like your juxtaposition of gateway and gatekeeper. I will keep that firmly in mind and that's not our intention. In fact we're trying to dismantle some of the gatekeepers and not construct new ones, however, the public purse, the overall fiscal sustainability of the system must also be kept to the fore and there must be mechanisms by which a balance is struck between providing services to older people, older people contributing to the cost of those services and the sustainability of that funding model.

MR WURF (ACAA): Look, it's a bit hard to keep self-interest out of this argument that I'm about to present but the workforce engaged in our community and residential approved provider base is in the main incredibly skilled. It has just been through an enormous amount of up-skilling around assessment processes for both community and particularly residential care and it would be a great shame, in my opinion, if that skill set was devalued by not continuing to be engaged in the reassessment processes.

MR FITZGERALD: You would have heard me say yesterday and we have said it in Melbourne that is possible in relation to the ability of the providers to reassess people without the need to go back to the gateway or reassess people with a need to have that ticked off by the gateway is still under consideration and it may well be

that the approach we take for residential is slightly different to that which we take for community but we're working that through. But certainly we recognise in residential care there is almost an ongoing assessment or reassessment taking place. In community care we just need to understand that a little bit better but we are conscious, certainly in the residential area, that expertise is vital.

MR WURF (ACAA): Again a gratuitous comment in support of flexibility in that space. I think it's important for the commission to contemplate that increasingly community and residential be an integrated space and therefore I think if you have good quality assessment skills in the community environment it's important for us all to recognise that sometimes that assessment will be to residential as the most appropriate outcome.

MR WOODS: We fully acknowledge that.

MR FITZGERALD: Absolutely.

MR WOODS: Any other final comment you wish to make?

MR WURF (ACAA): No. Thank you again for the opportunity.

MR WOODS: Thank you for your ongoing contribution.

MR WURF (ACAA): Thank you.

MR WOODS: Can I ask Clara Jones to come forward, please. Thank you. Welcome. Could you please, for the record, state your name and if you are representing any organisation.

MS JONES: My name is Clara Jones. I am the coordinator for the Mangrove Mountain community group's aged issues. I also feel that I am representing not only the members of my own community but the almost 3000 people from across Australia who signed a petition I carried to Canberra some years ago, also the many who were unable to put in a submission because they don't know that this commission is happening. I didn't know until three weeks ago. I would have put in an original submission had I known.

MR WOODS: That is a pity because it was advertised extensively but we apologise if it didn't reach you.

MS JONES: We're a rural community that don't get mainstream papers.

MR WOODS: Please proceed.

MS JONES: I am going to give just a part of submissions I have received from two older people in this because I know that they would like to have been able to put something is. The first one is from a 90-year-old ex-businessman and he's actually a speaking one:

> - - - and we've had the strangest outcome because I've had a medical doctor, a geriatric fellow, attempting to deal with our best interests, I guess, but turned out not to be our best interests because he was talking to our kids before he spoke to us and I have absolute concrete evidence and experience that he helped them plan to Shanghai us into a nursing home.
>
> Now, those who know me know that I'm not in some ways ready for that nursing home and my wife needs to be looked after by me with their help and not by any other means until such time as that can't be done. I've hade eight children, 20-odd grandchildren, 16 great-grandchildren and so I dare to suggest that a very simple little roster system would mean that they would not be very heavily burdened to keep in touch with us and give us a bit of company and a bit of support.
>
> Now, what has been offered to me by seemingly well-meaning people is the opposite to what I say any person needs. I said this to my kids, I have dealt with no end of people, many, many people in my course of ministry as an ordained minister, both rich ones, poor ones, black ones, white ones

> and, of course, I have my interests and my own experience to draw on and this my conclusion, this is my statement, that whenever you are determined or saying that you're going to help someone this is how it ought to be: you find out what they are trying to do and you help them do it but you never browbeat them, you never manipulate them, you never dominate them. You never, ever say that, "You're too old to make your own decisions." You don't say, "We know about, think and act in your interests better than you do." So they are the never nevers.

The second is from a 70-year-old who a couple of years ago got an AOM for community services:

> How about we show some compassion and commonsense and invent, "Elderly driver. Be patient signs." Now, the modern cancer or plague of aged care centres, the poor unfortunates are no longer a useful part of their community or family. How many times do I need an elderly member of my community's words of wisdom or time hands on to help at fund-raising contributions or expertise, craft, cooking during my lifetime of volunteering et cetera these people, even if not mobile, whilst ever they live. I have known many who did not sign agreements in haste and under pressure to go to care, "It's best, safe," whatever. They reconsidered, came back home, regained hope, independence, much less medication and five are so years on area older but free, hopeful, interested and happy always against family and expert's advice.

Staying in one's community is important to many older Australians, not just our indigenous people. It is no medical secret that removing older persons from their community frequently causes them to go gaga and, if against their will, even more so. Staying in one's own home can have many problems, especially rural or outer urban areas, loneliness, malnutrition, depression, limited access to care, they are vulnerable to scammers and violence as recent history has demonstrated. Bullying, either actual perceived is a major issue and very much so in our area.

Why is there no alternative in the community for the short time they could remain independent and mutually supportive of each other? What is needed is community land which can never be sold, set aside to be used by the community to provide for all other members. Each community would be expected to take responsibility for determining priority but the outcome must cater for everyone in that community whose needs dictate they would be better in a more integrated system.

Many of the hospitals built in rural areas were built by way of community effort and would be ideal sites for an community aged care centre. That came out very much so when I carried the petition through rural areas of Australia that they

wanted the rural hospitals that were being closed to be used for community aged care. Maintenance of independence and dignity is equally as important, so cottage hostels with residents allowed to contribute towards the day-to-day workload and decisions or composite and cottage homes would allow older persons to remain happily independent in the community at much less burden to the taxpayer.

Another one that touched our community very much: many older people worked in the public service for very low wages to help make this country what it is today. They were assured that they would be compensated as money was being set aside to take care of them in their old age. Some remained in cheap rental housing. Other sacrificed and managed to purchase modest homes. For many this meant that children and grandchildren also worked alongside the parents, especially in rural areas, to keep the farm and lift the family out of the poverty trip.

While making these homes subject to the assets test one would frequently be stealing from the younger generation their rightful recompense for labour putting good experienced farmers off the land and condemning several generations back into the poverty trap. What incentive would be left for others to try to get out? When older persons are forced to leave the community the effect is far greater than just the loss of one person. The partner is frequently put under considerable stress unable to visit often, if at all; children and grandchildren likewise. Friends and peers become apprehensive lest the same fate befall them, not to mention the brain drain on the community.

It may be considered financially cheaper to condemn older people to huge geriatric centres outside their community where they may continue to exist beyond the time they would have lived in the community. I doubt that many of them would the trade-off worth it. Certainly many communities are the far poorer for it, not only in the financial loss of farms that would help them to keep them stronger but the brain drain, learning of tolerance and consideration by the younger ones, having a granny or grandpa with time to listen or to impart knowledge of the past era, the valuable experience and knowledge that only old age can bestow.

One has to wonder why, when the emphasis for the past 30-odd years has been to keep persons mentally ill, intellectually handicapped and disabled persons in the community has the emphasis been for people over 55 to be encouraged to leave the community and enter a commune with only older people. Their resources are often rapidly used up on corporate fees and the fruitless search for acceptance and fulfilment. They can't return to their community because they end up lonely, forgotten people, just ripe for the older abuse that so often happens sometimes becoming difficult, embittered individuals who are drugged to keep them in a cooperative existence.

I've worked in the aged care sector and I've had relatives in the aged care

residential sector. I know what I'm saying and so do a lot of other people in our community. If voluntary work could earn Brownie points towards later aged care needs in the community maybe the older people could continue to have a productive life in their community. After all, you don't need to be able to walk to listen to a child read. Our community came up with the idea of a composite home. There would be a central community room with facility to make a cuppa, talk or watch TV et cetera and a toilet and a common laundry. Of this would be several wide corridors into which older people from the community could lock an independent living unit, eg, a mobile home or a caravan which could be removed by family if so desired when no longer needed. A lot of the older people said that they would put one there and donate it to the centre when they passed on.

There were several units that could be made available for those unable to provide their own. This would overcome most of the problems without putting undue financial pressure on individuals. It would give far greater protection to the oldies because in rural community of the loneliness and isolation. We would, however, need the land to set it up, community land that couldn't subsequently be sold. It is felt that one in each village centre would be ideal. Initially one at central Mangrove with enough land to establish a small cottage, convalescent, respite care, permanent care hostel with paid carer and community volunteer assistance where people either temporarily or permanently unable to remain independent, could be cared for.

We thought a biannual competition to determine the best maintained facility would ensure community pride and involvement. There are seven village centres in our community. Our community feel that they don't want to set up something where people from other areas are made to come because we had a vacancy. It was generally felt that this would be tantamount to premeditated cruelty as we would not like it to happen to us. The attitude that because a family home is registered in the name of the older people, therefore, the younger have no right to expect to inherit is false in many cases, especially smaller towns and rural communities. It is not uncommon for the entire family to contribute both money and effort in order to keep the family home. Many older people will stay in the home in an effort to ensure the younger ones get what they, the oldies, consider is rightfully theirs or to ensure they have a chance to stay out of the poverty trap.

There seems to be no conscience about allowing already rich CEOs of public companies to take an obscene remuneration at the expense of the superannuant. There appears to be no mention of the fact that the majority of people get no voice on this matter, that is, if their superannuation has been invested in public companies or that they would have a far better retirement fund if this was not allowed. That superannuation is invested in these companies cannot be denied. That many were set up at the taxpayers' expense is also true, like, Telstra, Commonwealth Bank et cetera. So why is there no push to protect that asset rather than take equity out of the family

home of the poorer people of the land?

If a family is expected to live on the minimum wage, surely others could survive on 10 times that amount. The difference could be invested to provide real care for the elderly in their own community were the cash flow would benefit everyone in that community. After all we have paid twice for these companies in tax and then in the purchase of shares. It seems to me that the rich wants to get their hands on more in a plan to inflict on the rest something they don't really want and which will leave the following generations worse off, both financially and humanely. The message that coin takes precedence over care and showing integrity appears all to evident.

To conclude, slavery was profitable, forced child labour certainly was, so why do we condemn them? Is not the intention to make profit from another vulnerable section of the community by business equally immoral? Why not give communities the government money to help them to care for their own. Greed and care are mutually exclusive, don't you think? Which is more important, that people stay alive as long as possible or that they are able to live as happily as possible for as long as they can.

You mentioned a review of the accreditation system. I suggest - and a lot of others I know suggest - try giving that process over to local retirees who have a vested interest and let them do totally unannounced checks and maybe the abuse in these centres will decrease. A final suggestion, sponsoring of a hands-on, hands-free walker would help many, many elderly to stay out of care a lot longer because most people who fall because they have let go of the walker to get something.

MR WOODS: Thank you for that. You have clearly put a lot of thought into that and have spoken to a wide range of groups.

MS JONES: I would like to hand over to the commission two submissions, a tape and a submission from the other person.

MR WOODS: We will accept that gratefully. Thank you very much for coming today and your contribution. Thank you again for coming today. It's appreciated.

MS JONES: Thank you again for allowing us to go at the last minute but we were totally unaware that the commission was going on until three weeks ago and then I had to get the draft report.

MR WOODS: You have worked very quickly. You have done very well.

MR WOODS: That concludes our scheduled presentations. Is there anyone in the audience who wishes to make brief unscheduled presentation? Please, a brief statement. Could you please state your name and if you are representing any organisation.

MS STEFANO (TACS): My name is Maria Stefano. I am the manager of the New South Wales Transcultural Aged Care Service. We made a response to the interim report but I am here basically to say that we appreciate that CALD issues have been covered quite comprehensively in the interim report. We have made a couple of extra suggestions in our submission and you will see that, I think.

MR WOODS: Thank you.

MS MACRI: We have actually met with your counterparts in some of the other states, so it has been very useful.

MS STEFANO (TACS): We agree on each assumption that they have taken on board.

MR WOODS: Thank you very much for that. Anyone else? Yes, please.

MS GEAGHAN (WC): Thank you for the brief opportunity. My name is Louise Geaghan and I work for Willoughby Council. I'm the aged and disability service coordinator there. I provide policy to the council about local government issues but we also help auspice seven HACC services. The thing that concerns me is the gateway approach, and I know that you're talking about the fact that creating the regions will be very important, but I'd like to point out - and I'm sure other people have done this - that the failure of Carelink, certainly across New South Wales has been just staff training, it's the way that service provision in community care has been provided.

In our individual area we've got six home care providers, we've got six personal care providers. Within our council we auspice services that cover the whole HACC local planning are, the HACC subregion, plus just our local government organisation. So it's really important for the gateway that you keep that local because local people have the knowledge about the way that services are distributed. That is just the point I wanted to make.

MR FITZGERALD: Can I just raise a question. Why do you think the Carelink service has not been as successful as people would have liked?

MS GEAGHAN (WC): I don't think it's lack of advertising because there is a lot of advertising that we see in local newspapers and in the larger media. I think it is because people ring Carelink, they often get diverted to a different so that the staff

don't know the local area that they're inquiring about. But it's also because the people within Carelink aren't trained to the extent that they should be. They're not give the local knowledge. It is very difficult for them to have that, within a region, within a local planning region. As I said, within just one local government organisation there is such complexity just within the HACC service, not even considering packages and residential care.

So it is a combination of staff training and the complexity of the way the services are provided. So I applaud you for trying to make it less complex but I think that is going to take a long time and there is a lot of funding out there that is not going to be relinquished very quickly so that is why I am imploring you to keep the gateways local so that we can continue to provide that information. In my role I get probably four or five calls a day from older people who are desperate for information and have already called Carelink and have been given a list of phone numbers. They call those phone numbers, there's waiting lists, they're on multiple waiting lists and they don't know what to do about that.

MR FITZGERALD: Thank you.

MR WOODS: That is very, very helpful. Thank you for that.

MS GEAGHAN (WC): Okay.

MR WOODS: Is there anyone else who wishes to make an unscheduled presentation? Last opportunity.

MR WAY: It's Cameron Way again. The speaker after me referred to the contrast between our two presentations and I had a chance to catch up with him. I don't know whether he is still here - yes, he is, the gentleman there. I just want to make the point that in terms of raising complaint processes that need to get the on the ground evidence - I think we're in agreement here and please object if you don't agree - that in - - -

MR WOODS: You speak on your behalf, they can speak on theirs if they so wish.

MR WAY: Sure. One of the things I see with the complaint process of getting it right is I believe it frees up the providers as much as the advocates and the concerned citizens. As I was saying to him, if you can get that direct on the ground perspective that many nursing homes, even if they're not perfect, are doing their very best, particularly in regional areas, and they should be left alone to get on with the job. As a person who has been on the wrong end of that, I really do want to reaffirm that and it's that evidence thing of the witnesses because - as I said before. I don't want to repeat myself.

I just want to highlight with the different submissions, including the last one, that I perceive a variable interest in that integration of aged with the rest of population as far as possible and I'm seeing that out of what is coming out of the productivity report as an openness in the market to do that and I think it's a very good thing. I find that with a lot of people it's socialisation - where you are having social connections matters so much. So I guess they're the two points I wanted to make. Lastly I just want to say I don't know how much impact you have from people who are direct consumers - - -

MR WOODS: Quite a fair bit.

MR WAY: You seem to have a very good brief but I get a little bit concerned with quietly spoken, very confident industry representatives and that they have very valid points and I know that they provide all the means to all care to provide it but I hope submissions like myself are really giving that reality check on the ground as well for the people who have to use it. Thank you.

MR WOODS: Thank you very much.

MR FITZGERALD: Thank you.

MR WOODS: That being the case, no further presentations, we will adjourn here and resume in Adelaide on Thursday.

AT 5.10 PM THE INQUIRY WAS ADJOURNED UNTIL
THURSDAY, 31 MARCH 2011