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TRANSCRIPT
OF PROCEEDINGS

PRODUCTIVITY COMMISSION

DRAFT REPORT ON CARING FOR OLDER AUSTRALIANS

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

TRANSCRIPT OF PROCEEDINGS

AT ADELAIDE ON THURSDAY, 31 MARCH 2011, AT 8.39 AM

Continued from 29/3/11 in Sydney

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

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

These hearings represent the next stage of the inquiry and the final report will be presented to government in June this year. I would like these hearings to be conducted in a reasonably informal manner, but remind participants that a full transcript will be taken and made available to all interested parties. At the end of the scheduled hearings for the day, I will provide an opportunity for any persons present to make an unscheduled brief presentation should they so wish to do.

I would like to welcome to the hearings the Aged Care Association, South Australian branch. Could you please for the record state your name, the organisation you represent and the position you hold.

MR CARBERRY (ACAASA): Paul Carberry, the Aged Care Association of Australia, South Australia, and I'm the chief executive officer.

MR WOODS: Excellent. Thank you, and thank you for your contributions to date in this inquiry - not only the South Australian branch but the national organisation. We've been very appreciative of your input and look forward to today's hearing. If you wish to, a statement and the contribution you wish to make.

MR CARBERRY (ACAASA): Thank you, Mr Woods, and good morning to you and to Mr Fitzgerald. Welcome to Adelaide.

MR WOODS: Thank you.

MR CARBERRY (ACAASA): Can I say at the outset that, as a member of the Aged Care Association of Australia or ACAA federated group, our association supports and endorses the response to the draft report provided by ACAA. There were, however, a small number of the commission's recommendations about which we wanted to express a different perspective or a different emphasis and so we've provided a brief separate response to the draft report. I would like to speak briefly to

the matters which we raised in that separate submission - in fact, just two of them, as the third matter has already been mentioned by the commission as one which it will review before the final report is presented, and that is the basis upon which the Commonwealth should set the price it pays for supported residential accommodation, and I don't want to take unnecessary time in discussing that.

Firstly, we fully support the commission's objective that the Australian aged care system should be more centred on the needs and wishes of aged care consumers and that the system should enable consumers to exercise choice over the type of services they want and the manner in which they receive them. We also agree with the commission that for this to happen the system needs to become more competitive and more responsive to the needs of its clients.

In seeking to achieve the required level of competition, the commission has recommended, among other things, that regulatory restrictions on aged care supply, both residential and home care, be removed over a five-year transition period. Mr Commissioner, we have concerns that this recommendation may result in higher cost for those who fund aged care and an increased rate of market failures by providers.

Regarding our cost concerns, our concern is that the complete removal of supply restrictions will increase the financial risk for providers, and this has been acknowledged in the commission's draft report. Increased risk requires an increased return on investment. In other words, a higher price will be required for accommodation and services than would be the case in a lower-risk environment. The increased risk will also result in a higher margin being required by banks and other lenders, so they will need to charge a higher rate of interest than they would otherwise have done, and the cost of this additional risk will be passed on to those who fund the system; that is, the Australian taxpayers and the clients of aged care.

Perhaps our more pressing fear is that unrestricted supply will lead to much lower occupancy levels and that in turn will lead to a higher rate of provider failures. As the commission will be aware, one of the critical variables in determining an aged care facility's viability is its occupancy level and, although 40 per cent of providers enjoy occupancy levels above 98 per cent, the average for Australia has fallen over recent years to around 90 per cent, meaning that many providers will be well below that figure.

We have concerns that adding bed numbers without control will exacerbate the occupancy levels overall and will lead to failures, including by organisations which have operated efficiently and provided good care and accommodation. After all, consumer choice can only be exercised if there is a permanent excess capacity in the system, and we accept that premise but we believe that the level of excess capacity needs to be subject to some control. Excess capacity will be a further driver of price

increases. At whatever level of excess capacity there is, providers will have to build into their prices the cost of income they will forgo because of a higher proportion of empty beds. In other words, those occupying beds will pay a premium due to the existence of higher numbers of unoccupied beds. This may well be the price of choice, but the lower the overall occupancy rates the higher the price, and so we suggest there is a need for some continuing control over supply.

In summarising this point, we urge that caution be expressed in moving from the present overly regulated situation to one where complete deregulation may bring new problems. We believe there needs to remain some control over the supply of aged care beds, albeit on a much better target basis than the present system, so that good providers don't become casualties and so that the cost of aged care does not increase unnecessarily. Shall I continue with my next point?

MR WOODS: Yes, please.

MR CARBERRY (ACAASA): Okay. The second matter I want to raise concerns the removal of the distinction between high and low care. We support that recommendation. However, we feel that to do so immediately in stage 1 of the implementation could be unfair to certain providers, including some within our South Australian membership. We would argue that providers who have made investment decisions under the current rules will be unfairly disadvantaged by an immediate removal of the distinction.

For example, a provider who has invested in a specialised high-care facility based on the local competitive environment would be able to reasonably predict their future levels of occupancy under the current rules. They will have based their decision to invest in a new or expanded facility on such factors, so they will know the number of high-care beds with whom they compete locally and they will have formed a view about their relative competitive position. They will also know the number of low-care beds with whom they do not compete directly under the present rules.

If the distinction is removed in one single step, these providers will become immediately exposed to competition which was not there before the change and upon which they could not have possibly based their investment decisions. This would not prevent market rates or periodic payments or their bond equivalent from being allowed immediately in high care, which we understand is the underlying intention of the recommendation, and the commission could recommend that this change in the rules be made immediately as part of the transition to removal of the distinction altogether.

Under a transitional arrangement, a facility with say 98 low-care beds would transition to have universal beds progressively. If the transition period was seven

years, then 14 beds each year would become universal. Conversely, facilities with high-care beds would transition to universal beds by the same process. We feel this would allow providers in a given area time to adjust to the new environment and it would provide more time for providers who had made investment decisions under the current rules to avoid being caught out financially by an immediate moving of the goalposts.

MR WOODS: Thank you very much. You have raised a couple of important issues and we'd like to explore those. In terms of your first point about opening up supply, before we then go on to the more detailed issue of high and low care, et cetera: you talk about concerns about adding bed numbers without control. In fact it wouldn't be our proposition that there be a government process of adding bed numbers. Any increment to capacity would be by providers who make a market judgment that they can achieve a level of occupancy that meets their financial criteria and their mission to supply care, particularly residential aged care in this case, to the population.

So if you could take us through: why would an area where there are good providers who are meeting the demand for residential aged care and there's some capacity so that potential new residents can make a choice of facility according to the merits of the various providers - why would that lead to significant oversupply? Why would investors come in unless they felt confident that they were likely to attract people to their facilities because of the quality of what they were offering?

MR CARBERRY (ACAASA): There could be a range of scenarios. However, it's quite possible that organisations, perceiving that the long-term return on aged care is likely to be more favourable in the longer term, could invest in an area with a long-term view, being prepared to accept low or poor returns on the basis that after several years, if less financially powerful providers have left the scene, their returns will improve and their long-term position will be as they had hoped. That's a scenario that's quite possible and, I would think, probable. Aged care has been of interest to large public companies for some years. Some of them have withdrawn their interest over recent years.

MR WOODS: They have.

MR CARBERRY (ACAASA): But I'm sure their long-term interest hasn't vanished, so I could imagine a scenario in attractive areas where, for a short term, financially powerful organisations will be quite prepared to lose money.

MR WOODS: Of course, we're only talking about the accommodation component and that's what they would be competing on in that respect. For the care component, all providers would get equal payment for people of equal need, so there isn't competition in terms of the price that they receive for care or the minimum quality of

care that they're required to provide.

MR CARBERRY (ACAASA): That's understood.

MR WOODS: There is some potential for competition in terms of additional services that they may wish to offer people and at what price and at what quality over and above the approved care. So that's where the competition would be primarily: on the quality of the accommodation and the price being charged for that accommodation.

MR CARBERRY (ACAASA): Indeed, yes.

MR FITZGERALD: Can I just look at the related but different area of retirement villages. I understand absolutely that a residential aged care facility is of a different nature. I understand that, but in a sense in the retirement village area we've said that, subject to local government approvals, the market provides that accommodation. We know that some providers at the moment are having difficulty selling certain types of stock and we know that some providers are having no trouble selling other sorts of stock, but there we've got a retirement village market which is unregulated in the sense of licensing.

Why would we see residential aged care being of a different nature? They're both high capital-intensive businesses. They both have very long-term investment scenarios. They are of a different nature, but in terms of investment decision they're not all that different in terms of the accommodation or their capital stock, and putting the care thing aside. So why should we treat differently residential aged care from say the retirement village market?

MR CARBERRY (ACAASA): Mr Fitzgerald, I take the point. I can't predict the future. I think there's a risk of the scenario that I've presented. I can't put a percentage on that risk. However, if I were an investor in that financially strong sector, having had my eye on the aged care sector for many years, having had a go at it and not quite having achieved the result that I'd expected, but seeing the long-term obvious potential as we have a continuing ageing population, I would not think it a poor policy to invest for the long term, expecting that that will drive out some of the less financially strong competitors. However, I take your point and I think that, to some extent, has happened in the market that you just referred to, in fact, and there have been some failures there. We have an opportunity to in some respects determine whether we let that happen in this industry or whether we don't, and I'm suggesting that some caution could be exercised.

MR FITZGERALD: Let's assume we accept your proposition that in fact there needs to be some sort of continued licensing or regulation in relation to the number of beds. What do you want to see changed from the current system? At the moment,

the industry says to us, "Well, we don't much like the way in which government sets the accommodation limits," and yet on the other hand you're saying that opening it up too far has perverse or unintended consequences perhaps.

MR CARBERRY (ACAASA): Correct, yes.

MR FITZGERALD: What's the midway? What's your recommendation in relation to how we should deal with this conundrum?

MR CARBERRY (ACAASA): We think that the current target based on 70-plus Australians is a blunt instrument and it's been poorly administered, so the culmination is that it's left some areas overbedded and some areas underbedded. We think that the data - and if I may just refer to our earlier submission. The data is available to produce a detailed profile of the aged care recipient, from HACC right through to high-care residential, and we think that information should be gathered and analysed. It should be filtered on a local basis because we know that health and frailty varies according to local conditions and socioeconomic conditions, and we think that, from that, reasonable projections can be made to forecast the demand over the next three to five years on a rolling basis and, on that basis, the government should set its targets and allocations. And I think it should build in an excess. We accept that an excess is necessary for consumers to have choice. My concern is about an unlimited excess. I guess that's where I see a difference.

MR WOODS: The "unlimited" would be at the response to providers who choose to move into the market.

MR CARBERRY (ACAASA): True.

MR WOODS: So it wouldn't be unlimited. The limits would be market perception of opportunities.

MR CARBERRY (ACAASA): True.

MR WOODS: I did look at your other proposal. Thinking it through, one issue that did concern me is, if you do focus on those who are currently receiving HACC and CACPs and EACH, et cetera, as well as residential care, because each of those is currently a constrained market it would take quite a while to understand just what is the level of unmet demand and work through, because if you base future supply on a current constraint benchmark you're not going to necessarily have a very accurate perception of what the actual demand underlying - - -

MR CARBERRY (ACAASA): True. There would need to be better research done on the real demand.

MR WOODS: Yes. So I didn't think that was a full answer, but I could see some way through in using that as a base. Can I pick up a related issue, and that is that in your more extensive submission, which is on the record, you also talk about the issue of less attractive areas, and to some extent that could include rural and remote or delivery of services to groups with particular or additional needs. The current system doesn't actually address those, in the sense that there's no compulsion on providers to provide services in those regions. You can make sure that there are sufficient either bed licences or packages available to be picked up by providers, but there's no compulsion at the other side, so our reforms and the current arrangements are fairly neutral in that respect. There's still a need to work out what is the additional cost of delivering services in those regions where there is a thin market, if we could describe it as that.

MR CARBERRY (ACAASA): Sure.

MR WOODS: Your proposal, by having licences available, doesn't ensure that actually that be taken up, unless there are these other measures in place to recognise any additional cost.

MR CARBERRY (ACAASA): That's true, Mr Woods, and we may have said, and I certainly would be of the view, that in those areas where there isn't sufficient potential return for investment the government would still need to encourage investment by subsidies or other incentives. I think that that situation will continue forever, not just necessarily in remote areas but in any areas which can't attract because of the potential returns, sufficient beds or sufficient care services, and that's true in other areas of our society, isn't it?

MR WOODS: Absolutely. We are running out of time, but if I can come to your second point, and that's on the removal of the distinction between high-care beds and low-care beds and extra service beds. Basically, we're talking about accommodation in the future.

MR CARBERRY (ACAASA): We are.

MR WOODS: And ultimately people will choose whether they live in their long-term home or whether they move to a retirement village, an independent living unit, or if their needs are such that they move to a residential aged care facility, but it's accommodation of a different type.

MR CARBERRY (ACAASA): Sure.

MR WOODS: So ultimately removing the high and low is a necessary part of the reforms and you suggest a more transitioned approach, which we're happy to go through. My concern is if we deregulate the pricing ahead of deregulating the supply

then there is a chance for monopoly power or market power to be exercised. You're referring to opening up the pricing across the range but ahead of the transitioning of high and low, as I understand your comments.

MR CARBERRY (ACAASA): Concurrent with the first stage of the transition.

MR WOODS: We wouldn't want them to be out of step. You wouldn't want to deregulate price ahead of deregulating supply because it may lead to unfortunate consequences from some providers who have a market power in a region that they could take advantage of.

MR CARBERRY (ACAASA): Sure. I was just looking at the position of providers who have invested heavily in high care. Under the current rules - - -

MR WOODS: High care or extra service?

MR CARBERRY (ACAASA): Or extra service, although extra service is - yes, both, and under the current rules they are reasonably able to predict the occupancies and would have done their homework. On day two of the reform they would be exposed to a totally different local competitive situation, which may throw out the window their plans. Their bank may come knocking, whatever. Whilst we support entirely the end point, we just feel, as the commission has said in other parts of its draft, that the transition should be as least disruptive and cause as few failures as possible, albeit recognising there may be some, but not to I guess promote failures. This perhaps has the potential in some cases to cause considerable stress to providers whose high-care occupancies decline dramatically because of the competition which wasn't there yesterday.

MR WOODS: We're very keen to ensure that there's an orderly transition.

MR FITZGERALD: What would you do in relation to new stock? Taking your first proposition that the licensing arrangements should continue in some way, shape or form, let's assume we go forward and the government says, "Yes, we're going to adopt these recommendations," what we do with extra/high care? Should there be another round of extra/high-care licences or do we simply, for new stock, have universal price?

MR CARBERRY (ACAASA): I think for new stock it should be universal and that extra care should be excluded as you've recommended.

MR FITZGERALD: So you're talking about the transition of existing stock, for removal of the distinction between low and high care, but for new stock coming on after the government decides whatever it's going to decide, then all of that new stock is universal?

MR CARBERRY (ACAASA): Yes, because the people who have made those investments about new stock will have made them with the full knowledge of the new rules.

MR FITZGERALD: Okay, that's fine. Thank you for that.

MR WOODS: Thank you. Are there any concluding points?

MR CARBERRY (ACAASA): No thank you.

MR WOODS: Okay. We appreciate your contributions, not only in the past but today and into the future, so thank you very much.

MR CARBERRY (ACAASA): You're welcome. Thanks.

MR WOODS: If we could ask ECH, Resthaven and Eldercare to come forward please. Thank you for agreeing to come collectively.

MR HANKINS (ECHI): Thank you for your time.

MR WOODS: It makes it a useful discussion to have your individual and collective experiences, and thank you for earlier submissions, for opportunities to visit your facilities, as well as your response to our draft report. It has been a very helpful contribution to the inquiry. You do have a submission to us on our draft report but I assume you'd like to make some comments, so could each of you please separately identify who you are, organisation you represent and the position you hold.

MR ZIMMERMANN (EI): I'll kick off. Good morning, everybody. My name is Klaus Zimmermann. I'm the CEO of Eldercare and, just for the record, I want to say that I'm also the national president of ACSA, Aged and Community Services, but I'm here today only in my capacity as CEO of Eldercare and only responding to our joint submission.

MR WOODS: Just before you do, if everyone could introduce themselves first, just for the record, and then if you proceed.

MR ZIMMERMANN (EI): Sure.

MR KEMP (ECHI): My name is David Kemp. I work as an adviser to the three CEOs.

MR HEARN (RI): Richard Hearn. I'm the CEO of Resthaven.

MR HANKINS (ECHI): Rob Hankins, the CEO of ECH and also with the South Australian chair of ACS South Australia and Northern Territory.

MR WOODS: Thank you. Klaus?

MR ZIMMERMANN (EI): Okay. Could I start off by just congratulating the commission on an outstanding report and the comprehensive coverage on all the issues and information that you've included in that report. I think, as we've stated previously, the draft report has been very well accepted by us three organisations and also around the industry by various stakeholders and ACSA, and so we're very pleased to be able to work with the commission in what we think is a very comprehensive first draft report.

The three of us here today - each of us has some individual comments to make and I just want to start off by making some comments around your recommendation 1.4, accommodation bonds. In our supplementary response to your

draft report we strongly support the regulatory restrictions on accommodations payments be removed, so we've very favourable with that part of the recommendation. There are aspects of the recommendation - if the uncapping is not carefully legislated and implemented it may result in a number of unintended consequences. There's also, as the commission would be aware, an inquiry going on into the prudential requirements on accommodation bonds which, together with any freeing up of the regulatory requirements through this commission's inquiry, need to be carefully thought about in detail.

As we understand your recommendations, you are saying that the restriction on the amount of the accommodation payment be removed and lump sums be allowable for what are now called high-care places. The payments would be negotiated between the client and the aged care provider and these rates made public by them being published. The prices set should be at a level to cover the investment return. In addition, there are two new options proposed: the Australian pensioners bond and the Home Equity Release Scheme. We understand that if either of these two options are taken up by the client it would not affect the person's pensioner eligibility status.

The issue for us as providers is that if sufficient incentives are provided for clients to take up either of these two options - that is, the Australian pensioners bond or the Home Equity Release Scheme - and not pay lump sum accommodation bonds to the provider in the same sort of percentages that apply now, then this will have serious short-term to medium negative effects on cash flows and of course balance sheets. As an example, in Eldercare some 98 per cent of people who pay a bond, so who are asked to pay a bond, choose a bond over a periodic payment. So only a very small percentage of people pay a periodic payment. The vast majority of people pay a bond.

MR WOODS: And a number of them have incentives to do so, too.

MR ZIMMERMANN (EI): Correct. The point we want to make to the commission today is that in any thinking going forward if there are incentives provided for one option over another, then it will have maybe unintended consequences, depending on how the government responds and depending on how they write the legislation. In Eldercare's case our board has already, because of the uncertainty going forward, taken a much more conservative view over the next two or three years in terms of building new facilities, renovating, because it wants to set up, if you like, some extra room in the balance sheet and P and L in case we go down the path where we can't get the accommodation bonds in to the same levels as we do now.

What's really important for us as an industry, and particularly in Eldercare's case, is that the pricing of any bond lump sum and therefore its conversion to a periodic payment should include all the relevant inputs, occupancy percentages,

weighted resident numbers according to concessional and non-concessional residents. The commercial sector out in the general industry uses a capital pricing model called weighted average cost to capital and our recommendation today is that the commission undertakes or requisitions for the work in this area to minimise any unintended consequences going forward.

We believe these details on the accommodation payments and bonds need to be further explored in your next report and, if left unanswered or left open, it leaves it too open to interpretation by the government and will have negative short to medium-term impacts on balance sheets and P and Ls. I think long term these things will balance themselves out, but of course if you have balance sheets and have bank covenants, et cetera, then the short to medium term needs to be covered in any transitional arrangements. That's it, thank you, for my part of the presentation.

MR WOODS: You people know what you're going to tell us. Would it be better for you to make your statements and then we have a broad-based conversation?

MR ZIMMERMANN (EI): I think so.

MR WOODS: Go for it.

MR HEARN (RI): Thank you. I was just going to focus on some of the areas of potential risk. I premise that with the dilemma, I think, in such a complex topic that you've dealt with, that you had to draw the line somewhere on detail, so I think you've tried to allude to the areas that the system would have to cater for, but they remain uncertainties for us, obviously, in terms of how the government will respond.

The first one builds on Klaus's area, in that in essence we read the model as predicated on the assumption that where the pricing goes for supported residents in residential care will be adequately identified. That's I think what we're assuming. The history has been that we've argued for many years with government about those issues and at this stage we didn't have an outcome, so I wanted to reinforce that issue that for socially disadvantaged people that pricing will need to be at the appropriate level. It may be an obvious statement - - -

MR WOODS: No.

MR HEARN (RI): - - - but I felt we need the statement.

MR WOODS: That is inherent in our proposal. It's just an argument about what that standard is.

MR HEARN (RI): Yes.

MR WOODS: But the concept that, when the standard is determined, the price should properly reflect the cost of delivering that standard of accommodation is in common between us.

MR HEARN (RI): I understood that, yes. The second point which is mentioned in the report goes to the issue of some exemption to extra service providers on the issue of provision of concessional ratios. In principle we don't agree with this. We do acknowledge, though, that existing providers have made certain decisions in residential care at least that were based on the assumption. Our view there would be that over a period of time we would have all providers captured in that area, but there may be a transitional period of 10 years or so.

On the issue of competitive tendering of supported resident ratios, that doesn't fit comfortably with us. We feel there could be a risk that the price based tendering that would occur for government would drive down in an unexpected way the outcomes or funding for socially disadvantaged people. So that remains a concern for us.

MR WOODS: We understand those concerns and they've been raised by a number of people, so we'll be re-examining that particular issue.

MR HEARN (RI): On the areas of risk in relation to residential care as it applies to maybe groups that don't have the ability to pay for what will be the cost of care - - -

MR WOODS: The cost of care or the cost of accommodation?

MR HEARN (RI): Accommodation, sorry. Thank you for that clarification.

MR WOODS: Keep these two things separate.

MR HEARN (RI): Yes. I know I get them confused, yes. We highlight that group that currently would not be defined as concessional, so in today's terms that's someone with assets above $98,000 and who would not have the asset level to pay for what will be the average accommodation cost. We assume there may be different ways to deal with that, but in the current system it doesn't allow for reassigning the status of an individual, so one option may be that someone can move from being non-supported to being supported during their time in care.

With respect to the issues generally of some special needs groups, I think we're inclined to the block funding model as being the vehicle by which there will need to be a response. Will the new funding system itself cater for those special needs groups, whether they be rural, remote, Indigenous - that type of need? We suspect that there will be something in addition to just the block funding of the equivalent of the funding model. There will need to be additional funding.

MR WOODS: Yes. Create a base funding that ensures that the entity is there providing services and then some variable component to reflect changes in actual usage.

MR HEARN (RI): Yes.

MR WOODS: We're exploring those sorts of options.

MR HEARN (RI): And in my experience over some years, but limited, in the way flexible services have been used and funded, a key issue is about the size of those special needs services and the occupancy levels, and because they generally be legitimately a lower size, a lower number, there's a real issue there about what that funding should be.

In the context of community care, I think generally our comments about transition and how we move forward link a bit with your previous speaker's discussion. We see the issue is giving people in community the best chance. That's the focus: to stay in community. That should be the priority. We see some risk with residential care as that is subject to further deregulation. In general terms, I think we hold the view that we should emphasise staging in a way that really tests that model; that if we give far greater access to entitlement for people in community when they're living in their homes, at an appropriate funded graduated level, that in itself, we believe, will free up supply in residential. So we don't think it would be inappropriate to move in a staging sense with a greater focus on community, reviewing how that affects the market in residential as well and then make a decision, following such a review, as to how we advance the issue of deregulation if it's required further in residential.

MR WOODS: Thank you.

MR HANKINS (ECHI): I just wanted to make a couple of points around the Gateway and the assessment process. We strongly support the notion of the Gateway, and certainly as an information/brokerage type service to help people understand what might be available in the marketplace in terms of servicing their needs.

The question we do have is a concern that a number of us provide a range of services, including independent housing or independent living units for people, and if a client already has a relationship with a service provider, the notion that there might be a wrong door, that the client can't actually get their initial base assessment supported or assisted by the current service provider or where they're living, as opposed to having to go to the Gateway or apply through the Gateway directly, is a question. We think there should be no wrong door in terms of accessing into the

service regime. That's for the base-level support.

When you get to the more advanced levels of support and assessment, we strongly believe that the assessment process should be based on enhancing people's independence rather than creating dependence. Two of our organisations have tried, using ACFI for an example, in a community setting, and the ACFI tool as it currently stands is not appropriate for use in community. It would need a major refocus, rewriting, to achieve that outcome.

Our view is there are a number of tools. In our submission we provided one example of such a tool, which focuses on people setting their goals in the community striving to achieve those goals with the support of a service provider, to enable them to actually use less services rather than more services for a period of time as we enhance their capacity to live independently in the community. If we have an enhanced independence type focus in our assessment process, it should then be possible to replicate in community what's being proposed by the commission in residential care: that reassessments of care needs can be done by the service provider; they don't necessarily have to go back to the Gateway in a community setting to get a reassessment.

We think that the potential risk that the commission might see around either service providers or clients gaming the system, service providers capturing clients, would unlikely occur under an entitlement system where the client is not beholden to the service provider who's been given the funding but the client actually is allocating their entitlement to a provider. They can take that entitlement back and go to another provider. That market force means that if the service provider is not meeting the needs of the client, the client can go somewhere else and they are much more able to do that in a community setting than in a residential care setting.

MR WOODS: Absolutely.

MR HANKINS (ECHI): So we don't see a reason why it has been proposed in the commission's draft report that further assessments of care need in a community setting should require the client to go back to the Gateway or whoever is going to do that assessment. We think that should be at service provider level.

In terms of case coordination and care management, we noted in the report, and we understand, that that might be an option for a client to pick in a community setting rather than a requirement for the client to take. We would just advocate caution against duplicating a cost which community providers already provide in terms of that service.

The last point I would like to make is around a single integrated entitlement process. The report currently indicates that, if Rob Hankins has been assessed for

care needs in the community and my care needs go up greater than what is reasonable in a community setting or deemed appropriate in a community setting, I would then need to move to residential care. So, figuratively, if I was entitled to $150 a week or a day of community setting and if I went to a residential care setting because my frailty had increased, I would be entitled to $180. I'd have to go to residential care to get the $180.

If we are looking at an equity of entitlement, I should be given the opportunity as a consumer to take the $180 I would be entitled to and, if the level of care I needed was $220 in a community setting but the efficient cost of providing the care is $180 in residential care, then I should be given the option of taking the $180 in a community setting and topping up, if I can afford to do so, to receive that level of care in the community setting. So it should be able to flow both ways, for both community and in residential care, and that the accommodation choice is the choice of the client, as has been proposed.

MR WOODS: Okay. Thank you. David, are you being allowed to speak?

MR KEMP (ECHI): I'm just here if needed.

MR WOODS: Thank you. That does raise a range of issues and we appreciate the further development of those points in your written material. Can I start with the accommodation charges, the matters that Klaus started with. It's not our intention to distort the incentives to favour periodic charges; it's our intention to remove the distortions that are in the current arrangement that favour the payment of bonds, so we're actually trying to neutralise those issues, and there is a strong incentive for a number of people to pay a bond to retain their pension entitlement. The purpose of the pensioner bond is purely and solely as a consequence of the way in which the age pension is structured: nothing more, nothing less. If the pension didn't have those distortions in it, this would go away. It wouldn't be needed. So that's all it's responding to.

We are very clear on our views that people should have no biases embedded in the system that allow them to make a choice between periodic charges or bonds. We feel that there are certain circumstances where people are uncertain about how long they might need the accommodation or whether they want to remain in that facility for an extended period; all sorts of issues that may encourage some to make a daily or weekly rental payment rather than a bond. We do understand that there are consequences for those whose balance sheets reflect the current situation and we do want to discuss with the industry an appropriate transition to allow that to occur.

The actual periodic charge that providers offer to the market, as long as it's a published charge, is entirely up to them. We're not going to be setting a formula that says, "This is how you will determine that charge." That's a market judgment based

on the quality of the accommodation you're offering, what's the quality of other providers; how much capacity is in the market; what's the sort of average housing price in the local area - all of those factors. You take that into account. You set the daily charge and you set the bond: as long as you publish what they are and that you do offer a periodic charge as one of those options.

But there are consequences for your operations and we do need to ensure that it is an orderly transition. But we don't have a bias to periodic charges; we just want to neutralise the current biases.

MR ZIMMERMANN (EI): I think my comments were made in the context that if governments were to set a maximum bond level and subsequently that conversion to a periodic payment - my comments were around that context.

MR WOODS: Yes, okay.

MR ZIMMERMANN (EI): If those things are not capped, then my comments are somewhat diluted and I accept your argument. So it was really a caution to say that this is what the commission is recommending, but if the government then says, "Well, we don't like providers charging obscene amounts for bonds" - as, you know, if you take the old bell curve, the majority of the industry sits inside the bell curve and there are some providers who charge $1 million plus on the right-hand side of the curve and there are some providers who charge nothing on the left-hand side. So if government were to take the view that you can't have a $1 million bond or a $2 million bond and therefore artificially cap it, then the comments I made in my opening remarks are true. But if that's not the case, then I'm less concerned.

MR FITZGERALD: If we continued with the current system as it were, there is no doubt that political pressure on governments to cap the bonds would be intense, and so there is much more likelihood of a government responding by capping bonds in the current system than anything we're proposing. But as Mike has indicated and you've just commented, our intention is not to cap the accommodation bond. Our intention, however, is to make sure that the accommodation charges better reflect the actual cost of the provision of those services than currently is the case. So there's no question about that.

But I'm intrigued as to what you think will happen. I know that this is uncertain but we've had a number of providers present to us, particularly in Melbourne. All of them have said the same sort of thing: that they recognise and welcome the fact that the consumer can choose the periodic payment or a bond or a combination of those. They've equally said that they believe that still a fairly substantial percentage of consumers would in fact choose to pay a bond. Nobody actually knows what will happen, but the view is that there won't be a sudden shift to periodic payments, for a number of reasons. So I just wanted to get a sense from

you: is that your view as well? Whilst nobody can actually predict with certainty, is that your sense?

MR ZIMMERMANN (EI): That is my view. If I take Eldercare's case, as I said earlier, 98 per cent of people choose pay a bond. If we introduced the Australian pensioners bond and Home Equity Release Scheme, there will be some people who would choose those options and therefore that 98 per cent currently will be diluted. However, you are broadening the base as well, so that will, in theory, more than compensate for any drop in that percentage. So I'm pretty comfortable with that.

What I was concerned about, as I said earlier, was that if there is a cap put on then that will seriously diminish the discussion that we're having today. So if it remains uncapped I'm much less concerned; if governments introduce an artificial cap, then we have a completely different context. So that was the caution I wanted to give to the commission to adequately cover that, and I think David wants to add something.

MR KEMP (ECHI): I was just going to say there is still the issue though of the government setting a price for accommodation for supported residents.

MR WOODS: Yes.

MR KEMP (ECHI): So I think we would still remain concerned as to all the inputs that would go into some sort of formula - - -

MR WOODS: Yes. No, that would have to have an appropriate return on capital.

MR FITZGERALD: One of the things we want to do in the final report is to outline some principles by which the government regulator would come up with a recommended price. So we've taken that on board because some people have assumed, for some reason which I don't quite understand, that when we talk about that particular cost, it doesn't have an inclusion for a return on investment, which clearly it should and would. So we will try and put out a set of principles which could guide the regulator in recommending the price to government.

MR HEARN (RI): Could I add a comment? Maybe some other variables would reflect what may be the market in the context of - well, my observation and experience is that people tend to go for the simple option, so the bond has been the simple option as against managed money ongoing. I think how the pension bond scheme was introduced and its impact on co-contribution, and how that is seen as a relatively better outcome than a bond if that affects co-contribution differently, is a factor that could be a dynamic we can't predict, but I think it's a significant factor potentially.

MR WOODS: It wouldn't affect the level of wealth assessment of an individual, so it wouldn't affect their co-contribution. It would just be included in their total wealth assessment, so whether the money is embedded in property, whether it's embedded in the pensioner bond or in other investments, it all gets swept up into the total assessment of their wealth as well as their income.

MR HEARN (RI): I think the final dynamic would be that currently, in the current system, a significant percentage of people move very quickly from hospital to residential care. That is a very different market to retirement villages. That's not the market of retirement villages. Their time frame for making decisions is significantly reduced.

MR WOODS: Sure.

MR HEARN (RI): They're very frail, and I think that makes it another factor that impacts on which decision they make.

MR WOODS: In which case they may choose to have a daily or weekly rental for a period until their circumstances resolve and then they may choose to switch over to a bond or part bond, part rental.

MR HANKINS (ECHI): I guess the question which we don't know at this stage is how much residential care will become an end-of-life care or a dementia care. End-of-life could be very short and therefore a daily charge would be more appropriate, by the family, if the person can't make the decision, whereas with dementia it could be quite long and therefore the bond may be more attractive.

MR WOODS: But if you look at your own facilities at the moment, what's the trend? What does your profile of resident look like now compared to 10 years ago?

MR HANKINS (ECHI): Sure. It's moved to those two areas.

MR WOODS: Yes. So they're either dementia and potentially long term or they're frail aged and moving very quickly to palliative or end-of-life care.

MR HANKINS (ECHI): Yes.

MR WOODS: And we don't expect that to change. But what you do have is a facility which can be the framework for delivering high-quality care, and whether that care happens to be transition care, subacute care, palliative care, restorative care for a period, you've got very good facilities that can deliver high-quality care.

MR HANKINS (ECHI): Yes.

MR WOODS: And what we're trying to do is give you a much broader menu of ways in which you can use those facilities and care delivery to assist older people. It would be interesting to get your views on where you see your place in the market moving over time. Do you share that vision that it does give you a greater range of opportunities as to how you use those facilities and the care that's delivered in them?

MR HANKINS (ECHI): Certainly from ECH's perspective that is the case. Because we run such a large stock of retirement housing and in an entitlement system we're restructuring that housing to make it adaptable for people as they become more frail, we could look after people much more readily in their independent housing, using residential care beds more for short respite care, if there's a daily charge requirement that suits that, that supports that, together with the care need: subacute, post-hospital discharge - all those kind of issues. Residential care could become partially what ECH did when it first started: residential care was restorative care, where people went in, spent six or eight weeks and then went back to their independent living unit. That's where our residential care started, until the gatekeeper role of government came in and stopped that from occurring.

MR WOODS: Excellent. Certainly if you move back into that area, that would be very good.

MR FITZGERALD: Can I just raise the issue about supported residents and assisted residents or assistive residents, this group that falls just above it, just firstly in relation to your recommendation that extra service providers over time would also be subject to any quota. Over what time do you think that should occur? In other words, we have taken the view of grandfathering because they currently don't have to provide that. Your recommendation is of a different nature, so do you have a view as to how long an extra service provider should be not required to have a quota of supported residents?

MR HANKINS (ECHI): There are two factors that need to be taken into account from our perspective. One is, when does residential care become opened up in terms of competition? That time frame would probably be the starting gate for extra service count and we would think somewhere around 10 years - maybe it's a bit less, maybe it's a bit more. You really need to look at what the supply and demand ratio is for places and where extra service is located, but we do think around the 10-year mark would be a time frame for extra service to be opened up and to have to then look at accommodating concessional.

MR FITZGERALD: And what was your view, if you have a collective view - it's probably in your recommendations - in relation to the tradability of that quota obligation?

MR HANKINS (ECHI): I think we had mixed views, is the way to put it.

MR FITZGERALD: That's fine.

MR ZIMMERMANN (EI): We discussed it at some length. We support the idea. We're not quite sure of the mechanics and I think that's where we started diverging on our views. I think, as I've stated previously, we see a secondary market opening up here for tradability, which is not a bad thing necessarily, but there wasn't quite enough detail to form a strong collective view. But in general principle I think we support it, subject to detail.

MR HANKINS (ECHI): I guess one of the defining factors - and if I pick one of our facilities which is up in Smithfield in the northern suburbs, where we have a 70 per cent concessional ratio because that's what we can attract in terms of bond payments. If the concessional accommodation payment by government is adequate to meet the cost and give a small margin, then that's fine, it can trade, but if it's not and there has to be a cross-subsidisation, that makes it much more challenging.

MR WOODS: And we're certainly wanting to get rid of the cross-subsidisations, because they distort all sorts of patterns of behaviour.

MR FITZGERALD: Just to complete the assisted residents, we are very conscious in the final report that we will need to deal with this in more detail than we did in the draft. It's that group of people with modest needs. Yesterday and the day before, we had this raised in different forums with us. Do you have a particular view as to how one deals with assisted residents, this modest needs group? They've got different names, I notice, but we'll just call it "assisted" for the moment.

MR HANKINS (ECHI): I guess my assumption had been - and Richard referred to it just briefly - that if a person - let's pick a figure - had assets of $200,000, so they were above the $98,000 but they're not going to be able to pay a bond of $300,000, for example; if they were required to pay the daily charge, for example, or a proportion of bond and daily charge to meet that and they spent down their assets and hit the current threshold of $98,000; if they were then potentially to be reviewed and become a supported resident where the government then starts capping in, then that's not too bad an issue, because they are pulling down their daily cost and they can choose to pay it as a bond and get a refund or not. That gives them an option. It's pretty much like retirement living. In our retirement housing, people can pay different prices and the deferred management fee varies, depending on how much they pay, so there's a bit of a clawback-type arrangement, and if there's that flexibility but the safety net, then we think it's not too bad.

MR HEARN (RI): The other option would be to extend the definition of "supported" well beyond its current definition and extend it out to what will be the average cost of build and then graduate it down to the full concessional person.

MR FITZGERALD: Okay. Good.

MR WOODS: A couple of issues that (a) came out of your presentation, but (b) out of your more detailed submission: one is in terms of additional services. If I can just clarify. It's our intention that additional services are just market opportunities for providers to offer services. To illustrate an example, if somebody is assessed for personal hygiene reasons that they should be approved to get an entitlement for a daily shower and dressing, and they also like to have a shower before they go to bed but it's not an approved service in terms of essential to their personal hygiene, then they would just negotiate with the provider: "What does it cost?" and "Can I have that person who helps me in the morning come back in the evening?" So it's equal across resicare and community care. These are just market transactions. People buy all sorts of services when they're living in their own homes. They would continue to do so.

On the question of assessments, we understand two things. One is that the current ACFI has been designed specifically for residential but we are exploring what an assessment tool would look like that focused on people's needs, and so we would get rid of the situation where the ACATs, or ACASs if you're in Victoria, have one tool and then the providers have a different tool. That would all migrate to the front end and it would be one tool and the tool would be focused on people's needs. Picking up the ECH attachment - although I did notice you had some intellectual property reservations around it, but never mind - the proposal is also to focus on restorative and rehabilitation care very much. So, you know, what can you invest in somebody for eight to 12 weeks and where have they got to at the end of that? And all of those issues.

So we will need to work with industry and health providers, et cetera, to come up with a tool and we won't develop that tool - that's going way beyond our level of competence; we do understand the danger of that - but map out a pathway and principles for having a tool that can apply broadly based. So we take your views on that and agree with that. There is then the question of who does the assessment. What is clear, to use a Commissioner Fitzgerald phrase, is that the Gateway has to be the final authorising entity. It won't employ all of the staff and do all of the assessments; it would, in fact, on day one, probably just use retrained ACATs and others, as well as a whole range of other professionals.

The role of the provider, particularly when you look at what happened with Carelink, where the Chinese Wall between the providers, advisory services and the delivery arm in our view wasn't sufficiently high enough, we would be very cautious of that. You talk about sufficient arm's length from other business interests, but we would have to understand quite what that means. There would be a multitude of different assessment capacity and expertise that would be drawn on, depending on

the individual's situation.

For reassessment, where there's a material change of circumstance, then clearly for somebody in residential care that daily understanding of where a resident is at, the DON and the nursing staff of the providers, they know that and they would do that work, and they would notify the Gateway who would authorise a change of entitlements. But there would be an auditing check and in some cases in fact the Gateway might say, "Well, that's very interesting but we'll come out and we'll just have a look at that, thank you, before we authorise it."

Community care: we're conscious that might need to be a little different, but we don't know how different, so we would appreciate any further thinking on that. Clearly, again, the individual personal care workers and nursing staff are the best to understand where a person is at, but just what role is then played between the agency in its authorising role and that staff who provide the care we just need to explore. Does it need to be different from residential care? If so, to what degree or not?

MR HANKINS (ECHI): I think we would be happy to have further discussions around how do we keep the independence of that assessment, to at least understand that, and we've got some views. I think the thing we want to be careful about is not have an assessment which becomes a drop-down menu type assessment where, you know, "Rob's entitled to this, this and this," but rather an assessment of what the overall care needs are, because under an entitlement and a restorative focus you may actually need to restructure what is the service delivery to get the re-enablement of the person which falls outside of the drop-box type situation.

So we need to be able to have some flexibility as a service provider to work with the client as to how best to restore them, and then move forward from that process. It's very hard to do that in an assessment which is disengaged from the organisation that is providing the care.

MR FITZGERALD: The fundamental issue for us at the moment is - at the end of the day, whatever tool you use for the needs assessment is an issue that, as Mike says, we're looking at. But at the end of the day, what does this entitlement look like? One of the issues that we haven't clarified in the draft but do want to clarify in the final document is exactly that issue. You can go two ways: you can have a highly prescriptive entitlement that says, "You are entitled to one hour of this and two hours of that and three hours of this." That has a dollar figure attached to it, based on the prices set by the government, and that's one approach.

The other is to go to this sort of levels approach. You say, "All of this leads to a level 1 package," you know, and it's got a modest amount attached to it. So one of the things we're still trying to work our way through and welcome your thoughts about is: what does this entitlement actually look like? Is it more in the nature of a

level? Is it more in the nature of a prescription as to services? What degree of flexibility is in that when it's taken to the provider? So we're still trying to work that through, and it may well be that we can only go part of the way in our report on that.

MR HANKINS (ECHI): I guess in our discussions - and certainly as a community service provider, Resthaven and ECHI are strongly into, and Eldercare not so much - we would favour a levels rather than individual drop-down boxes - "You're entitled to one of this and two of those," et cetera - because within a level framework you can actually be flexible around the level of funding with the client to say the client will electively choose to pay for XYZ or will have their family provide this level of care and support; but they would actually prefer the service provider to do something slightly differently in terms of supporting their needs. Within a levels payment you can negotiate that with a client. With drop-down boxes, it's much harder to do that.

I guess within the levels - and I haven't discussed this with my colleagues but I was thinking about this in a plane flying back last night - if the base level as you're proposing is $100 for a certain amount of care a week and if assuming the next level was $250 - so you've got the base of $100 and an extra $150 - you could set up five or six levels. Forget the CACPs, EACH and EACH-D; there probably needs to be a few more within that. But there could be hours of care per week. So if the base level says that's three hours plus a bit of extras, and then the next level is five hours and the next level is seven hours or nine hours - whatever it is - pick some hours of level and then you fund that. Then there's flexibility within that and maybe over all of community and residential care from the base level, right to the highest level, you might have 15 levels - whatever.

MR HEARN (RI): Can I just add: one of the things is - and it's not evident by a particular experience - our mission is about service with a lot of people. Hopefully we get it right all the time, we don't always get it right, but that's where our mission is. That mission in part relates to relationships with those older people who have a service need. I get concerned if my mind tends to defend the issue that will stop the relationship. So if we get into specific definitions of specific points of contact, I see that as starting to demean the relationship and I will lose a relationship. It will be like more a contract of a particular service or a particular point in time - "Here it is. 10 minutes. I'm in, I'm out." As a principle, in trying to wrestle with the most effective system, I see my organisation and our sector built on a mission to be involved with the relationship.

The second thing that I think is a dilemma that has no easy answer is that we do know that within any system that's established there are individuals in the community that have significant special need and the current tools don't cater for that and they're between the health system, mental health system and our system, and somewhere we need to recognise that and there needs to be some flexibility. I can't tell you what that is but whatever we come up with it is an add-on, because we do in

our population still have people with very special needs.

MR WOODS: We have run out of time. There is still lots of detail to be thought through, and just how big the final report is going to be, and we're reluctant to produce sort of three volumes with operating manuals. We won't. But you can see some of the areas where we would appreciate some further exploration and thought and we've received good contributions to date and look forward to your further thinking.

MR HANKINS (ECHI): Thanks very much.

MR WOODS: Thank you very much. We appreciated it.

MR WOODS: Can we ask Multicultural Aged Care to come forward, please. Thank you. For the record, could each of you separately please state your name, the organisation you represent and any position you hold.

MS COLANERO (MACI): My name is Rosa Colanero and I'm the CEO of Multicultural Aged Care.

MS JOHNS (MACI): My name is Maria Johns. I'm the manager of Multicultural Aged Care.

MR WOODS: Thank you, and thank you for your written contributions to this inquiry. They have been very helpful. Do you have a presentation you wish to make?

MS COLANERO (MACI): I thought it might be useful to give just a brief description of Multicultural Aged Care because I think as a model it's unique in Australia and I think that provides a certain perspective. Multicultural Aged Care is an incorporated body, incorporated in 1993, and we often describe it as the lead agency in CALD aged and community care. Multicultural Aged Care receives funding from the Department of Health and Ageing and runs and has facilitated the Partners in Culturally Appropriate Care Program, PICAC, in South Australia for the last 13, 14 years and also receives HACC funding.

Multicultural Aged Care's mission statement is about strengthening the capacity of CALD communities to deliver aged and community care services to their older people. We support service providers to deliver culturally appropriate care and we try to advise government peak bodies on what the needs of older people from diverse cultural and linguistic backgrounds are. So that's our role.

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

MS JOHNS (MACI): No, we can proceed now.

MS COLANERO (MACI): We can go to our points, if you like.

MR WOODS: Yes, please.

MS COLANERO (MACI): The reason I explained sort of the model was that in the eight points that we have identified there has been a consultation process and a bringing together. So on the MAC board we have representation from culturally and linguistically diverse communities and also service providers. Some of the priority areas that have been identified, that I will go through fairly quickly - and I'm happy to sort of go back.

One of the issues that has been raised is actually the engagement with CALD communities and older people from diverse cultural and linguistic backgrounds - I think you're aware of the statistics - and yet there is a feeling in some areas that in this very important review of the aged care sector that engagement with older people from diverse cultural and linguistic backgrounds themselves perhaps hasn't been as coordinated and integrated perhaps as it could be.

This brings us to the second point that because this is such a significant reform there is certainly a commitment to the need for the participation of CALD communities and CALD older people to actually have a say in this process because obviously, as the reforms are - you know, they want to be participants in that reform process rather than just spectators or on the periphery.

MR WOODS: Absolutely.

MS COLANERO (MACI): So I think that's sort of understood.

MR WOODS: And we've had many organisations come and present evidence and deliver submissions on behalf of various CALD communities and that's very helpful.

MS COLANERO (MACI): That's great. That's what we like to see. The other issues perhaps are more specific to the draft report and the recommendations, the comments about the Gateway, and we are aware that the actual structure and perhaps the final infrastructure of the Gateway is perhaps still to be finalised but there have been some queries, and perhaps even concerns, about the structure of the Gateway and how it would engage with older people from diverse cultural and linguistic backgrounds. Many like to actually engage within their own communities and so the questions have really been about how will the Gateway facilitate connections to the specific CALD communities; the opportunity to link, say, a Dutch older person to Dutch-speaking services. Those sort of links I think at this particular time in the draft report are probably not unpacked to that level. They're some of the issues that have been raised.

MR WOODS: That was an interesting example because DutchCare in fact have been very active in this inquiry and they feel that they can certainly reach out to their community and work with the Gateway in that context, as have also the Ukraine society and a whole diverse range of organisations.

MS COLANERO (MACI): From the information that we have, what people are saying is that they'd like to see it incorporated in a coordinated way, rather than just that it's there but not sort of spelt out. They'd like to see it in the outcomes so that it doesn't rely on someone's goodwill to actually do it, but rather that - as I said - the infrastructure or the pathways are a little clearer about addressing that connection with the CALD community. They're the sort of issues that have been raised.

Interpreting services are certainly valued but many CALD older people will make the point that their first preference is to deal with bilingual providers, whether that be allied health professionals or not, and they do actually like to have bilingual support. So there's obviously a point to be made there. But also the emphasis that the responsibility of funding for interpreting services and to actually aim - and I know that the draft report does try to address some of those issues, but the whole area of interpreting and engaging with the professionals, I actually get a bit cheeky about that to say that the interpreting services are actually for the professionals, not for the older person. It's often seen as, "This Italian old man needs an interpreter." Well, I end up saying to the doctor or the specialist, "Well, actually, no, you need the interpreter to be able to communicate with him."

MR WOODS: Yes, absolutely. They are the client. They are the ones in need of assistance.

MS COLANERO (MACI): Exactly, yes, that's right. Yes, there's that. But there is the issue of course of funding and I'm in the probably not so strange situation at the moment with both my parents beginning to access aged care services, and the number of times that they get told, "No, no, you don't need interpreters. You speak English very well," and then be told that, "Well, it's quite expensive," et cetera. So I think some of those things need to be looked at as far as processes and funding and integrating into the service delivery.

I think that there are lots of programs around Australia which demonstrate better-practice models in the delivery of aged and community care. I think that there are many ethno-specific organisations that are delivering better-practice models, but there are also general service providers that are delivering some excellent models. We think that more should be done with that knowledge that they're delivering inclusive and targeted services and those programs and those better-practice models could do with perhaps more spruiking so that people are more aware of it so that people can share the knowledge, et cetera. I know that is a role that the PICACs play and we do that, but I think it could do with more coordination and integration about how that's done and how that message gets out.

There is a comment about that there are ethno-specific and CALD community service providers and I think in principle there's a lot of support for those services to provide aged and community care services to their older people, but we do target the idea that it needs to be integrated into their service delivery and they do need training. Sometimes from a perspective of saying that if you give some funding to, I don't know, a Serbian aged and community care service provider, sometimes there's an assumption that that particular service provider knows everything about the aged care system, about palliative care, about continence, et cetera. But I think that what needs to happen is that in giving that support funding, which we think is in principle

very important, that funding needs to also take into account the training that's required with the people who are going to be delivering that service so that the service is certainly accountable and, as I said, coordinated, integrated, and so the older people are receiving current reliable information.

We think that all aged and community care services could do with training in culturally appropriate care, because we are aware that not all CALD older people will access their ethno-specific services. So we think that that's an important area which needs to be coordinated so that it's provided for induction and for the delivery of all staff, so that all facilities, all community service providers, have staff which are well trained, and can deliver culturally appropriate services. At the moment, that's a little bit scattergunned, and I think it depends on the ability of the service provider to do that.

The final point that we'll make is that from the CALD community perspective, there's a principle in many of the communities that they are concerned about the aged care system, in what we're describing as the propensity to think about the older person as an individual in their own right, whereas in many communities there's the collective, and that the idea of the individual - for example, selling their home and looking after themselves. Even though we can say, "You'll be able to get the money back," there's this concern, particularly with the migrant communities who have come out in the 1950s for whom the purchasing of the house is not just an asset, it's actually their home and, coming from perhaps war-torn Europe, the idea of actually selling that to look after themselves rather than handing it on as a cultural asset to their family I think is actually quite threatening for them and might mean that they will not access services or, for example, residential care in that particular manner.

Maybe that will just exacerbate the fact that when we look at the stats, older people from diverse cultural and linguistic backgrounds are accessing HACC services and the community services to a greater extent than residential care, and maybe there are some cultural aspects of that that could be further explored.

MR WOODS: Thank you. That raises a number of very important issues. Just picking the last one, in fact with our reforms we're encouraging people to remain in their own accommodation, whether it's their longstanding home, or whether it's a retirement or independent living unit or serviced apartments; for people to receive care in the community for a lot longer and be supported and be engaged in and relevant to that local community; so hopefully instead of, "Is there a package available to me?" or "Does the HACC provider have some budget coverage?" the older person actually gets the entitlement to care and then goes and takes that funding to provide it, so hopefully that will be of some benefit.

MS COLANERO (MACI): I think the comment about that is that, yes, that is showing greater flexibility. The comments that we've received are even looking at

perhaps the retirement village sort of situation as well. That, I think, gives the flexibility to many CALD communities perhaps to get together so that they can set up not necessarily an ethno-specific facility, but there's a bit more flexibility about that, and delivering on the community services and not perhaps as structured as residential care.

MR WOODS: Yes, and that can be small congregate living opportunities and the like.

MS COLANERO (MACI): Yes, that's right. Yes, because we understand here in South Australia there has been a program with the Asian communities, and the example is that at the beginning there was quite a bit of hostility and reticence about going into - essentially it was a bit of a retirement village sort of model, but then when they were moved into there, they actually quite liked it because it was very much a village life. I think it's about six units and it meant that then services could be provided to the older people. It was more taking them back to their village situation, where they could walk out the door and there were people who could speak their language. So that model worked quite well. I think that the draft report is suggesting that there's a little bit of flexibility in that area, and that would be great.

MR WOODS: In fact we encourage as much flexibility as people want to take up the opportunity, which broadens out to the broader issue of opening up the market so that those providers who are delivering services that the CALD communities in their various aspects want and favour those providers, that the providers can respond because the entitlement is with the person. Then if there are providers who are delivering good-quality care that meets their particular needs, they can expand to the extent they wish and they don't have to be restricted to, "Well, I've only got 10 packages here, and I don't have any over there, so sorry, I can't help you there." If they wish and are able, they can expand service delivery in a whole range of areas.

MS COLANERO (MACI): We think that flexibility - certainly we've heard very positive comments about that, because I don't think South Australia has been - you know, similar stories in the other states. The changes that happened with the act in 1997 actually did provide some barriers for CALD communities in having ethno-specific services. So as you're aware there are, say, Dutch-specific or Italian or Greek here in South Australia, or Serbian, but then the newer communities - certainly at MAC over the years, the Vietnamese will come to us and say, "Well, we want 60 beds," and you have to say, "Well, it doesn't quite work that way." Or the Chinese say, "We'd like to build a residential facility and we want umpteen beds," and we say, "Well, the process isn't quite that way." We think with the reforms suggested there will be greater flexibility to be able to address those needs.

MR WOODS: Provided they meet the quality standards.

MS COLANERO (MACI): Yes, that's right.

MR WOODS: And are properly accredited then, yes, they can expand whatever the market will - - -

MS COLANERO (MACI): That's right, and I think it opens up that flexibility, because one of the problems with the CALD communities is that issue of regions and where you actually allocate the places, et cetera. Over the years that's caused - as I said, I'll call them barriers, whereas I think some of the reforms should actually break down some of those barriers, as you say.

MR WOODS: Take those barriers away. One final one from me before Robert asks some issues: we do have to confront the basic issue about people drawing on their income and wealth for their co-contributions, and I understand your point about they've saved and they've built up an asset, but there's still that fundamental dilemma of how much does the general taxpayer support them so that they can protect their wealth and pass it on to their next generation. There has to be a balance in there. You can't just take as a blanket situation, "Well, the general taxpayer pays everything so that you can protect what you've accumulated and pass it down to others."

It's just a matter of trying to find where that right balance is, while protecting particularly those with least income and assets, to make sure that there are no barriers to either care - and there won't be any barriers for anybody on the care side - but even on the accommodation side; that if you are low-income assets, you do get supported accommodation systems. It's a balance issue.

MS COLANERO (MACI): Yes. I think that's important and I wouldn't want to create the impression that CALD communities wouldn't want to pay their way, so to speak. It's really along the lines of communicating the principles of what is being tried to be achieved and, as you say, the balance, and I don't have the balance. But what needs to be explored is that pulling apart what is the collective - whether it's the income or the asset - can be quite hard to do, and we're just really making a point to say that it needs to be done with some cultural sensitivities about the collective nature of it.

You know, it happens already, and we also need to keep an eye on going from a collective culture and making sure that it doesn't go to abuse. But in CALD communities you have the situation where the money is all managed by - whether it be by the father or by the son, et cetera, and you do need to have safeguards in place so that you are respectful of the cultural norms but also you're not putting a person in a position of, as I said, a victim of financial abuse.

MR FITZGERALD: Just a couple of things. In relation to the Gateway, we hear your concerns about that. One of the things we haven't made clear in the draft but

will in the final is the role that support agencies, such as many of the CALD agencies, will play in relation to that. There's a level of support out there in terms of information, advice, advocacy, which enable people to make decisions which are part of the overall system and will aid people to go into the Gateway. Nevertheless, at some stage people will get assessed through the Gateway but those supports will be there, so we think that's the right way to approach that, and we haven't made that very clear in the draft report.

But in relation to the actual Gateway itself and making sure that it's culturally sensitive and also that it actually has people that can provide appropriate services for particularly non-English-speaking background communities, apart from us saying that in the report it's actually very hard to know how you go further than that, in a sense, requiring government agencies or any authorities to be sensitive and to have those things in place. Have you got anything specific that we can say beyond that?

MS COLANERO (MACI): From a MAC perspective what we do encourage people to do is to - we think cultural awareness training, cultural competency, needs to be done across the spectrum and this would be the same as with the Gateway. What we talk about is getting the planning in place, so in setting up the Gateway; that in the planning of it you would set it up so that there's cognisance of the fact that - well, use whatever statistic but let's use 25 per cent of old people over the age of 65 are from perhaps non-English-speaking background, that they're likely to be reverting back to their first language, first culture, so that the people at the front line would come across that. So it's a matter of then the Gateway itself in its planning, in the people that it employs, having the people who have the skills and competencies to be able to do that.

I think that sometimes in a planning way we sort of say, "We'll have this Gateway and it'll be fine. We'll have interpreters and all you've got to do" - and so we have a bit of a laugh and go, well, this 86-year-old Greek woman is going to ring the Gateway and say, "I need a Greek interpreter," and so a very efficient public servant or worker will say, "Well, that's fine. If you ring us back tomorrow we'll have a Greek interpreter for you." You can plan for that, you can set it up so that you're not going to get that 86-year-old Greek background woman who's going to ring. It's going to be family and there are structures in place. We believe that, if in the outcomes for the Gateway it includes the delivery of culturally targeted services and the people are trained, that's a start.

MR FITZGERALD: Okay, thanks. That's fine.

MR WOODS: Thank you very much and thank you for your contributions.

MS COLANERO (MACI): That's fine.

MR WOODS: If you have further thoughts that are prompted by this inquiry process then please come back to us.

MS COLANERO (MACI): Terrific. Thank you very much.

MS JOHNS (MACI): Thank you.

MS COLANERO (MACI): Thank you for the opportunity.

MR WOODS: Can we ask United Voice South Australia to come forward please. Welcome.

MR MARTIN (UVSA): Good morning.

MR WOODS: If you could for the record, each of you separately, state your name and the organisation you represent and any position you hold in it.

MR MARTIN (UVSA): Certainly. My name is Paul Martin. I'm the lead organiser, lead official for United Voice, working in the aged care sector.

MS CAMILLO (UVSA): I'm Mischelle Camillo. I'm a member of United Voice and I've worked 30 years in aged care.

MR FARROW (UVSA): I'm Martin Farrow. I'm representing United Voice. I've been in the aged care sector for 12 years.

MR WOODS: Thank you very much and can I say that we've certainly received a lot of very helpful advice and information from your national body and had strong cooperation from them and we look forward to your contribution today.

MR MARTIN (UVSA): Thank you. Thank you for the opportunity. Allow me to start. I would like the commission to - and I'm sure our national officials have explained this too. United Voice has a long and proud history of working with the staff involved in the aged care sector and we have, in many cases, a very close working relationship with the providers of care. In the great majority of issues that have come up in aged care over recent years, providers and advocacy services for clients and residents, and United Voice, have actually had the same view; that the constraints around funding are putting ever-increasing pressures on providers, which in turn is providing extreme pressure on the people actually required to deliver the services, both in residential facilities but also in the community.

We look forward to the Productivity Commission's report going some way in assisting the industry and the participants to provide a better standard of care and also a better career path and better outcomes for the workers providing the care. Can I just say that the focus of our presentation this morning is very much about the quality of care. We know that you've heard from our comrades, particularly in Brisbane and in Sydney, about some other issues but our South Australian branch would very much like to focus on quality and what it actually means to work in the sector.

Can I just say that from my personal experience I never dreamed that I would end up being a union official but I had a personal experience with aged care which left me in a situation where I effectively vowed and declared that if I ever got a

chance to be involved in advocating for the sector that I would be. Just briefly, my mother was my grandmother's personal carer and primary carer for about the last four years of her life. Mum had a massive heart attack and we had to find, at very short notice, respite care for my grandmother. I worked in the Barossa Valley at the time and I made a point of every night, at the end of my shift, calling in and seeing nan, making sure that she was okay. On the fourth night that I went to visit she asked me to smother her.

As I'm sure everybody in the room can imagine, when I spoke to the people that were in charge at the time, they were incredibly sad and incredibly stressed because one of the staff hadn't turned up for the shift, so there was one staff member who wasn't a qualified nurse - she was a personal care worker - attempting to look after 23 respite clients. It's impossible, it can't be done, and it leaves both the people receiving the care and also their families in an incredibly distressed state. So from my perspective an opportunity came up to come and work in United Voice, predominantly in aged care, and sometimes you get an opportunity to do something that makes a difference and that was, I thought, my opportunity. So here I sit before you with a couple of workers who have spent, between them, almost 43 years of performing these duties. Mischelle, I'd like you to kick off.

MS CAMILLO (UVSA): Hello. I've worked in aged care for 30 years. I've seen a lot of changes in that time. I class the residents that I've looked after for those 30 years as my second family, listening to their life stories with great respect. We used to take care of all of their basic needs but over the years the paperwork, documentation, more bureaucracy, et cetera, means less time for what we consider to be the important issues - basic care. The nursing homes are more concerned with productivity and profits, rather than residential care. I work night shift. I've worked night shift the entire time I've been working. We have one RN and two carers on at night.

MR WOODS: What size facility are we talking about?

MS CAMILLO (UVSA): We're talking about from 45 to 48 residents.

MR WOODS: And high care?

MS CAMILLO (UVSA): Which were originally part high care and part were supposed to be low care but it never worked.

MR WOODS: But ageing in place in there now?

MS CAMILLO (UVSA): They never were low care. They've always been high care.

MR WOODS: And is the acuity of their care needs, though, increasing? Are people either coming in more frail or are they - - -

MS CAMILLO (UVSA): Absolutely, yes.

MR WOODS: Okay.

MS CAMILLO (UVSA): So with the more paperwork: the RNs are expected to do more paperwork, there's more responsibility on making sure that they get the proper accreditations, you don't get the help from the RNs so you're virtually working with two people on at night. You've got time limits, you've got extra duties, you've got laundry work, kitchen work, other work that you're supposed to get through in a certain time, as well as looking after the residents. And their needs vary. They're different. Sometimes they sleep, sometimes they don't sleep, contrary to what people think - that they sleep all night. They don't. We have a lot of wandering people, a lot of people that ring the bells, requiring assistance.

MR WOODS: Do you have a dementia part of the facility?

MS CAMILLO (UVSA): We have one end that is a dementia part but, having two staff on at night, you're virtually looking after the whole lot anyway. There's nobody specialised to look after the dementia wing in itself at night.

MR WOODS: But is one of the two permanently in that dementia wing or do they have to just span whatever the needs are?

MS CAMILLO (UVSA): We just have to span the entire place, yes. So if you're having a really bad night, you will often have no break. Sometimes you will start at 11 o'clock, our first round will finish at half past 4 and then you start another one at 5 o'clock in the morning. You don't get the time to spend talking to the resident. I take great pride in listening to the resident, listening to their stories and their issues and things. It's increasingly getting harder to do that, with all the other expectations that are put on you. It puts pressure on people.

They've recently, in the daytime, put the meal breaks forward for the residents. Their breakfast, lunch and tea is at a later time and this is putting extra stress on the carers that work in the day and evening. There are four carers on to cover four areas at night. They each in those areas have residents to feed, to look after, to supervise in the dining rooms.

MR WOODS: This is the evening shift before you come on.

MS CAMILLO (UVSA): This is the evening shift. And that makes it almost impossible. If there's an emergency on the floor - for four people in four different

areas, to have an emergency - yes. It's making it impossible to look after them and we feel it's compromising the care of the resident. It's just going downhill, and with the residents coming in requiring more care and with more acute conditions, it's just really putting a lot of stress and pressure on the workers. And the residents aren't happy with having to have different mealtimes. They're used to having their meals at certain times, they're used to going to bed at certain times, and they're missing out on that care. They're missing out on what they've got used to all those years.
Thank you for listening.

MR FARROW (UVSA): I've been in the aged care sector for over 12 years. I've worked in two nursing homes. I have done agency work with NASA. The nursing home I work in now is close to home, so I class it like in my own backyard. I used to do day shift and that, but what I've found is, our nursing home or facility starts at 8 o'clock and you've got until 12 o'clock to get all your ressies up. In one area we've got 20 residents between two people and we've got a float that comes and does the four easy ones. Brekkies take an hour to do. So if you can work it out, you've got the rest of the ressies to do from 9.00 till say 12 o'clock, but in that space of time one of the carers has to go for a half an hour meal break plus a 10-minute meal break. Another carer has got to go for a 10-minute meal break. You work it out, how much time you've got to actually put the resident on the toilet, make their bed, get them showered or washed or whatever. It's not that much time between each resident to the next.

I now do night shifts. I've got 140 residents in my nursing home. There are two floors, so two carers for the top floor, two carers for the bottom. We've got one RN. Like Mischelle said, everybody is under an impression that they sleep at night-time. Totally not true. The dementia people, no matter what time it is, they want to get up and wander and we have falls every day at my nursing home, and there should be somebody in the dementia wing, like probably 24 hours a day, to stop the falls and that at night-time.

I timed it the other night, how many call bells we had. In an hour and 15 minutes we had 30, and our nursing facility is on a scale of a block, so it's a lot of walking around for two carers, especially when you've got ones that want to go to the toilet, and no matter what reasons they may be. You've got your serial bell ringers, you've got your ones that just want to get up, and we've got about six residents on the ground floor that have sensor mats, so even if they're just getting out to put their feet on the side of the bed, you've got to go and answer their bell.

When it comes to the last round, which usually starts about say 5.30, 6 o'clock in the morning till we finish - the other morning we had a resident that had slight gastro and got out of bed. He didn't make it to the toilet and of course he had faeces from his bed to the toilet. Our job was to clean it up and to help the resident. Well, that just put us way behind. We're supposed to be a 24-hour-a-day facility and we're

supposed to pass things on that you don't complete, but it's hard to pass bookwork over, and you're supposed to do the bookwork at the end of your shift and that, and sometimes you get very stressed.

We get letters from our employer and that. If we don't answer bells within 10 minutes we get letters to say, "Why weren't they answered?" but in the letter it says it's not to criticise us, it's just to find out why it took so long. But, like I said, sometimes the bells just ring nonstop, especially at the later part of the shift, because they see daylight and they just want to get up.

I must admit, though, the nursing home has just employed two extra staff members to go in a couple of the areas and, from what I heard from staff, it's made a hell of a lot of difference. But there's also the afternoon shift where you get the majority of the carers on at the first part of the shift, but for the last two hours there are only two carers. So from 10 o'clock till 12 o'clock there are two carers and then from midnight to 8 o'clock there are another two carers, so it's not many staff for 70 on each floor to do.

MR MARTIN (UVSA): Martin made a really good point that some of the providers have acknowledged that the workload is becoming increasingly difficult and have in some cases added additional staff, but the bit that Martin left out is that that's after four years of that group of staff making constant reference to the fact that they can't get their work done. Employers that we speak to on a regular basis tell us that their turnover rate for staff is somewhere between 20 and 30 per cent per year. Much of that - when we talk to our members who transfer from facility to facility or ultimately leave the sector, they tell us it's because the workload is simply to the point where they can't go to work knowing that they're going to be able to achieve what they're required to achieve in their shift.

Can I just also add that you will hear much about the work of the personal carer in the sector. They are incredibly important, but when we look at costing care, we must take into account that the provision of a home environment for the residents, particularly in the residential facilities obviously, is about more than simply being able to receive the appropriate level of nursing care, which is important of course, and also having somebody who is able to spend that quality time with you to assist you in your daily activities, but there's also the requirement for the facility to be presented appropriately, to be appropriately cleaned, that the quality of food that's provided is reasonable.

Prior to electing our delegation today, we had a delegates' and activists' meeting in our office and we had a couple of the cooks report to us that they are being expected to feed residents for less than $6 per day, and when I said to them, "How are you expected to do that and what is required for $6 a day?" that's breakfast, morning tea, lunch, afternoon tea, evening meal and provision for residents who may

wish a light snack for supper.

I said, "How on earth do you cope?" She said, "Generally, we don't. You know, we'll be directed to buy, for example" - one of the examples that was given was that a cook was directed to go to the local Foodland who had sausage rolls on special this week for 99 cents, and they were expected to provide the residents on a Saturday evening with a third of a sausage roll and a bowl of jelly - was going to be the evening meal. When I said, "Well, why was it specified that that was going to be done on a particular night?" It was a Saturday night, and the cook was told, "Well, you know as well as I do that most of the family have got, you know, local sporting club functions and they've kids off doing that, so we rarely see visitors on a Saturday evening," and that's the reason that's going to be the Saturday night menu.

Now, I don't believe that that's being done - and certainly this employer wasn't doing that because they wanted to add some extra profit. They simply are at that stretching point where something is having to give. So when we factor in what care costs, can we please be cognisant of the provision of healthy food. Can I just say, lastly, accreditation: when we talk in the sector people say, "Well, we're meeting our accreditation so we're obviously doing okay." I don't accept that. Meeting accreditation does not mean that the residents and clients in the community who are receiving care are receiving a standard of care that we'd actually be happy about. It simply means that we've set the bar, and we've broadened the gate for people to gain accreditation to the point where it's difficult not to actually achieve accreditation at the end of a process.

MR WOODS: No, that's useful. It's very helpful having you here, because I'd like to test a couple of other things out with you. One is your views on the quality of training, so a lot if not most of your members would have done the cert III personal care worker or some variation thereof.

MR MARTIN (UVSA): Yes.

MR WOODS: What's your view on the adequacy of the curriculum? Does it cover all of the material, so that if the person learnt all of that material and was competent in it, they would come out with all the right skills and competencies? Second is the delivery of those. Do all RTOs produce a good delivery mechanism so that there is adequate learning?

MR MARTIN (UVSA): Certainly we believe the curriculum properly delivered and in an appropriate time frame does deliver the skills that are required to perform the duties. There is an enormous difference between providers and RTOs about what is the quality of a qualification from trainer X to trainer Y. I note that an increasing number of large providers are actually getting themselves accredited as an RTO because they have concerns about somebody presenting with a cert III which has

been obtained in a five or six-weeks period, and a maximum of 36 hours of actual direct contact with clients. It is certainly not enough for those people who then go onto the floor.

It is part of the problem that we have staff who have obtained a certificate, an accredited training package certificate, who are then allocated onto the floor with very little buddy shift. We use the term "buddy shift", where they're actually able to demonstrate, "Okay, well, I've got the certificate, but am I competent?" Also, in a conversation with Martin on the way down, he was really clear in saying that when you first come onto the floor as a cert III personal carer with limited amount of contact time, your colleagues carry you. He came to the realisation after three or four months that he'd actually got the view that this work was quite manageable. He was quite good at it, and he actually came to the view that rather than it being that he was managing, it was that everybody else in the workplace was carrying him.

MR WOODS: Providing support.

MR MARTIN (UVSA): Yes. It was at that stage that he acknowledged that, "Okay, well, I actually need to step up," but stepping up means going quicker. It doesn't mean working smarter. It actually means shaving a minute or two off each resident's assistance package, and that is where the conflict comes between a staff member needing to do their job and get their work completed, and the conflict between knowing that that's not meeting what they believe is a reasonable standard of care in providing the assistance in an appropriate manner. Some people take more time than others. We'll get somebody with an infection who yesterday was somebody that you could absolutely get up and about comfortably in eight minutes; today they take you 15, and there's no ability to have any flexibility around that. So we've already based rostering on really tight schedules - and both of the personal care workers have explained to you - and, as soon as something out of the ordinary happens - - -

MR WOODS: It blows it out.

MR MARTIN (UVSA): - - - everything goes to hell in a hand basket effectively.

MR FARROW (UVSA): Anybody can do caring and that, but to be a good carer and that, you can't learn it overnight. It takes a good few months to know what you're doing and to get certain things out, what to do and that; how to go about doing certain things. When you get new residents, everything changes. Every day is different in aged care, so you have your good days and some days you have your bad days.

MR WOODS: Mischelle, you've been for a long time in the industry. What about ongoing professional development and skill training? Is there an adequate support

structure so that you are able to tap into additional units? Are you sort of attracting additional competencies over your career, and do you see yourself having a direction and a pathway and taking on more management responsibilities, et cetera?

MS CAMILLO (UVSA): Just day-to-day training on everyday things that we are able to do, not to a management side, if that's what you're talking about; just general care of the resident and that sort of thing.

MR WOODS: But having being in the industry for the number of years you have, do you now have a sort of responsibility of managing others in the team or are you still just operating collectively?

MS CAMILLO (UVSA): Well, being on night shift - - -

MR WOODS: It's a team of two.

MS CAMILLO (UVSA): - - - there's only one other worker, and that worker has actually been there for 35 years so, yes. No, I haven't actually had - - -

MR WOODS: Okay, so it's just a partnership. I'm ignorant.

MR MARTIN (UVSA): You're the junior.

MR FARROW (UVSA): What I've come to know and that, when you do get new carers come on you have to train them. Even though they've done all the courses and that, you have to train them and, like I said, you can't learn it overnight.

MR WOODS: Yes.

MR FITZGERALD: We've had presentations from your union in other places, as you indicated and Mark indicated as well. This issue about staffing is a very significant issue, but some people have said to us, "Well, the way forward is to have these very defined ratios of staff to clients, or staff to residents." On the other hand, other people have said that, not only is it a blunt instrument but it's also a false instrument because the nature of the various aged care facilities are so different - the client mix, the needs, the complexity of needs is so different - that in fact just coming up with ratios won't solve the problem. So I just want your sort of view about this. We acknowledge the staff loads is an issue. We acknowledge that there needs to be greater funding, which should ease that to a degree, but I'm just wondering what your recommendation is to us in terms of the way forward on dealing with workload issues.

MR MARTIN (UVSA): We don't pretend to have all of the answers for the sector. We do believe that the issue of ratios should be on the table and that there should be

a discussion between the relevant participants - the providers, the appropriate unions and the advocacy groups - because you're absolutely right: the one size fits all ratio model doesn't work. And having been to certainly in excess personally of 180 facilities in this state, they range in size and the way they're set up is incredibly different, so I think your terminology "a blunt instrument" is absolutely right. I think it would be negligent of us to accept that a particular ratio is going to solve the problem.

That doesn't mean that we shouldn't have a minimum ratio perhaps. Now, that's a view that hasn't come from a considered position this morning, but it may well be that there needs to be that minimum because when we hear stories of two people having responsibility for 70 residents for an eight-hour block of time, that just doesn't sit right. It just doesn't seem that that could be a reasonable expectation that those residents are going to receive the attention that they need. So it would probably be quite a difficult project to do, but it may well be that when we look at the new style of facilities being built, which are generally much larger and multilevelled, we perhaps could have some form of a minimum ratio for that sort of facility, and also some particular focus on the dementia part of these facilities, because we are increasingly hearing that - and I think Mischelle sort of alluded to it as a response to a question - there isn't a secure wing that is permanently staffed, that there is a response time to a bell, et cetera. But if somebody doesn't press a bell, who knows what's going on in there? And God help us if we get to the Nurse Ratched One Flew Over the Cuckoo's Nest, where we've got dementia residents being observed through a window rather than assisted appropriately.

MR WOODS: Just one quick final one: oral health. Is that primarily the responsibility of the personal care worker rather than an EN or an RN? It doesn't sound like you've got ENs there anyway. What is your training in that area? So how well skilled are you at identifying issues when you are assisting the residents for cleaning their teeth, and other oral health issues?

MS CAMILLO (UVSA): We've just had an education session on oral health which involved videos, DVDs, questionnaires on the procedures of dental care and how to look after the residents and how to care for their teeth, and when to clean them, and that sort of thing.

MR WOODS: So up until that time, what - - -

MS CAMILLO (UVSA): No, there has been over the years - - -

MR WOODS: From time to time.

MS CAMILLO (UVSA): - - - several different courses on that, probably because it's more younger people coming in at the moment. They've had a few extra sessions

on that.

MR FARROW (UVSA): What I find is that we're getting a lot of carers that come from overseas and, without being racist, some of them can't speak English properly, and it makes it very hard for the residents to understand the carers and that. I mean, they can't speak English themselves and, yes, it's one of the first things I learnt in aged care; that you know the residents sometimes don't get on with different nationalities because of the war and whatever. So, yes, that's what I've just found and experienced.

MR WOODS: I think we understand your point. Thank you very much for your presentation and for coming forward, and also for the opportunity to test out a few other ideas. It's been very helpful.

MR MARTIN (UVSA): Thank you for the opportunity.

MR WOODS: Thanks very much.

MS CAMILLO (UVSA): Thank you for listening.

MR WOODS: We will take a short break and resume at 11 o'clock, thank you.

MR WOODS: I call forward Aged and Community Services South Australia and NT. Thank you. Could you please each of you state your name, the organisation that you represent and the position you hold.

MR GRAHAM (ACS): Certainly. Alan Graham, chief executive officer with Aged and Community Services South Australia and the Northern Territory.

MS BRAENDLER (ACS): Peta Braendler, community services manager with Aged and Community Services South Australia and Northern Territory.

MS BONNICI (ACHG): Julie Bonnici from ACH Group. I'm a senior manager there of health services.

MR WOODS: Excellent. Thank you, and thank you for the cooperation that we've had to date. It's been very helpful and we've benefited greatly from your insights and contributions. Please, continue that process. Talk to us.

MR GRAHAM (ACS): Thanks very much, commissioners. Between the three of us, we would like to focus on one particular subject and, time permitting perhaps, use the opportunity to deal with another. The particular subject we'd like to focus on - and we're doing this quite deliberately - was in the ACSA Federation. You would be aware that you have spoken to other people within ACSA Federation and they're dealing with state-specific subjects and matters of general interest.

So our two subjects, firstly, will be day therapy centres in terms of the services they provide, and that's part of the ACSA submission you would be aware of and, as I said, time permitting we would like to use the opportunity perhaps to delve a little bit into rural and remote issues, particularly Indigenous, if we get that time, but more a kind of question and answer session.

So by way of introduction and before I hand over to Peta and then on to Julie, I'd like to say a couple of things. We're very conscious of a couple of things within your draft report and one is the emphasis around restorative and rehabilitation and that general focus as being a primary consideration in the context of how we deal with older Australians. We believe that day therapy centres provide a real focus on that and we'll detail what we mean by that in a minute.

The other thing that perhaps comes out of the consequence of reading the report and considering things is that when you look at the report, understandably there are a lot of issues around and a lot of focus on the reform agenda, and I would like to compliment the commission on various recommendations that are made in that context because I think it does add deliberately to the debate. The other area I think where a further exploration could be undertaken is in the area of the interface between aged care and health in particular. I would suggest to you that what we're

going to talk about provides a little bit of a segue into potentially a broader discussion about that particular interface.

I won't detail the actual services provided by day therapy services, but what I will say at the outset is that in many respects this particular service is effectively a front end of what is commonly called the continuum of care. These services provide services to older people perhaps looking to assist and enabling them to actually stay out of community packages and potentially stay out of aged care facilities per se. So in that context I think it's important to think about it, as I said, as a front end of the continuum of care and to look at it from that perspective.

What I would like to do now is hand over to Peta who will talk a little bit about the history of the day therapy centres - they've been around for a long period of time - and then go to Julie to talk a little bit about the actual service that's being provided.

MS BRAENDLER (ACS): Thank you. Day therapy centres started in the 70s and were initially linked with residential care and over time have evolved to providing more and more support for people in the community and, in many instances, certainly in South Australia, not so strongly linked with residential care; they're often stand-alone facilities and providing support to people in those centres or in their own homes. It's been a program that has not expanded for a long period of time. We call it the forgotten services program. There's been ongoing funding but on an annual basis and not really looked at by the government for a fair period of time, but they are looking at it now.

In South Australia it's evolved quite a lot, and probably quite uniquely from some of the other states, where it provides very much a restorative, preventative, maintenance role and supports people to self-manage chronic conditions. It links very strongly now with the health system, the subacute system; strong links with GPs and with community. That's the broad history of therapy services. It's something that we think is inherent and essential to keep people living well at home. I'll hand over to Julie now to give some more operational perspective.

MS BONNICI (ACHG): Within ACH, as an example of a provider, we have three day therapy services. They're community based teams. I pick up in the report a strong emphasis around wellbeing and independence, and day therapy is positioned, I think, rather uniquely within the aged care sector, in that we do interface with the health system and people are transitioning out of hospital, but people will often come to us with a direct referral from a GP, so perhaps someone who has had no contact with the aged care system at all yet but perhaps has a painful shoulder or is requiring some physiotherapy. Our interventions tend to be short term, but because we are so well established and linked within the aged care sector, for people who have got more complex issues or longer-term issues, we're very well positioned to actually link people either into the aged care service system or very strongly back into the

community as well.

Day therapy services in this state are very much a restorative model short term, so the majority of people who go through day therapy would be receiving services for approximately one to three months. Each individual has their own individual assessment. Person-centred goals are set with that person. They're very often not therapy based goals but much more about a lifestyle. An example would be if someone comes to us because it's really important to them that they continue to be able to do the child caring role that they currently have, say, with their grandchildren, but they've recently had a flare-up of their arthritis. So they will actually come to us for a period of time and we provide those interventions.

The other thing where day therapy is very well positioned in the aged care sector is that we are not restricted as a HACC-funded service or a CACPs package provider, so currently we can provide those interventions to people all along the continuum. We actually have seen over the years that people have very many complex comorbidities and I'm looking at your building block approach to the provision of care and actually see that day therapy has a contribution to make at all of those different levels within the care.

MR WOODS: Can I ask what's the sort of profile of providers in this area? I mean who are they and what prevents them from expanding further?

MR GRAHAM (ACS): What prevents them from expanding further? Primarily it's the Commonwealth funding which is, as I understand it, about $80 million annually. I think we mentioned that really funding hasn't increased since about 2002. In South Australia, if I'm correct, there are seven or eight people involved in day therapy.

MS BRAENDLER (ACS): In metro.

MR GRAHAM (ACS): And in South Australia we represent probably 30 per cent of the total package nationally.

MS BONNICI (ACHG): I'm not sure how it occurred but historically South Australia has had the majority of the national funding for day therapy.

MR WOODS: We won't record that one.

MS BONNICI (ACHG): But I think in one way that's why we wanted to really highlight that, looking at it from a national perspective, I think the model of day therapy service provision in this state is one well worth looking at, particularly that it fits so many of the principles within this report.

MR WOODS: What about the staffing profiles? Who's engaged in them? What does it look like?

MS BONNICI (ACHG): Each day therapy is somewhat unique but almost of them would have the core services of physiotherapy, podiatry, occupational therapy and fitness leaders - fitness programs. So they would be the core that you would have.

MR WOODS: So it's an allied health block.

MS BONNICI (ACHG): Very much an allied health and nursing service provision.

MR WOODS: So there would be an RN or somebody, or maybe an - - -

MS BONNICI (ACHG): A lot of our organisations don't employ RNs. In one of my sites I employ an RN only on a sessional basis and that's because she's a diabetes educator and she links in with our exercise physiologist and our podiatrist in looking at - one of the areas that we target are people with chronic conditions and very much the principles that are applied are the principles of self-management. Our staff have been trained - we invest a lot in the training with the Flinders University approach, the Partners in Health approach to care. Each day therapy has an individual contract in terms of the services that we provide. It very much is a multidisciplinary allied health service and I see that matches in with some of the recommendations that have been made.

MR WOODS: Absolutely the way to go. Just before Robert comes in, one final one on this issue and that is, when you're getting referrals from GPs is that the sort of five interventions type model or is it a - and does the GP willingly say to their patient, "Well, off you go," and that will be a separately funded and delivered set of services or is their linkage back to the GP? How does that interaction work?

MS BONNICI (ACHG): The majority of our referrals are from GPs. We do keep data on that and in ACH about 45 per cent of our referrals come from GPs and not around the enhanced primary care items. The day therapy program is funded in block funding at the moment, so we employ staff, and I think it's a really important strategy around how are we going to retain staff to work in the area where we actually need to have that guarantee that there is going to be that ongoing funding line to be able to employ the staff. With the enhanced primary care being episodic care there's no guarantee of when those referrals are going to be coming in. Recruiting is becoming increasingly difficult, I think within this state in particular.

I think an important difference with the GP and the five allied health referrals, for example, is that the five treatments in total for the year can equate to about one and a half to two hours of, say, physiotherapy a year - to use all of your five

appointments for physiotherapy. That would be what that program is able to provide in that time, whereas with the day therapy programs it's very much an individually designed response. Quite often the GP will refer for one particular identified need; so, for example, would refer someone with type 2 diabetes to the podiatrist. But our podiatrist, being part of that multidisciplinary team, will actually look that there are some carer stress issues or there may well be some early indications that the person might be having some memory loss, and will refer to the occupational therapist in the team.

Most day therapy services provide both clinic and home based service and we do also provide services into residential care. With the previous classifications of low-level care and high-level care, people who were receiving low-level care were also entitled to receive day therapy services. It's becoming increasingly difficult to identify who is low level and who is high level.

MR FITZGERALD: Can I just go back a bit to the funding. At the moment you're saying the funding is all Commonwealth, 100 per cent funding, and it's block funded.

MS BONNICI (ACHG): That's right.

MR FITZGERALD: And are they exclusively ageing clients? These day therapies, do they actually provide services to people with disabilities who are not ageing, or what's the client base?

MS BRAENDLER (ACS): The majority are ageing but there are some clients who are under 65 that would come into some of the facilities and I think probably more in some of the rural areas than in the metro regions.

MR GRAHAM (ACS): And the general age cohort for the ageing is 70 to 85.

MR FITZGERALD: And your proposition is - correct me if I'm wrong - that the day therapies should continue to be block funded?

MS BRAENDLER (ACS): That would be the ideal. I think that would be the way it would work the best, yes.

MS BONNICI (ACHG): And also made available to people at all levels of care.

MR FITZGERALD: Sure. So the other thing is, if it's block funded would somebody require, from your point of view, an assessment through the Gateway or should they be able to directly access the day therapy on the referral of the GP or anybody else in the same way that they currently do? It goes with a little broader context and maybe, as an association, you might want to comment. We've recognised in the report that the vast majority of aged care services could in fact be

and should be moved from a block funding to an entitlement basis. But we've also acknowledged that there's a range of services for which that may not be appropriate, for a whole range of different reasons.

So I just want to be clear with the day therapy one. Do we see that as a service that can be directly accessed rather than through the Gateway or block funded? And the other question I've got is whether you believe that there are other services of a similar nature to day therapy in South Australia that that same model should apply to.

MR GRAHAM (ACS): Perhaps we can answer from the association's perspective in terms of the Gateway issue and that's an interesting point, commissioner, whether you do the assessment through the Gateway. That isn't currently the case and individuals are referred directly by GPs to particular providers. I think it does make some sense to have some sort of referral process through Gateway. If nothing else, you're monitoring the program and you have a fair understanding of what's actually happening with it. How far you go in terms of assessment as to then referring the individual on to the particular service might need some teasing out. But I think it does make some sense to actually monitor and control and perhaps evaluate that process through the Gateway. Sorry, Peta, did I cut you off?

MS BRAENDLER (ACS): I'll just say one of the risks we see of people going directly to the Gateway - and I guess through a referral of a GP that would be overcome - is a lack of understanding perhaps around therapy services and the breadth that they can provide. Around the entitlement based funding, if it did go down that path there would certainly need to be a clear understanding of the costs associated with that preventative restorative model, that it actually can take more intensive support for perhaps a shorter period of time, but more intensive support and hence additional funding for that to support that model of support.

MR FITZGERALD: If it goes through the Gateway basically it ends up as a referral to that service, and in that service the actual services provided would in fact be negotiated and dealt with at that level, so it wouldn't be a very prescriptive type of referral or entitlement. Do you think that there are like services that should be treated in the same way? You may not want to answer that now but we do think the day therapy is one, and people have put that view to us, but there may be others of a like nature. For example, if I can use a very different one, community transport. It's pretty clear that most people believe that should be block funded in the same way. If you have a thought about that and might come back to us.

MR GRAHAM (ACS): I'd prefer to sort of think about - -

MR FITZGERALD: Yes, please.

MR GRAHAM (ACS): - - - and take it somewhat on notice in terms of a response

to it. I think there potentially are other services that could be looked at in the context of how we would actually run this particular service. If I may just take the opportunity: we spent a lot of efforts, understandably, on looking at allied health and that service delivery in the context of the centres that we're talking about. But the other thing which I think is really important and should not be underestimated is the importance, from a social perspective, of what these centres actually provide older people.

They provide that support, which potentially means that they don't necessarily access in a formal sense a community package, or perhaps even look to go into - and it may well be the only contact an older person actually has with "the aged care system", in inverted commas. They may not go near a community package and they never go near a residential facility. We need to think about it in that context. That's why, as I said, I alluded to the fact that this is essentially in many respects the kind of front end to that whole continuum of care.

MS BONNICI (ACHG): Can I just make some comments?

MR FITZGERALD: Sure.

MS BONNICI (ACHG): I think the name "day therapy centre" may give somewhat the wrong impression as well. Perhaps in the 70s, when they were first established, these were functioning much more as a centre where someone came to for the day; came in in the morning and spent the whole day there; might have had a little bit of an exercise program or something during the day. But by far the vast majority now is very much on an appointment-type basis, so either an individual home visit or a person coming in for their podiatry appointment, and if they're also being seen by the OT then they will be seen at the same time, but it's certainly not that concept of centre based care. That's the big distinction I'd like to make.

Also, just going back to the Gateway for a moment, as a provider, one of the things that I think has really been the basis of a lot of the success around the day therapies in this state has been the local connections the day therapies build up, very much with knowing the local resources, both within the formal sector but also knowing the informal programs, such as, "There's a bridge club that happens on a Thursday afternoon at this particular location." So very much I think the Gateway - while there are some positive benefits around that, I would not like to see any barriers put in the way of where local GPs - because very much we work closely with our local GPs. They're our main referrers, but we also do link back to them in terms of our correspondence back to them as to what has been happening with that person.

MR FITZGERALD: Just an issue that Michael raised on workforce: in the aged care workforce we've heard a lot about the lack of parity between what health professionals in aged care are paid vis-a-vis the health system. Given that you

employ a large number of allied health workers, is that still an issue, or are your wages relatively on par with the public health system?

MS BONNICI (ACHG): We have different wages paid by different organisations and certainly there's been real upward pressure on our wages in the last few years to try and compete with across the public sector; also, again, some of the private for-profit aged care companies, I suppose, who are out there now supplying allied health services into the aged care area; and ACFI has certainly driven the whole market around taking a lot of allied health providers into that area.

MR FITZGERALD: Is that a good thing, a bad thing, or just a thing that's happened?

MS BONNICI (ACHG): I think it's made it very difficult for some of us to attract and retain the staff that we need.

MR FITZGERALD: So it's caused competition for staffing, but in terms of for the individual older person, does that give them a greater range and choice of facilities and services they can draw on?

MS BONNICI (ACHG): I think that a lot of the allied health resource is now being deployed more in the area of assessment around a lot of the ACFI tool, rather than necessarily in provision of the therapy interventions. There's also been able to be an increase in the amount of therapy that's been provided in residential care. I mainly speak from the provision of allied health in the community area. As an NGO, what we have to do is try and compete around the areas of say salary sacrifice and other things that we can do, but certainly for a lot of the day therapy providers - we meet regularly as a management group, and there have been some positions in professional areas we've had longstanding vacancies that we can't fill.

MR FITZGERALD: My last question on day therapy: I think you were going to talk about some rural issues in a moment, but just in relation to the tendering for this, I presume a day therapy centre, given it's block-funded, has to tender for this. Is that so? If so, do you have to tender on a triennial basis, or what's the basis of tendering for this?

MS BRAENDLER (ACS): At this stage it's funding on an annual basis and it's not open competitive tendering yet.

MR FITZGERALD: It's not an open tender?

MS BONNICI (ACHG): We've sort of been in - it feels a little bit like limbo, for a long time, and we had to reapply to have our contracts renewed some two years ago. There was a tendering process then where we basically resubmitted, and at the

moment we've gone back to a recurrent - - -

MR FITZGERALD: Okay.

MR WOODS: Your relationship with the acute sector - because again they're repositories of physios and OTs and others, and then when you do discharge through subacute or through transition care and the like - how do you interface with them? Where are the good parts of that process and where does some of it fall down?

MS BONNICI (ACHG): Obviously through the professional associations there are gerontology-specific groups where groups meet. There are also a lot of regional networks. I've been involved, for example, with an aged care and acute interface group in the southern region of Adelaide, as have many of the other providers, where we've actually looked at how we can stream referral pathways. Within the health sector there's a range of falls prevention and chronic disease management programs now, where we've actually been contracted by SA Health to do some specific areas. So in addition to the day therapy services, we may have been able to then employ a physio say for an extra four hours a week and that's where we've actually been trying to build up that health interface as well. So within our organisation, day therapy is certainly by far the bulk of the funding that we receive for our allied health, and then we're sort of expanding into some of the other more transition programs as well.

MR WOODS: And how do you control the demand side? Do you queue people or do you say, "I'm sorry, our books are full. We can't take you on"? What do you do when demand exceeds the capacity of your service?

MS BONNICI (ACHG): Most day therapy services will run a waiting list if there are areas of high demand. Quite often that's in our podiatry area. It's one of the longer-term services, so if someone comes in to receive podiatry, quite often that's an ongoing service. There's very strong cooperation between the day therapies across the regions. For example, if we knew that there was a three-week wait for physiotherapy with our service but with another one perhaps they had a shorter wait, we would actually suggest that they contact the other day therapy service. But we're very much aware of what each other is providing. Our service provides social work and not all of the services will employ social workers, so quite often we'll get an inquiry from another service to say, "Would you be able to visit this person?"

MR WOODS: What about the distribution in rural and regional areas of these services? How do residents access them? What's the coverage like?

MS BRAENDLER (ACS): There is a problem with the equitable distribution of services at this point. Some providers can provide an outreach into rural and there are a couple of rural day therapy centres, but it's not broadly distributed. The majority is metro.

MR GRAHAM (ACS): I think the other point that's also worth mentioning is, whilst at a local level there may well be cooperation between state-provided services and the centres per se, there is some difficulty in terms of a formalised approach around that interface: how does that actually operate? What discussions have taken place formally with state health departments, not just here in South Australia but in other places, as to how you actually maximise the opportunities being provided by both parties?

MR WOODS: But if you've got a 94-year-old who's lived by themselves and been coping quite well, and might still even be driving, but is having increasing difficulty walking and is starting to become uncertain and won't go out if there's any wind blowing and they might fall over and so on, how do they know that you exist? How do they access and what would you be delivering?

MS BONNICI (ACHG): I would say that typically that sort of person would be referred to us through their GP.

MR WOODS: How good are GPs at doing that?

MS BONNICI (ACHG): I've found that they're quite good.

MR WOODS: All of them, most of them, some of them?

MS BONNICI (ACHG): There are obviously certain GPs that refer to you regularly, a lot more often, and there are probably some that refer very infrequently. But certainly, as I said, building up that local knowledge, the local connections. Being community based services, very much there's regular contact with GPs - letters being sent, correspondence back - and also through councils; other HACC providers; the fact that the day therapy services are part of the NGOs' aged care system. So we're all well known by other HACC providers, CACPs providers. Basically, we're part of the service system as well, and I don't know if it's word-of-mouth, but it's just that we are specialists in multidisciplinary aged care. We are just known locally. If you have a day therapy service locally, people will know about it and know how to tap into it.

MR WOODS: Rural and remote: what particular things do you want to draw to our attention?

MR GRAHAM (ACS): I'm aware of course that you've been to Tasmania and spoken at the north-west Tasmanian project in terms of how that is actually operating. I just want to make some preliminary comments about rural and remote in the context of how important they are from a socioeconomic perspective re local and regional areas and, in that regard, there is also some emphasis I think not just from

the government's perspective about how you deal with rural and remote issues. I mean, the report covers a whole series of issues there around block funding and MPSs and those sorts of potential issues and there are lots of variations on a theme there.

But it also struck me the other day that there is an onus, I think, on regional providers to have an honest look at themselves in relation to how they're providing services and certainly I don't mean to demean in any way, shape or form the contributions particular communities have made about actually establishing those aged care services in a particular town or region, but I do believe that in the context of thinking about these things there are some synergies and some opportunities by which cooperation and/or amalgamations may need to seriously be considered. It's something that we in ACS will be broaching with some of our regional members in the next sort of six months.

The north-west Tasmanian project, for example, was essentially a catalyst that got us thinking a little bit about what else could be done in the South Australian area, particularly where services are geographically fairly well located in the context of distance. So that was really the point I wanted to make. It is a hugely difficult task for the commission to deal with - rural and remote services - because the market forces, as you well know, don't apply. You have to think about this from a whole different perspective.

We also argue that when you look at the ACSA submission the emphasis in there is particularly around: what do you do about recognising regional differences and peculiarities and how do you take that into account when those circumstances may change? For example, all of a sudden there's a mining development in your particular region and you've gone from a fairly sedate, stable little community to, you know, "Everything's gone mad." That includes how on earth do you ever get staff when you're competing against mining companies that are paying $80,000 for a cleaner at a particular facility.

From our perspective, I think the industry itself needs to have a really good careful consideration of some of those issues and how they deal with their services moving forward. That was the comment I wanted to make. I don't know whether you wanted to question me.

MR WOODS: Also, even looking through South Australia, the populations along your Riverland area compared to the population at Ceduna or along the Eyre Peninsula, they're very different types of populations with different needs and how do you tailor services to those circumstances? You've got some vast distances; anything north of Port Augusta, some of those small isolated villages and things, are difficult to service. So we are interested in your further thoughts and, as you say, the main ACSA submission does delve into a number, but here in South Australia you do

have some particular perspectives that would be very helpful to understand.

MR FITZGERALD: Trying to unpack them between the residential and the community is also very important. So could I just ask a couple of questions about the residential side. The multipurpose centres seem to be widely favoured but very varied models exist around Australia as to that.

MR GRAHAM (ASC): Yes.

MR FITZGERALD: So in the South Australian experience in relation to small regional centres, rural centres, is the advent and the development of the MPS in some form or another the way that the government and yourselves see you moving?

MR GRAHAM (ASC): I'd say simply yes to that. I think that in many respects the MPSs have been a valuable addition to how you think about how you operate in a regional context. I would add one corollary to that and that is that the South Australian experience has been very much that when MPSs have been established - and I think there are something like 13 or 14 of them in the state now - there has been very much an emphasis around health service delivery as opposed to aged care delivery and the two are quite different. That permeates lots of things. It permeates the actual operations, it permeates the governance arrangements in relation to these MPSs. So I think that in establishing those things there needs to be a greater balance between the health service delivery, which is obviously important, and aged care and how we're going to go about that in terms of providing the really flexible service that that community needs.

MR WOODS: Do you follow the different models of, say, Tasmania versus New South Wales, where New South Wales again is predominantly a medical model extended into aged care, whereas in Tasmania quite often the providers are the core, and it's a care and community service model that has additional medical support? From your comments, are you suggesting that maybe the balance here in South Australia needs to change?

MR GRAHAM (ASC): Adjust more towards the Tasmanian model. I would certainly prefer the Tasmanian - I think the Tasmanian model offers more. It involves community engagement. It's not about edicts from afar in terms of providing that health service. So I think the Tasmanian model has a lot to offer. There are always going to be variations of a theme in terms of how you deliver certain things and I think it's really important that we recognise that from the outset, but I would suggest, I would stress, that what's really important is that the local community itself determines how the MPS is to be governed within a broader framework; about how it could operate.

MR FITZGERALD: The second thing is in the rollout of community based

services across the regional areas of South Australia. Is there a particular characteristic of a region that would give you cause for concern? In other words, many of the larger regional towns can well support a couple of providers of community based services, and then there are much smaller towns. So in trying to come up with a policy around regional ones, what are the sorts of communities that you're most deeply concerned about in relation to community based service delivery?

MR GRAHAM (ASC): The obvious ones, commissioner. In the South-East of South Australia and perhaps the Riverland, the Mid North, colder Mid North, there are some difficulties but I don't think the geography and the spatial distribution of the towns makes it something that's insurmountable. But I think when you talk about Port Augusta, north and west, and look at the Eyre Peninsula, then you think of how far the distances are between certain things and obviously that's a problem. So we don't have the same sort of spatial distribution of communities that exist in Queensland which makes that kind of more central model in outreach activity easier; hugely difficult. The same thing applies in Western Australia and parts of Queensland, I guess. So there are areas where I think some synergy and cooperation and a different approach to things can work dramatically. I don't know how you would do that in Oodnadatta and various places in the APY lands. It just won't work.

MR FITZGERALD: Sure. My last question then is: to what extent do you see the role of local government playing a part? As you know in Victoria, local government is a huge provider of HACC services.

MR GRAHAM (ASC): Yes.

MR FITZGERALD: And they have particular views about our report because of the changes we're recommending. But here, do you see a significant role for local government as being a provider in those more remote communities, or has that not been the tradition here?

MR GRAHAM (ASC): It's not necessarily been the tradition here, but I'm aware in the Northern Territory it's essentially the role of the shires.

MR WOODS: Shires, yes.

MR GRAHAM (ASC): I'm not convinced that it's necessarily worked terribly well there. I know they're having huge difficulties employing people to undertake various community service type roles. So I think there are some difficulties around that. I don't think there's one simple answer. I don't think local government is necessarily the be all and end all. I think there are other ways of doing things. If and as it's appropriate and if and as there's interest within local government, then I would certainly foster that. That's some way to providing some service delivery.

MR FITZGERALD: Thank you.

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

MR WOODS: Can we ask the Royal Society for the Blind South Australia to come forward, please. Could you please for the record state your names, the organisation you represent and any position you hold.

MR MOIR (RSBSA): Dennis Moir, Royal Society for the Blind. I'm the deputy chief executive officer. I've also managed some of our client services, and still do, and I also manage the HR function.

MR MULDOON (RSBSA): My name is Chris Muldoon and I'm the service manager for the Royal Society for the Blind guide dog service.

MR WOODS: Excellent. Thank you, and thank you for your written submission. Please.

MR MOIR (RSBSA): Thank you, deputy chairman. What I would like to do first of all is just outline what the RSB does and then I can touch on the Caring for Older Australians report and also briefly on the Disability Care and Support report.

Briefly, the RSB is the primary provider of low vision and rehabilitation service to blind and vision-impaired South Australians. We provide a complete range of services from a low vision assessment from the time that someone is referred by a mainstream eye care professional. We have adaptive technology centres, open employment. We have community outreach services which operate right throughout South Australia. We have five regional offices. We also provide a guide dogs service, mobility service, alternate print. We provide the full range of services.

The thing with our services, where it differs probably to aged care and care and support, is it's not ongoing. It's an episodic-type service. So we find that people are referred to us. We can provide them a service. We may not see them for another five or 10 years, or it could be two years. It depends on their requirement. So that briefly sums up what we are.

In terms of the two reports, the significant difference we saw - and we commend the Productivity Commission on both reports - but the Caring for Older Australians and the Disability Care and Support - there seems to be the potential for a gap, for people that are blind and vision-impaired over the age of 65. I note particularly in the Disability Care and Support program, they do say that the aged care report is a particularly important parallel which should be considered in conjunction with it.

From the point of view where we sit at the moment, someone who acquires a vision impairment after the age of 65 would come under the aged care. Now, aged care traditionally is viewed as aged care support and aged care accommodation. We

view the majority of our clients - and we have some 13,000 clients, of which about 4000 would have received services over the last 12 months - we view them as particularly independent. They receive the services that they need. It fits in with the outcomes and the findings of the two reports, in that they looked for people to have independence, social inclusion, quality of life, and the capacity to make their own decisions, which is very important.

But with the report as it stands at the moment - and I was particularly pleased to see the inquiry into disability because I thought for once Australia is going to be at the forefront for disability and the provision of services. Unfortunately then, with the release of the Caring for Older Australians, on the one hand you see it coming to the forefront, on the other hand you potentially see it swallowed up with the aged care one, and I think it's particularly important - and I can comment on referral pathways, assessments and things like that and just what it means, but it is different for people with a sensory disability - in our case vision impairment.

The real difficulty as I see it is that when you look at assessments, all our clients are referred by an eye care professional or their local GP who no doubt would have access to an eye care report. We do not provide an initial service without that. We have seen instances where the stages tried to have a one-size-fits-all assessment, but all the assessment schemes that I've seen, including the ACAT, don't allow for that accurate assessment or practical assessment of someone with a vision impairment. It's just one of those little different things. It seems that they take care of the physical disability and the intellectual disability, but a sensory disability - it doesn't happen.

I can see there's a need for a Gateway for some services, but our gateway is actually through the mainstream community, through the eye care professionals. We have a very good relationship with both the ophthalmologists and optometrists in South Australia. We have some 98 per cent of those practitioners who will refer direct to the RSB. When they refer is when a person is diagnosed with being legally blind or likely to become legally blind. It's important that we actually are able to provide them that early intervention service, because if you can do that while they have more remaining vision, it is better. They can come to grips with it quicker. It's with counselling, occupational therapy services and so forth.

A lot of GPs are aware of us. I heard mention about education and information out in the community. We've been very big on providing community education. However, we recognise there's been a shortfall. We have now got what we call a My Eye Health community program which we're doing in conjunction with the Royal Australian College of Ophthalmologists, and a Sight For All Foundation in South Australia at which one of the major parties there is also an ophthalmologist at the Royal Adelaide Hospital. Their brief - and we've employed two community educators in the last six months - is actually to get out and spread the word amongst

the community about the need for people to look after their eyes, because there is some sight that can be saved, but at the same time they're providing the information about the services that are available.

They're talking to allied health people, consumers, potential clients, service clubs, and even the education setting. We mentioned the allied health setting. One would think that when they do their training, they know all about the various disabilities and impairments, but the reality is when we recruit occupational therapists they generally don't have a lot of idea about what the vision impairment is, the different types that you can get and the functional impact of that, so we find that we need to provide them training on the job.

I don't believe a one-size assessment is capable of meeting all the needs. It may well on some occasions, but my experience over some 16 years is that it just doesn't work for vision impairment. It was tried in South Australia many years ago, and it just doesn't fit in; the other thing being that if someone is referred to us, we know they're legally blind or likely to become legally blind. We do not require another referral unless they have a further significant vision loss. If we detect that, we would actually refer them back to their eye care professional to have a further diagnosis. So someone could come to us today, receive a quantum of services. Some people may only come once or twice. We assess them perhaps with counselling and provision of daily living aids. We may not see them again for five years. Others you may see a little bit later, but they don't need another referral, so there's no need to put them through that sort of process.

In terms of the breakdown of our clients, if we look at some 13,000 clients, 4000 clients accessed the service within the last 12 months. Now, that could range from one service to two or three, depending on their need. The breakdown of those people: 75 per cent of those were aged over 65. 80 per cent of people acquire their vision loss after the age of 65. It's one of those questions where we look and say, "Why if you acquire it after age 65 are you then" - and it's no disrespect to the aged care system, but it's very big now, and I do note that in the aged care report they mention the difference in the fair and efficient funding of those services. That is our concern: how are they going to be funded to provide services?

The reality is we do not receive enough funding to provide all our services. We have to raise 60 per cent of our funds each year. We do that. We know that. We try not to have clients waiting too long. We actually set waiting periods. If someone is referred by a mainstream eye care professional, we have a maximum waiting period of two weeks, or immediate if it's a serious case where someone is really traumatised. So we've funded all our services by, I suppose, prudent investment over the years, with bequests and things like that, and fundraising, but it's a fact that 60 per cent are unprovided.

In terms of information, I think I've covered off on that, that we're out there providing the information. We believe most people, including allied health - but there's always room for improvement. We have an agreement with the Royal Adelaide Hospital where we will have their registrars and fellows actually provide services in the low vision centre, so that when they go out in the community they're aware of our services. But we've also now had the opportunity with the Flinders Medical Centre where they will put all their registrars through a period of training with the RSB just to let them know what vision impairment is, its functional effect on the individual and what services are there.

There are various things like that that we try to do. On a note in the report, the idea is to set up information centres and it would be interesting to see how that goes, to see whether or not they can capture the breadth of information available that should be out there, but at the same time I think there's a need for individual organisations to promote their services.

MR WOODS: Absolutely. For sure.

MR MOIR (RSBSA): Assessment: I noticed in both reports that there will be assessment centres set up and things like that, but again I stress that for some specific disabilities, such as sensory impairment, it's very hard to do. Similarly, I don't believe that a specialist provider like the RSB or similar could be encompassed within a bigger organisation that provides a lot of other services. Certainly over time one of the biggest difficulties in the time that I've been there is where does disability fit. Does it fit within the Department of Families, Housing, Community Services and Indigenous Affairs? Does it fit within Health? That question is yet to be answered and it's similarly replicated at the state. Where does it fit? I suppose that's where you see, when you look at the report and you have concern for our clients, will they fall between the gap?

Referral pathways I've touched on. The workforce: we certainly have a very specific workforce. In terms of if we were to recruit against the salaries and wages reflective in the modern awards, we wouldn't be able to recruit anyone. We certainly pay in advance of the award rate to do that but we would not be at the level of, say, the state public sector. But we find that the majority of people that come to work with us do so because they have a passion for assisting people. In terms of skill development, we recognise that the majority of people when they come to us have actually had no prior experience in dealing with vision loss, its functional impact and how to assist people, let alone go about providing services. So we provide that service. An occupational therapist coming on board may take 12 months to be brought up to speed. It doesn't mean they can't deliver services but you develop as you go.

We have introduced cadet guide dog mobility instructors because there has

been a lack of resources around Australia and similarly mobility instructors. A mobility instructor is essential to someone that might still be working or someone that wants to get to a recreation group and they're in their 70s. There's a need to orientate them. They may not need further orientation for another 12 months. But we recognise that with the mobility service, an OMA used to have to have a postgraduate degree but the reality is they only actually exercise about 10 per cent of that skill and therefore the other 90 per cent, if you have a paraprofessional model - and we introduced an orientation mobility assistant - they can actually provide the services once the other person is assessed and set the program. So we're looking at innovative ways to do these things.

Funding: we get block funded at the moment for part of our services. The Low Vision Centre receives a grant from the Department of Health and Ageing. That certainly doesn't cover the services that we provide there. We get funding under the CSTDA and again that doesn't fund everything. We also receive funding for our business service enterprise which commonly used to be referred to as sheltered workshops but we've paid award based wages there all the time. We have a break-even there, we don't run at a loss, whereas when I came on board 16 years ago it used to run at a half a million dollar loss.

So certainly in terms of funding we see there's a need for the Commonwealth to look at what they do with funding. Do you look at funding individuals and individual services? Do you look at block funding? Certainly we know that the block funding to us has worked well. It certainly doesn't meet all our needs. Certainly when you go to acquit the funding or report on the funding, what we've found probably reprehensible is the fact that some bodies will only want you to report on the funding provided relative to the funding you received. Now, what we have said and we do, if we provide 1000 services but we're only funded for 30, we'll report on the whole 1000, otherwise the government has got no way ever of knowing what the unmet need is.

Services: again the majority of our services are specialist in nature. Part of it would be generic but generally you have to have that vision loss knowledge and the impact of it. Benchmark: I certainly agree with the commission in saying that there needs to be better data maintained on the services that are provided. We're certainly an accredited organisation, both under the ISO 9000 standard, the service excellence in South Australia, and also HACC for our factory. We have a large database. We capture all the services provided in respect of our clients plus the time spent on those services, so we actually measure the productivity of staff as well. So it's a fairly comprehensive thing.

We've looked at how we can benchmark against other organisations, not only within Australia but externally, and it's actually very hard to find that, but we certainly agree there is a need to have organisations and services benchmarked in

some manner. That's probably about it for the moment.

MR WOODS: Fairly comprehensive, thank you. A couple of points. One-on-assessments: certainly there would be no intention to replace the specialist assessment of sensory loss. That's a specialised service and that would need to continue and there wouldn't be any suggestion that that gets replaced by something that is less efficient or effective in dealing with those.

As you rightly pointed out, a lot of your client base are in fact older people and some of whom, with the assistance of your aids or adaptive technologies and the like, can then continue on within their limitations to maintain independent living in the community. But for a number of others, as their frailty increases and they have additional needs, how do you interact with - as they currently are - the HACC providers or package providers? Does that work well? Are there issues there about which bit you do and which bit they do?

MR MOIR (RSBSA): No, look, it's very clear. We provide services related to the vision loss. If we identify that they have a need for another service then we make an onward referral, be it whoever it is that can provide that service. Occasionally we have difficulties where people need modifications to housing and things like that because there is difficulty with funding in the state government and things like that, so you may refer on for what you consider to be an urgent need but you're continually having to chase it up. There is a need for overall improvement in funding and the provision of services in other areas but we certainly interact very well with the other agencies to find out who provides the various services and refer on.

MR WOODS: But you did talk about you also provide social worker support and a whole range of services which are starting to get into some broader service delivery issues. Again are the boundaries clear as to where you finish and where they - - -

MR MOIR (RSBSA): The boundaries are clear. Certainly we have counsellors or social workers, whatever you call them. They're there to provide counselling related to the vision loss and coming to grips with it - not only to the individual but also their family.

MR WOODS: Yes.

MR MOIR (RSBSA): When you newly recruit someone they might think the barriers go beyond that but we make it very clear what they are.

MR WOODS: Okay.

MR FITZGERALD: Just let me try to operationalise what you've indicated. I

presume you want a situation where the range of services that you're providing are available to people irrespective of age.

MR MOIR (RSBSA): That's right.

MR FITZGERALD: The service, be it yours or anybody else's, would be largely block funded as a significant contribution to the operating costs but not totally, because you rely on donations and what have you. The third thing is the funding. Where it comes from in a sense is not all that important. Whether it comes from the disability department in FACS here or whether it comes from the Department of Health and Ageing, or wherever it comes from, in the end it will probably be a multitude of funding.

MR MOIR (RSBSA): That's right.

MR FITZGERALD: So your view is that the last part of that equation is that people should be able to directly access your service without the need to go through a Gateway. Is that right?

MR MOIR (RSBSA): That's right.

MR FITZGERALD: In other words, you still have to - - -

MR MOIR (RSBSA): Their Gateway already exists, in that it's the mainstream eye care professionals and the GPs or other agencies that are referring on.

MR FITZGERALD: Right. Is there any component of your services that you think lends itself to entitlement based funding? That's the first point. The second point, and it's related to that, is do you think there's any part of your services that lends itself to co-contributions by consumers irrespective of age?

MR MOIR (RSBSA): Certainly when you look at our entitlement base the services are there to assist those people that are blind or vision-impaired, and that's to live independently. It's hard to put an entitlement basis on that because you want them to be able to do what they want to - you know, within reason, but live life as full as possible in the community, and quality, and that's what we aim to do.

In terms of co-payment - and I read that in the report - again you've got to look at what that really means. If we're providing a white cane to someone, we actually provide it free of charge. I mean, if you were to charge for it and put a cost to it, is it $70? What are they paying? You've got to look at: okay, you've then got to introduce a billing system. Is it actually going to cost you more than what you're going to recoup back? I think with the majority of our services it would. Certainly if we provide a guide dog to someone, that costs us in excess of $25,000. We're not

looking for any payment there; we don't get any.

MR FITZGERALD: I understand that, and I understand why people are generous in their donations to you, and it's exactly for that purpose. And it's probably less important for the sensory disability area, but just take a guide dog for a moment. Somebody acquires a vision impairment through an accident and they're insured by an insurance arrangement. In that case is there an argument that the insurance should pay part for the provision of that service?

MR MOIR (RSBSA): You could certainly argue that, yes.

MR MULDOON (RSBSA): Certainly in the past there have been occasions where workers compensation, for example, if the accident has been work-related, have contributed to the cost of the ongoing care of the dog, but generally speaking the initial cost is borne by the agency that provides the dog.

MR FITZGERALD: And you believe that there's no reason to reconsider that in the light of the disability insurance scheme proposed, or the private insurance schemes? I'll come to the aged in a moment, but just that area.

MR MULDOON (RSBSA): To give you an example, that's quite common practice in some European companies, particularly in Germany, where insurance companies are actually the provider of services to the blind and vision-impaired through dogs, and there's a standard set for the quality of dog that's received by the client and that's mitigated and supported by the organisations. I think if you took that outside that and made it an insurance based thing, there are some question marks about the quality of the dog or the quality of the service.

MR FITZGERALD: Sure. But essentially, in relation to disability, you don't see any particular reason to change the model; that is, as a free service to the consumer, however funded by government and private contribution?

MR MULDOON (RSBSA): Yes, and topped up by other agencies if there was a relationship.

MR FITZGERALD: If we talk about adaptive technologies and assistive technologies going forward, many of those are very expensive - not necessarily in your own field but in growing fields of supports. Again, if you've got somebody who is, you know, 68, 70, 75 and they are a high-wealth individual, again the question is should all of the adaptive technologies and assistive technologies be free to that consumer?

MR MOIR (RSBSA): In relation to adaptive or assistive technology, the only thing that clients will pay for from us is low-vision aid, such as a hand-held electronic

magnifier, a large watch, things like that. To defray the cost to them, what we actually do is purchase them direct and import from overseas. We will actually wholesale them around to other blindness agencies and other organisations in Australia to keep the unit cost down low. So they certainly will purchase them.

In terms of adaptive technology like computer software and that, that can be expensive if it's screen-reading software; that can be two or three thousand dollars. But things are becoming cheaper. Braille technology is particularly expensive. But the dearer stuff is for the person under 65 who might be doing university and things like that.

MR FITZGERALD: But again what's your approach there to charging? I want to make it clear: my questions are not indicating that we believe you should charge. I'm trying to get an understanding of your philosophy on that. Let's take that more expensive adaptive or assistive technology.

MR MOIR (RSBSA): Okay, and I can probably answer that best - we do do that at the moment in terms of adaptive technology which costs in excess of $1500. That could be a large closed-circuit TV or electronic magnifier. People can apply for a subsidy towards that, up to 50 per cent of the cost but no greater than $1500. So that does take into consideration, as you have rightly said, where someone does have the means, and people have applied for that and they have not been assisted but they've still managed to buy the overall equipment. That higher-priced equipment we actually don't sell, because what we do is try and have it all on show and they go to the distributor. So certainly there is that co-payment there. Some people will get a subsidy. The only one where we don't look at a subsidy is braille equipment, but again there's only a maximum subsidy of $2000.

MR FITZGERALD: But to finish that, then, so there are parts of the services and/or equipment that there is a co-contribution, to use our language?

MR MOIR (RSBSA): In answer to that, over $1500, yes.

MR FITZGERALD: The question is, should that be a determination of government in terms of policy or do you believe that your organisation should be able to establish its own regime for charging of the equipment and other services that we're talking about? Again, there's nothing in my question to say that we have a view, but at the end of the day should we simply say, "Well, that's up to you, the various organisations that support vision impairment," or should the government say, "Well, as we are a co-contributor to this, there should be some sort of broader policy"? And again let me restrict that to the area of ageing.

MR MOIR (RSBSA): My answer to that would be that, on the basis of the current funding arrangements where we're only funded for 40 per cent of the services, I think

it should be left to the organisation on a voluntary basis. I think any organisation that's prudent and has wise business practices will do something like that anyway. The other thing I might add there is that the people that have a sensory disability, in this case vision impairment, there is a state based equipment scheme which they're not able to access.

MR FITZGERALD: Okay.

MR WOODS: Thank you. That's been very helpful. We appreciate your time.

MR MOIR (RSBSA): Thank you.

MR WOODS: Can I ask Jenny Briggs to come forward, please. Could you please for the record state your name and whether you're representing any organisation.

MS BRIGGS: My name is Jenny Briggs. At the moment I'm not representing anybody but me. However, just to expand a little, if you'd like me to - - -

MR WOODS: Yes.

MS BRIGGS: For 13 of the past 17 years I have been employed by Alzheimer's Australia here in South Australia and have retired - well, sort of retired - three or four years ago and in that time I've been working as a freelance dementia consultant within the aged care industry.

MR WOODS: And you were an RN?

MS BRIGGS: I'm a registered nurse, yes.

MR WOODS: You still maintain registration?

MS BRIGGS: Yes.

MR WOODS: Very good. You've provided us with some written material, but please take us through your presentation.

MS BRIGGS: I've made two distinct areas, and I'll just get rid of the first one first, which was about the Gateway and its potential to be providing information more broadly, particularly about ageing well. It's a good idea, except I just have a little sense that, while the Gateway will be mainly involved in the Gateway processes to services, it might not necessarily appeal to the people who are well elderly who want to go and find somewhere how to maintain their wellness. That part of their role would need to be very sensitive and very expertly promoted, I think.

MR WOODS: We'd like, when you've finished your presentation, to come back to that, because there is that broader issue of where do people go to find out about how to retain their wellness.

MS BRIGGS: Exactly, yes.

MR WOODS: So if we can log that one and we'll come back to it.

MS BRIGGS: Yes. I guess the other one was my amazement at finding dementia didn't rate a mention in words in the draft report to any great extent and that, while I'm aware that you've had significant submissions from Alzheimer's Australia, anyone reading just the report would perhaps get a sense that all older people in aged

care were relatively homogenous. The level of care needed for people with dementia might be very different from someone who is competent cognitively but maybe very frail, so I really just wanted to make that an issue, and I had to think about how am I going to do this without going on at length, so I thought that the Alzheimer's submission, number 79, made some points that I could perhaps elaborate on a little bit for you.

MR WOODS: Thank you.

MS BRIGGS: Apart from the time I've worked for Alzheimer's, I used to run a gerontic nursing course that started in 1986, which was about the time that the first residential care assessment process changed. So I've been fairly involved in watching this process over the last - whatever it is - 25, nearly 30 years. When the Liberal government changed the process from the RSC to the RCI, which were the two earlier, the whole business of the facilities being very accountable for care as opposed to the infrastructure costs went.

MR WOODS: CAM and SAM days.

MS BRIGGS: CAM and SAM days, yes.

MR WOODS: We remember them well.

MS BRIGGS: I remember them well. While it might have been a nightmare for everybody, at least it was very clear where the funding for care was assessed from and where the money went to.

MR WOODS: Yes. There were a number of distortions in that process.

MS BRIGGS: I'm sure there were some distortions. The assumption was made that the accreditation agency would deal with all those care issues. I don't necessarily think that that's the case either. I've worked within, as part of my job, a lot of aged care facilities, particularly when they've had difficulties with clients, and you do get fairly well into the nitty-gritty of the everyday and you sort of come away thinking, "How did that get through?" and so I guess maybe the actual standards are not written with a dementia focus and it probably needs the assessor to put their dementia hat on and really think about it in terms of people with dementia and then how do they report on it because the reports are so well structured that they really haven't got a lot of opportunity. So I don't think it necessarily does people with dementia any good service.

I was really impressed with the three people from United Voice and their clarity about the difficulties that careworkers have. This whole business of having to hurry and rush really doesn't give the opportunity for the careworker to actually be

really well aware of what they're doing when they're providing care, and even getting back to earlier assessment in the Gateway: how does the assessor recognise some of the retained abilities for somebody with dementia when really all they're confronted with are the things people can't do. So how do you develop a model of care within a very busy organisation that allows careworkers to say, "I've noticed Mr So-and-so or Mrs So-and-so can actually do this"? How do they actually get the opportunity to pass that information up and how does that get incorporated to care on a regular basis? It might be the only level of independence that person has.

So in terms of the dementia management behaviour services, they do a really good job for the purpose, because there are people in facilities with quite extreme behaviours and it doesn't look like that when you read the report.

MR WOODS: And variable at different times.

MS BRIGGS: Yes. Absolutely. But sometimes you can actually find that there is a pattern. I actually saw someone yesterday. It was very clear that by 3 o'clock in the afternoon they are pretty wound up, but because they only had anecdotal evidence that actually gave you this time, then they'd find it really hard to present the information to a doctor in any organised fashion. There are a lot of strategies that may be seen to be time-expensive to start with but can actually help you with your time management, if you utilise them. I guess it's just saying that the care of people with dementia is a lot more complicated than appears on the surface often.

Other people who may not provide a problem may be very apathetic and just compliant but have given up because nobody helps them to do some of the things that maybe they can do for themselves, and it appears to be that they're not the squeaky door so they don't actually get that degree of consideration.

MR WOODS: Thank you. You've raised a few issues in relation to training and staff development and the like, and that's very helpful to us.

MS BRIGGS: Yes.

MR WOODS: Let me assure you at the front end that we are exceedingly conscious of dementia issues and the increasing proportion of people, particularly in residential care, who exhibit those behavioural issues. We are working closely with Alzheimer's Australia and various bodies around the states to pursue how we can further finetune our recommendations and please don't measure us just on the number of times a word appears because - - -

MS BRIGGS: I guess I wasn't measuring you, if I can just state this. It's just that if you were reading it from outside, you actually wouldn't get that impression.

MR WOODS: We understand the perception side, although we were hoping that a number of the - and we still do consider that a number of the more generic recommendations would in fact be of great assistance to those suffering from dementia. A couple of issues: I would like to start at the first one of maintaining wellness. We see the Gateway as the official provider of authorised information but is not the exclusive provider of either that information - because it would want to disseminate it as broadly as possible through a multitude of outlets. But also there is a much broader need for education on wellness and support, and that's why I was interested in talking to the day therapy centres issue.

How does somebody in the community who has done very well and maintained their independence and has retained their cognitive capacities in these particular cases - where do they go, how do they understand what additional supports are needed? The Gateway would be one source of information. There are lots of others. But what are your particular perspectives? How can we better help the older cohort to support them in this process without sort of delivering massive services that just take away their independence or care for them rather than with them; all those sorts of issues?

MS BRIGGS: I really didn't come prepared to think of it, to talk about this, but we do have the television, and actually the current little thing is actually quite good because people probably just need a jolt. People don't want to consider themselves potentially ill, they want to consider themselves potentially well, and I guess we've got a very great range of people in this town, country - wherever you like to talk about. I think just some awareness-raising to start with, but I think perhaps local government. I live in an area which is pretty fortunate in that - I actually haven't accessed their services, but I do read about them. It's just called The Hut, and it's well known for providing computer literacy, exercise classes, and it's funded I understand by the local council but it doesn't have that tight connection that, "This is part of the council."

MR WOODS: Here to help you.

MS BRIGGS: Yes. Maybe being able to subsidise people to go to gyms or even just to let them know that, you know, going to a gym as an older person is a really good thing and encouraging private providers to provide services for older people in a way that they'll accept the classes. The general practitioners, I think - I know, you raise your eyebrows like I do - have at least an opportunity occasionally.

MR WOODS: Absolutely.

MS BRIGGS: Everyone over 70 has to go and have a driving test, if you drive; a test for your driving. That's really an opportunity for the GP to say, "What are you doing about staying fit?"

MR WOODS: That would be good, if that happened.

MS BRIGGS: You think, "We're young. Oh well," and then you get to 75 and you do the enhanced primary care thing. I think it's really communication within the whole community.

MR WOODS: Okay. Let me go to a specific issue, and you raised the situation of somebody with behavioural issues in a residential care facility and they will have different demands at different times. You'll be able to observe patterns of behaviour and the like.

MS BRIGGS: Yes.

MR WOODS: How broadly should you identify their entitlement to care so that within that entitlement the different needs that they have at different times, their response to different forms of support and care which may in fact assist them to become a bit more independent - if there's a bit more intensive investment at this stage then their independence can increase a little at that stage - do you have a view or a vision as to how broadly or descriptively based their entitlement to care should look?

MS BRIGGS: I think once somebody is in care - and this is pretty much off the top of my head, thinking about how do you define them.

MR WOODS: We're having a conversation.

MS BRIGGS: Somebody needs to have their personal care done because they cannot wash themselves or shower themselves or dress themselves. It's probably difficult to say that you can discriminate finely within that. So if you say that that's a level of care, that you need that, then to me that's the maximum that you would need. But then again you might have some people who can do bits of their care. Yes, I don't think you'd want too many - - -

MR WOODS: Fine gradations.

MS BRIGGS: No. Just to perhaps take this in a slightly different direction, some of that ability to do things for themselves is not so much about what's done for any one person - but it could be - but it's what's available generally. I've been to several places recently where the people in the dementia-specific unit could not have got outside without somebody taking them. I just think that's totally unacceptable. There was no access to outside, and this was in a pretty reasonable facility. So to be able to go outside and just walk around, or sit outside, may increase somebody's interaction, their ability to interact. Just having things around that people can do

safely may in fact prompt them to do it. If there's nothing around, they're not going to do it. They're just going to go for a wander or interact with the person next to them, maybe inappropriately.

So it's as much about how the care is structured. Is there a lifestyle person or somebody who can do that sort of job in the mornings when these other careworkers are doing their however many showers and taking that person then somewhere where they're just left? It's really how care is structured sometimes that changes that degree of function. It's not so much the person as the way care is delivered.

MR FITZGERALD: I've just got one query. You would have heard our discussion with the Royal Blind Society in relation to the provision of supports to people with vision impairment.

MS BRIGGS: Yes.

MR FITZGERALD: Again, the same question I have in relation to people with dementia and their carers. There's a whole range of information, assistance, advocacy, peer support, those sorts of generic services, and in the case of people with dementia, also supports that can be available to people to allow them to stay in their home and what have you. Are those sorts of supports best delivered through the current regime like the Alzheimer's associations and other peak bodies, or are there other models that we should be looking at? So putting aside the actual personal care and all those sorts of things and putting aside residential care, the delivery of the social supports and also supports enabling people to make decisions such as advocacy, do you have a view as to the best way that that is delivered?

MS BRIGGS: I think the critical factor is that whoever is helping those people knows enough about dementia to be intelligent about it, rather than just draw on generic knowledge. I think that gentleman from the Royal Society for the Blind made the point that occupational therapists come from occupational therapy school and then have to be taught about vision impairment. I think you could probably say the same still about most of the allied health professionals who come from university with minimal knowledge of dementia. Some may have more because they've had an interest and taken a focus. Others have to learn. So if they're in a generic service, the dementia might get squashed, so I think the critical factor is that whoever provides that advice and that service needs to really know what they're doing.

I'm not speaking from current knowledge, but some time ago when the Alzheimer's Association was providing carer education to the carer, which is really one of the very fundamental supports, there was the hope that it could sort of be franchised out to other organisations - you know, that we would develop the material and practise them and really put them into place and then others could take them up, but that there would need to be almost an accreditation process so that if you've let

the course out, then you are convinced that the people who are going to do it are going to do it with knowledge. Does that answer your question a little bit?

MR FITZGERALD: Yes, it does. I think you make the very valid point that generic services need to be very conscious of and competent in dealing with dementia.

MS BRIGGS: Yes.

MR FITZGERALD: But over and above that there are those specialist organisations that provide supports.

MS BRIGGS: That can do it, yes.

MR FITZGERALD: And it's a mixture of both of those.

MS BRIGGS: Yes. And it's how many people find their way to the specialist service, and that if they're not finding their way then at least in the generic service they still get a really good piece of information and referral back. I think the general practitioners are a case in point, who sometimes have found it almost impossible to refer people to the Alzheimer's Association because they have to tell people their family member has got dementia.

MR FITZGERALD: Yes, that's true. We've heard that. Thank you.

MS BRIGGS: Thank you for listening.

MR WOODS: Thank you very much for your time and for coming forward. That was very helpful.

MR WOODS: Can I ask Betty O'Halloran to come forward, please. Thank you. Could you please for the record state your name and whether you're representing any organisation.

MS O'HALLORAN: My name is Berry O'Halloran and I don't really represent any organisation. I'm more of a visitor or an observer of the services.

MR WOODS: Excellent. Please talk to us.

MS O'HALLORAN: Right. Well, my sister has lived in a nursing home for the past 20 years and it's been a constant battle just to get her basic needs met, and I have this belief that staff that work in nursing homes should be trained specifically to work in nursing homes, because there's a gross lack of empathy, and the inability to let the clients make decisions for themselves, especially those with communication issues.

While I agree that the younger disabled people should not be placed in nursing homes with older residents, not every older person in a nursing home is dying. Some older people still have a lot of living to do. And contrary to popular belief, the over-65s have many needs other than physical ones, and many of these are not even being met. They also have social and personal needs and a need for self-worth.

Money is often used as an excuse for these issues. However, I don't think empathy and compassion has a monetary cost at all. I think that you should train the staff to work in nursing homes and move away from the medical model. I agree more funds are needed and more staff are needed, but I think the staff training leaves a lot to be desired. I have observed over the years and heard many things over the years that are quite horrifying.

I think the staff need to be trained for nursing homes, and I know there are RNs who are trained to work in hospitals and their skills are needed for the medication, et cetera, but most are unable to get away from the medical model and realise that this is the person's home, and I find that's a big issue.

The residents should be able to make their own daily choices. Many staff now take away their last ounce of dignity by speaking for them and making the decisions for them and I think that the residents should be able to make their own choices about their routine, like when to go to bed, when to get up, what clothes they wear, and they should be allowed to go outside and choose their own activities. Most of these things just don't happen. I find it hard to get people to realise that these things are very important. They're trivialised in lots of cases. And things like treating the client's clothes, jewellery and other personal possessions with respect, hang up their clothes even, iron their clothes, and even making sure they're wearing their own clothes - it happens sometimes that they're not even wearing their own.

I've had another problem, where the staff can't read and write English. I find that horrifying. And sometimes they have no means of calling the staff because the bell is placed too far away, and then when they do ring the bell, I have witnessed it taking 15, 20 minutes to get it answered, and on one occasion the person had fallen out of bed. So there just seem to be some serious problems involved there. I just think that compassion, empathy and patience can't be bought with money. I think that your pay is a reward for effort and I don't always see that effort being made.

MR WOODS: Clearly you have had long exposure to these issues.

MS O'HALLORAN: Yes, I have, and I believe it's fairly widespread, because I have visited three different nursing homes and the same problems exist, and over the 20 years they've got worse rather than better.

MR WOODS: Because the staff are under more pressure or because the training of the staff you don't think is - - -

MS O'HALLORAN: I think so, but sometimes it's a lack of understanding, especially when the person has no or limited communication skills. Some things might seem trivial, but people will come into the room and say, "How are you today?" and if this person has a problem with communication, by the time they say, "I'm very well, thank you," the person is halfway up the corridor, and then you look at the client and the client has got tears running down their face because this person asked and didn't wait to find out what the reply was. In other words, they didn't really want to know in the first place.

MR WOODS: They're very subtle but important issues.

MS O'HALLORAN: Over a period of 20 years, that builds up and that person becomes very depressed and then you have another problem on your hands.

MR WOODS: Yes.

MR FITZGERALD: 20 years is a very long time of involvement with aged care.

MS O'HALLORAN: Yes.

MR FITZGERALD: Why have you been involved for so long? Was this with just one person, your sister, or a number of people?

MS O'HALLORAN: My sister has been in a nursing home for 20 years, but I've had other relatives in other situations that I've also visited. They haven't lived in there for 20 years, no, but even a couple of months, it's still - - -

MR FITZGERALD: Very substantial.

MS O'HALLORAN: Yes.

MR FITZGERALD: I noticed you made the comment that in your view things have got worse over the period of time that you've been involved in that.

MS O'HALLORAN: Yes.

MR FITZGERALD: What do you think has been the principal reason for them getting worse, in your opinion?

MS O'HALLORAN: Staff changes. Sometimes you might go three days in a row and you don't see the same person, and then there have been occasions where the person can't read and write English. I did on one occasion speak to Kelly Vincent, who is in the upper house in the South Australian parliament, who is also wheelchair-bound, and she gave me some advice. She said, "Print some little notes and put them up in your sister's room," and I did that, only to find that they couldn't read and write English anyway.

MR FITZGERALD: Just in terms of your advocacy on behalf of your sister and raising these issues with nursing home managers and operators, have you ever had the experience of actually lodging a formal complaint at any stage?

MS O'HALLORAN: Yes.

MR FITZGERALD: Could you just talk to me about your view of the complaint-handling. We've had a number of individuals like yourself present, and one of the issues that's come up has been about the complaint-handling processes.

MS O'HALLORAN: I once lodged a complaint because they were going to shift my sister from being in a single room, where she had been for years, into a room to share with four other people whom she didn't know, and I didn't see that as being fair. It was resolved and she did eventually get her single room back again, so I was quite happy with the complaint process.

MR WOODS: And was that complaint process handled just within the residential facility?

MS O'HALLORAN: No.

MR WOODS: Did you have to go outside to - - -

MS O'HALLORAN: I had to go outside of the - - -

MR WOODS: Okay.

MR FITZGERALD: And had your concerns only been dealt with inside, if there had not been an external complaint-handling process, what do you think would have been the outcome?

MS O'HALLORAN: I have no idea.

MR WOODS: Have you also had to raise with the providers the quality of care and the issues of allowing your sister to exercise some control and choice and judgment?

MS O'HALLORAN: Yes. There are some good staff, I must say that. There are some that are understanding.

MR WOODS: So when you raise it directly with them, some are responsive and make a bit more effort.

MS O'HALLORAN: Yes.

MR WOODS: But others, not so.

MS O'HALLORAN: Yes. I just think they trivialise things that are very important to some of their clients.

MR WOODS: If that's all you've got left, then that does become very important.

MS O'HALLORAN: That's right. The few decisions they can make for themselves have been taken away from them, because I think the training for hospitals, for RNs for instance - when you're in hospital, nobody minds being told when to have a shower and when to get up because it's short term, but when you're living in this establishment for two or three years, the only decision you've got left is when to get up and what you're going to wear today. When someone else makes that decision for you, you've got nothing left. Your self-respect has diminished.

MR WOODS: Yes, a very important point.

MR FITZGERALD: In your experience with the residential facilities, is there a formal process by which your views have ever been sought? In many community services now, clients are surveyed - not all, but many. In this case have the carers and family members ever been formally surveyed as to what they think about the facility?

MS O'HALLORAN: Yes, that has happened.

MR FITZGERALD: And do you get feedback on that? Do you get informed as to what the general views were?

MS O'HALLORAN: I think on a few occasions they've had a telephone, and my other sister and I have telephoned in some of our issues, but when the report comes out it says, you know, "We only had one person complain about this," so they give themselves top marks. But there are all those other people whom you meet at meetings and things who have exactly the same issues, and some people say to me, "Oh, look, that's happened, but I wouldn't say anything because they will take it out on my client," and they're too scared to say anything.

MR FITZGERALD: Do you have that feeling as well or do you feel that you can raise issues?

MS O'HALLORAN: Yes, I think I can raise the issues, because if something nice happens, I also tell them that as well.

MR WOODS: So it's fair and balanced.

MS O'HALLORAN: Yes.

MR FITZGERALD: That's good. Thank you.

MR WOODS: Thank you very much. That was quite a useful insight. We're grateful for you coming along.

MS O'HALLORAN: Well, I hope it was a different perspective. It's coming from the other side of the coin.

MR FITZGERALD: We have had carers and family members representing in each of the cities and it is always valuable to us. Those insights help us understand how the system actually operates on the ground, so thank you for that.

MS O'HALLORAN: Yes. I just think they need training. The training definitely needs altering. Thank you very much.

MR WOODS: Thank you very much. We will adjourn for lunch and resume at 1.30.

(Luncheon adjournment)

MR WOODS: Can I invite the ANF to come forward, please. Thank you. If you could each of you please state your name, the organisation you represent and the position you hold?

MS DABARS (ANMFSA): I'm Elizabeth Dabars, the chief executive officer of the Australian Nursing Federation in South Australia.

MR WOODS: Thank you.

MS WAGNER (ANMFSA): My name is Joanne Wagner, and I'm a registered nurse working in management in aged care.

MR WOODS: Thank you.

MR BONNER (ANMFSA): And Rob Bonner. I'm the manager of industrial and education programs with ANMF in South Australia.

MR WOODS: Indeed. Thank you for your many contributions to this inquiry. We not only have had submissions, but we've had meetings, we've had useful and productive discussions, and we look forward to today's presentation.

MS DABARS (ANMFSA): Thank you. I will make some introductory statements about who we are and a bit of an overview, and then go into the three key areas. We're the professional and industrial organisation for the nursing and midwifery professions, and in South Australia we have more than 15,000 members who are nurses, midwives and personal care assistants. We do have substantial award and agreement coverage in South Australia, both in terms of registered nurses, enrolled nurses and more recently with personal care assistants, and I would like to provide - just for the purposes of the commission, it is a document provided effectively in confidence to the commission - a list of the agreements that we have negotiated within the sector over time. You'd be potentially interested to note that we've got approximately 104 agreements in approximately 300 sites. More recently we have negotiated personal care assistant specific agreements, and once again they are growing in proportion.

Although as noted when we indicated we'd make ourselves available to the commission, we have three key areas to talk about, but we do believe it's necessary to add our voice to the call to get action on closing the wages gap, and in particular the need for the commission to build on the recognition of the problem of the draft report discussion regarding the issues surrounding wages and conditions, and the disparity with the comparative public sector. I draw to the commission's attention the fact that we haven't been neglecting the area ourselves by trying to negotiate agreements as you can see there. Despite that, it still remains a terribly difficult area in order to achieve some form of parity in terms of wages, if not conditions of employment.

Secondly, we do once again press the need to address the staffing level and skill mix issues in the sector, and once again we draw to your attention the fact that we have been busy in the area negotiating agreements. Notwithstanding that, there are still significant gaps within the provision of appropriate provision of registered nurses, enrolled nurses and personal care assistants, in order to meet the demands that they face. We certainly press the commission to make recommendations that standards be developed; at least that they be developed including under the planned staffing levels and skill mix research that's going to be undertaken by the ANF with DOHA support.

MR WOODS: Yes, and we have expressed interest in being kept across progress on that.

MS DABARS (ANMFSA): Excellent, thank you. We do also understand that the commission has expressed concern at the varying training or varying quality of training and education, particularly in the VET sector, and we do share those concerns, as I know you're aware. We are very hopeful, however, that the creation of the national VET regulator, in addition along with the proposed greater partnerships between the regulator and the ISCs will provide a positive vehicle for performance monitoring and standards assurance.

MR WOODS: What level of hope additional does that provide you with? Is it 5 per cent or 50 per cent?

MS DABARS (ANMFSA): Percentage - - -

MR BONNER (ANMFSA): There is active consideration about involving the ISCs in the regulation of programs in areas like aged care, and the ISCs as you would be aware are the people who develop the training packages in the first place, so it would be our hope that if that relationship can be built on, without the ISCs turning into some sort of standards police at the same time, that would give us a tie-up between the actual training package and what gets delivered. That's currently sort of the missing link in that whole cycle.

MR WOODS: It is. Thank you. That's helpful.

MS DABARS (ANMFSA): Now I'd like to address those three key issues, and the three key issues that we were proposing to address include the Gateway, the regulation of all careworkers in the public interest, and equity relating to changes for accommodation and care. In relation to the proposed Gateway, we have as you're aware, in our written submission indicated that there is a concern we hold in relation to the initial level of assessment versus the ongoing assessment and care planning that we believe needs to continue to be vested within the provider's staff. We have

raised that concern, and we really do believe that it's essential that those staff members within the provider's remit have the responsibility and the accountability to provide ongoing assessment and care planning during the course of the resident's stay within a facility.

I do note that I have a particular case in point that I want to refer to, and I do have copies of a finding of inquest, or a coronial case, that relates to the issue. I do acknowledge that it is simply a particular instance, a particular example of where the need to continually assess and change the care planning needs of a resident in an aged care facility is important to be done on a regular basis. Within this particular case which relates to Dawn Patricia Heath, she died following a horrific incident in a residential aged care facility when she caught on fire when she was smoking unsupervised.

You will find that the coroner does make some comments about the level of supervision, and also the provision of staff within the facility, but the particular point that I want to refer you to is on page 21 of the document, and the recommendations - recommendation 1 at paragraph 5.9 - where it refers to the loss of manual dexterity of the resident, and other matters relevant to her ability to smoke. The coroner goes on to say that there was a need for appropriate assessment and supervision, but it specifically says:

> Such an assessment should take place on an ongoing basis, having regard to the possibility of deterioration in the level of cognitive ability and dexterity of the individual over time.

Our concern would be if it were the case that there was a lesser imperative for the organisation to actually have regular assessment and care planning changes, because of a potentially unintended consequence of the operation of the Gateway review, we may well have unintended consequences for the provision of care and safety of those residents who are receiving that care.

So we do note that if you believe that a further Gateway review is required in order to substantiate a change in care or substantiate therefore a change in funding, perhaps you might entertain the ability for the assessment to be conducted by the provider's staff to be accepted in certain circumstances. But we're certainly asking that the commission clarify its intentions so we don't have an undermining of the assessment and care planning needs on an ongoing basis within the facility.

MR WOODS: We'll deal with that briefly when you come back but I think we can satisfy your concerns on that. But if you want to proceed through, and then we'll come back through the issues.

MS DABARS (ANMFSA): Yes, certainly. Thank you. The second primary point

that I want to bring your attention to relates to the issue of regulation of careworkers. We believe that health professionals in sectors involving vulnerable clients are regulated health professionals, on the basis that they are dealing with those vulnerable client groups. We acknowledge that registered nurses and enrolled nurses are part of that regulated cohort, but we are deeply concerned that the continuing failure to regulate professionally personal care assistants does leave a gap in the system. They do provide fundamental nursing care to some of the most vulnerable client groups and we believe that there is a need for a comprehensive regulatory framework in order to address that.

We know within the context of registered nurses and enrolled nurses and other healthcare professionals the purpose of having regulation means - or the outcomes mean - that there are registers that are publicly available, that consumers and healthcare providers can do searches on and discover whether the person is credible and qualified to be providing the service that they claim to be able to do. There is an aspect of setting the standards of education to ensure that they have the necessary job entry, knowledge and skills; also, the reporting and disciplinary system to ensure that the person is fit in all aspects. We do believe that it's incongruous to regulate people who are called nurses in the public interest but not to regulate those who are providing nursing services.

We particularly want to draw your attention to the purpose of the fit and proper person test and the interest that would be served on the public by having a fit and proper person test. In particular, there are a range of cases, including Hughes and Vale v State of New South Wales (1955), which refers to the expression of "fit and proper person" which involves three things, and the judges in that case said, "It involves honesty, knowledge and ability," which we believe are fundamental tenets to the provision of safe and quality care.

I also note that the intention to protect the public is by ensuring that there are proper standards of professional or occupational conduct and people that fall short of those are prevented from continuing to deal with the public in that way. As you may well be aware, currently, in our submission, personal care assistants are only regulated to the extent that they may be disciplined by their employer. We say that's inadequate because they may be re-employed elsewhere. It just ceases at the end of their employment relationship.

Secondly, they are regulated by way of a criminal history check. Once again we say that's manifestly inadequate because it presupposes that the person actually committed a criminal offence, was found to be guilty of that offence and has been convicted accordingly. Of course, as you would be well aware, there's a very high standard of proof which is beyond all reasonable doubt. In contrast, regulatory bodies provide a slightly higher test of the balance of probabilities and there are cases such as Briginshaw v Briginshaw that describe that.

But I do want to bring two particular cases to your attention. This first one, Samadi v Frenchmans Lodge Nursing Home (2010), is actually a case, you'll note, which is in the jurisdiction of Fair Work Australia. It's an unfair dismissal case. In that particular instance, an assistant in nursing was alleged to have used excessive force and rough conduct to move a patient into bed, and bruising was later discovered. There were criminal charges laid and you'll note at paragraph 7 of that document it does refer to the laying of criminal charges but they were subsequently dismissed.

However, when we look at paragraph 87 of that case, on page 12, in this instance, when considering the matter on the basis of an unfair dismissal, they say in their considerations if they had concluded that that personal care assistant or assistant in nursing's actions were true and the employer actually believed that they were to be true, they could have terminated that person's employment. So the standard of proof differs obviously in an employment context. The employer can choose the version of events that are put to them. Of course, there needs to be procedural fairness and natural justice afforded to the individual, but ultimately the standard of proof differs. Ultimately, in that particular case, it's said that there would have been a valid reason for termination, particularly given the duty of care of the provider. I note that ultimately it was concluded that, in that particular case, the dismissal was unfair, but that was for other reasons.

I do want to contrast that particular case with another, which is HCCC v Gillies (2010). It was in the New South Wales Nurses and Midwives Tribunal that this matter was heard. This involves an instance of a registered nurse who faced the tribunal following an incident which included an assault on a patient in a nursing home. At paragraph 3 of the decision it refers to the fact that the person did face criminal charges, was found guilty; however, the magistrate didn't proceed to enter a conviction. In this case, it clearly outlines the difference between the standard that's required in a criminal context versus that which is required in a professional regulatory context and in this case the allegations were unsatisfactory professional conduct in relation to knowledge, skill, judgment and/or improper or unethical behaviour. The standard of proof is described - and I'll just refer you to page 4 at paragraph 5. It refers to the standard that's required, which I've already referred to.

So, really, what I'm trying to draw to your attention is the difference between the standard of proof but also the need to protect in the public interest, and I do note that it refers in that case to "the need to protect those who need protection", and the inherent trust that a person has in the relationship that they have with those care providers. We have been advised over time about instances where people have experienced these issues in real life, in practice. I mean, these are real life examples, but I do now want to ask Jo to explain to us some of her personal experiences working in the residential aged care facilities.

MS WAGNER (ANMFSA): Thank you, Liz, for giving me that opportunity. In a previous position I worked in, in a residential aged care facility as a manager - it was a part-time position and I also at the same time was working for a registered training organisation, working with certificate III students studying in aged care. I would love to be able to say that elder abuse doesn't occur in aged care, but unfortunately in all the positions I've been in I have been involved with situations.

In this particular case, we had a careworker who was witnessed purposely treading on a resident's toes and we certainly went through the mandatory notification process and we had the police involved, and that particular careworker was dismissed. But because of the cognitive abilities of that particular resident, it would have been very difficult to prosecute, even with a witness statement, so consequently no further legal action was taken.

In my role as an educator, I then had some privacy towards some students that were out in a facility, and during the course of those discussions, this particular name became known to me, and they were talking about another situation in a different facility, where this same person had obviously gained employment, and the same situation had occurred there. So, yes, Liz had just asked me to be able to provide that example.

MR WOODS: Thank you.

MS DABARS (ANMFSA): Thank you. So you have our written submission as well, so I won't go further on that topic but to say that we believe that they should be regulated by the associated professional board, the Nursing and Midwifery Board of Australia.

The final matter that I wanted to talk through today was about the issues associated with equity considerations arising from the charges in relation to both accommodation and care. As you'd know from our written submission, we principally support the imposition of charges based on the capacity to pay. However, we are seeking clarification in the final report that, if care within a specified care category must be provided, it's not with further charge to the client.

We also do not support the trading of public places, but in the event that there is a market based mechanism that's applied in the form proposed, we would prefer that the facilities be required to meet the quota for those publicly funded places to ensure that there's a good social balance and accountability in the sector.

When we're talking about this topic, I must also touch on the issue of the abolition of the high and low care which is a consequence of that market based approach. It does have serious implications that we need to have the commission

turn its mind to, including the application of industrial instruments in some jurisdictions so some awards or agreements have provisions that specifically relate to the high care/low care distinction. Also, there is other legislation in states and territories that has an impact, such as drugs and poisons legislation, and sometimes on staffing regulation as well.

Finally, the operation of the prescribed services which set out the obligations on providers in meeting the needs of clients in that residential aged care facility: it relates to the regulation of registered nurse mix in the sector. If we lose that high and low care distinction, fundamentally there is only that protection left in making sure that there is a registered nurse on site in a facility. That would be a serious consequence if that were to be lost.

So we say that, in the event the distinction is removed and there is an increasing level of acuity in the sector as a whole, we believe that the standards applicable for high care should be applicable for all services. So that's the primary crux of our submissions. We'd be happy to take your questions.

MR WOODS: We don't have a lot of time left, but there are a few things. Perhaps if I can just clear up a couple of issues first. One of them is in terms of care: that a person who receives an entitlement to care would be able to take that entitlement equally to all providers and there would be a total price attached to that care, and then there would be a division of that price according to the person's capacity to make a co-contribution, and the balance would be the subsidy. That doesn't deny the opportunity for additional services to be purchased by a person who is also receiving a care entitlement. So the care entitlement would focus on their needs and requirements, but if they chose to purchase an additional quantum of services, that would be a private market activity.

MR BONNER (ANMFSA): We accept that proposition. Our concern fundamentally is that there are episodic changes in care requirements that sometimes arise that we would want to make sure weren't going to be then levying further cost to the individual for, rather than it being sort of optional extras, if you like, that people were fundamentally acquiring. So the envelope of care that's being funded through the Gateway process in our view needs to be sufficiently broad to cover those sort of temporary or other changes in care needs that are assessed by the professionals providing care.

MS DABARS (ANMFSA): We would be particularly concerned, for instance, if it were a case that the person was assessed for, for example, one shower per day and something happened to them which meant that they required another shower that day, that they would have to pay.

MR WOODS: If it's a requirement rather than just a personal choice, then that

would get enfolded, and in fact we can tie that back to the Gateway issues that you raised in relation to assessment: that we continue to see the ongoing involvement of the care workforce and nursing workforce in the process of monitoring a person's situation, particularly but not only in residential care. You have a daily engagement, an understanding of the situation of the person, and where there is a material change of circumstance then the staff are best placed to report that and to propose a change in the care plan that would reflect that. The only involvement immediately with the Gateway would be in authorising - if it took the level of care beyond the envelope of care that has been approved, then they would authorise that that happen, but the assessment function would be undertaken by those who are best placed to do it, ie the nursing and care staff in the facility. So we don't see that changing.

There may be reason to have a slightly different approach in community based care, but we're open to views on that as to whether there needs to be a higher level of involvement of the Gateway in authorising a change in the broad envelope of approved care. We are open to views of people on that. It does raise the broader question of how big should the envelope be of somebody's entitlement of care, because as you say, if there's a situation where they have a particular need for a while for a second shower a day, or whatever it might prove to be - or additional wound dressing or something - then how big is the envelope to allow that to occur, particularly if it's just for a temporary period because of a particular set of circumstances?

So if you are able to give further thought to whether we're talking about levels, bands, blocks of hours - you know, what are the various approaches that could be taken. We're very conversant with what a lot of other countries do. The Japanese model is multitiered. We've put forward a building block approach so that in fact people can have some basic support as well as some personal care as well as, if they need it, some specialised services, and they're put together in a thing called an entitlement of care - but just what those boundaries are.

MR FITZGERALD: I should just make the comment also that the Gateway is meant to be fairly interactive so that an issue that has arisen in recent times but it's related to this is that we see that some of the entitlements will be time-committed, so there's an automatic review. Others, we see that the client themselves, the older person, the carer, the case manager, whomever may be there, will be able to reactivate a review, so if there's a change in circumstances we want this much more interactive, and I should say that doesn't always mean increasing levels of care. It could actually go the other way.

The picture when we get to the residential is of a different nature, and there I think our view is that the service provider will obviously have to do the day-to-day assessments, as Mike says. The question we're grappling with is when, if at all, do they have to go back to the Gateway, because that's an entirely different set of

circumstances from the community care. So your points, both in your presentation and subsequently, will be helpful in that area.

MR WOODS: Perhaps one last one on your third block of points, and that's in relation to the high care/low care. Yes, it's true: you look at the New South Wales industrial situation as a very good example of that, where high care and the ongoing presence of an RN are industrially tied together, as well as in terms of care delivery. It differs state by state, and we're also conscious of that.

We're also aware that in practice the distinction between high and low care is not what it used to be and with ageing in place there are many in low care who are of a higher acuity of care needs. So the reality is fast overtaking the industrial processes and there's a need to recognise that. We consider that a person's level of care needs needs to address their particular situation. A person's choice of accommodation, if they're not in the supported resident category and what standard of accommodation that is and how much of their wealth and income they wish to devote to a combination versus other parts of their life, should be a personal choice and there should be some flexibility.

MR FITZGERALD: In relation to the high/low care, we would seek your advice, and it's about smaller regional communities. At least in the transitional stage but for perhaps much longer than that, we have a whole lot of low-care facilities that do have high-care residents, but they've got 15 beds; they've got 20 beds. No amount of changing the formula can actually fund a registered nurse on three shifts seven days a week. So one of the issues we put to your union in another state is, what do we do about this? Given that we want to go for quality care, that's fine, but with smaller facilities there is an issue, both in transition and longer term. So I think it's inevitable that low and high care will disappear; there seems to be strong support for that, but we will be left with, for at least a period of time, quite small services who have a mix of clients in them. And that's not the multipurpose centres that have healthcare units attached to them, but there are stand-alone ones. So what's the way forward on that is an issue and we'd welcome the union's views about that going forward.

MR BONNER (ANMFSA): Certainly the ANMF's position is not that we should be retaining high and low care, but we raised the proposition as needing to be dealt with on a slightly longer transitional time frame than I think was originally envisaged in the draft report, first of all.

MR FITZGERALD: Sure.

MR BONNER (ANMFSA): Secondly, we think that there are issues about viability of some of those small stand-alone residential facilities that, to some extent, have evolved services through mechanisms like ageing in place to a point where they're no longer able to meet all of the care needs of their residents at a level that

was seen to be optimal on the way through. I think that ACS this morning in their submission talked about perhaps the need to revisit how we deal with some of those viability issues in these areas. We've certainly been working with ACS and some of the small providers to deal with issues like dealing with schedule 8 drug medications in those small providers in the country areas as well. So we think we need to go back and look at how they operate, whether they are in fact viable, how we construct services so they can be delivered safely.

MS DABARS (ANMFSA): The issues, as you're well aware, do presently exist. The question then becomes who, irrespective of their classification level, will actually work in those services because they are totally unable to meet their duty of care; absolutely.

MR WOODS: If in a timely manner you're able to shed some further light for us, that would be very helpful. I'm sure we won't have it totally solved by June, but if we can at least point to some directions that are helpful, that would be useful. We have run out of time, but let me briefly mention regulation, and we're having ongoing discussions on those issues.

You raised a couple of points: one is the fact that the third-tier worker has some role in providing nursing care but they equally have a substantial role of providing personal care and there's a question of medicalising the model. There are issues about what is the most important first thing to achieve and is it having a workforce that is properly trained and skilled and competent which, in itself, does not necessarily then require registration or regulation of any form, whether it be licensing or whatever, but it does require some improvements in the process of educating, not only the curriculum but the delivery of the curriculum certainly by a number of RTOs?

Then there's the fit and proper person test and, again - and I congratulate you on a very structured and focused presentation - the question is, is regulation an essential component of introducing an appropriate fit and proper person test. So where are the priorities and at what point does regulation become an essential component? We are out of time, but if you just briefly address that.

MS DABARS (ANMFSA): Yes. I just need to raise with you, when you said the distinction between nursing care and personal care, we don't see that distinction quite so clearly.

MR WOODS: I understand that.

MS DABARS (ANMFSA): In particular, you said it's a bit of a medicalisation of the model and we would say that nursing is the model as opposed to medical model. So it's a nursing model which involves patient-centred care and holistic care in order

to address all of the needs of the particular resident or client.

Certainly I recognise your comments about the improvement in education, but in terms of fit and proper I think we need to ask ourselves as a society what do we believe needs to occur in the public interest? When we say that health professionals or people involved with vulnerable client groups, such as doctors, nurses and, I believe, personal care assistants, do have access to vulnerable people in such a significant way, you'd have to ask yourself to what extent are we willing to ignore that public interest risk and at what cost.

MR WOODS: If I can also say that in community care, especially where there is unsupervised interaction in a person's home, but also in residential care, at what point is it possible to develop an appropriate fit and proper person test and at what further point is it essential that regulation be part of that process?

MS DABARS (ANMFSA): I'm sorry, I'm going to refer back to the case law which talks about the fit and proper person test actually being specific to the occupation or the particular circumstances in which that person is operating.

MR WOODS: Yes.

MS DABARS (ANMFSA): So that is why we believe it should be considered in the nursing context and there are such synergies between what is already occurring with registered nurses and enrolled nurses that we believe that personal care assistants can quite comfortably fit in that realm. I don't know necessarily whether I'm answering your question but - - -

MR FITZGERALD: I can only say for the record, as you know, we've had representation from United Voice in a number of states and also the Health Services Union East who have a very different view in relation to the registration of this profession. The other point about it is that there are flow-on effects of this. If you take the whole of the disability sector which also uses cert III and in unqualified workers as well, at what point do you stop registering people? There are 170,000 personal care workers, both in the community and residential aged care already. If you add disability onto it, which is not unrelated, it's a very huge part of the workforce.

MS DABARS (ANMFSA): Sure.

MR FITZGERALD: So there are issues. But we welcome your contribution. I must say in the last few days we've had very different views put on the effect of that issue. So it is challenging the commission at the moment.

MS DABARS (ANMFSA): It is and I'm sure it would be. I do know, however,

that there are other occupational groups who, surprisingly, do still need to meet the fit and proper person test, such as plumbers and the like, and I think we might be dealing with a different area. However, if you say that a person needs to be fit and proper in that context, I find it hard to comprehend why we wouldn't require them to be fit and proper when they're dealing with vulnerable people.

MR WOODS: Yes, we understand.

MR FITZGERALD: Yes, we take the point. Thank you.

MR WOODS: Thank you very much. Always a pleasure.

MR WOODS: Can I ask Carers South Australia to come forward, please. Thank you for coming. Could you please, for the record, each of you state your name, the organisation you represent and the position you hold.

MS WARMINGTON (CSA): Yes. Rosemary Warmington, CEO of Carers South Australia.

MR SAUNDERS (CSA): I'm Phil Saunders. I'm the policy project officer, Carers SA.

MR WOODS: Thank you. Please, talk to us.

MS WARMINGTON (CSA): On behalf of Carers SA I thank the Productivity Commission for the opportunity to participate and present to you today.

MR WOODS: Thank you for your submission ahead of time. That was very helpful.

MS WARMINGTON (CSA): Thank you very much; good. Carers SA has been representing the interests of family carers since 1989 whilst increasing the recognition and awareness of carers' needs and rights. To start with just to say that in guiding our principles we see that: carers have a right to an identity independent of the person they care for; carers have the right to financial, physical and emotional security; carers and the people they support have the right to live with dignity; carers have the right to access appropriate information and services without discrimination; and carers recognise the rights of the person being cared for.

In preparing our work today, we've consulted with carers, family carers over 20 years, through membership and more particularly in the last two years in our consultations around the state. We realise that addressing the issues of how we support older people in the future is a very complex one and to start by exploring how complex it can be, we would just like to present, in addition to our submission to you, just a case study.

The case study is a young woman, aged 16 years, who because her mother had a stroke, was separated from her mother and her family. Her mother went into aged care early, awaiting accommodation. The family was separated and the family lived in country South Australia. The parents obviously were separated and the father set up a new life and had to work in the country. For the past three or four years, this young lady and her two siblings, younger than her, who are twins, one with an intellectual disability, have lived with their grandparents in Murray Bridge.

She has played a caring role obviously as a sibling to her younger brother with the intellectual disability and over the past three or four years has increasingly

become involved in caring for her elderly grandparents when they have had emergencies, which have included access to hospital care, calling the ambulance, looking at her contact with medical appointments and so forth, as well as during those times working with her younger siblings to get them to school when she doesn't have access to transport and authority. In those times, her father comes from the country and leaves his work to care for his children; and the grandmother, when she's come home with injuries, has taken on some of the care of the younger children, whilst at the same time the grandfather has greater caring needs. So you can see within that situation how complex the future aged care issues are.

I think one of the key points that has been made is that the ageing population is increasing and the number of carers is diminishing. However, more of us will need to provide care. And I want to put into the minds of the commission what impact this might have on these complex family arrangements and young people who might be delivering care as well; and the rural and remote aspects, the workplace issues that have been presented in that case study; the transport issues; and how they all impact on how we deliver care in the community and in the aged care system.

If I might suggest, I think some of these case scenarios would be very useful in a final report in looking more carefully at the implications of the Productivity Commission's findings and recommendations on aged care in considering carers' issues within that. Thank you.

MR WOODS: Thank you.

MS WARMINGTON (CSA): What I'd like to do is just go through briefly some of the areas we raised, but really leave it more open for questions from you because I think that might be more useful. We are aware that Carers Australia has made a submission and we support that submission; we contributed to it and they canvass some of the very wide areas. One of the key concerns that we had was that we believe there needs to be a more substantial identification of family carers and their contribution to aged care within the final report, that family carers contribute around 80 per cent of support in the aged care industry or in the aged care area and that they need to be more recognised in the impacts of any reform on them.

The South Australian issues that we want to address relate to the respite issues, older carers that we believe exist in this stage, the financial impact on family carers, a carer support model that we think can contribute to the overall future, the rural and remote population which we have considerable information about, and some of the transport issues, and touch briefly on those. We've made a number of recommendations, that are separate from any other submission, that have come particularly from our experience here in South Australia.

First of all, respite is incredibly important to family carers and, as one carer

said at our consultation, without respite services, the only thing one could do is hand the care recipient over to an institution. I think this is the feeling of many carers. They're a struggle for a number of other carers who find that in fact the person they care for doesn't want anyone to come into the home, so in thinking about aged care in the future, we have to balance up how in fact carers cope with the ongoing role of caring - on the one hand where they need support to continue that caring role often when the person doesn't want services to come in and they must continue to provide that; on the other hand where they want services but can't find them. And respite is fundamental to how carers get a break from their caring role.

It's been identified as a critical service: they want improvements in the amount of respite that's available; they want access to planned respite; they want access to emergency respite when needed; and they want to be able to access longer-term respite to avoid crisis and relinquishment of their care. The travel costs and distance related to accessing respite can be significant for some carers, particularly in the rural and remote areas and respite can be as much as 30 per cent of the cost of delivering respite in rural regions and this needs to be factored in.

Retention and continuation of respite staff is really important. This is an issue that we know is critical and is well identified in your report. Accessing people who can deliver respite in-home for a short period of time is very important. The other thing that we do need to recognise is that as the people going into residential aged care become older and more frail, this indicates that the people staying at home are become older and frailer as well and is an important point.

Another point that we do want to identify is older carers. South Australia has the oldest population - and by that, it means that the carers are going to be also older and be caring for people who are older and we believe that needs to be considered very carefully within the report as an impact on South Australia. Another is that many of the carers are female, so the impact particularly - the gender issue associated with caring and delivering that needs to be well recognised within the report. The other, of course, is that carers themselves suffer from very poor health, indicated by much research and evidence and if they're particularly females, then we have an issue for the female older generation.

And carers in South Australia: just to let you know that 50 per cent of those attending our consultations were over 65 years with 8 per cent over 80 years of age, and so many of the carers are quite elderly and many of them of course are caring for older people with disability and mental illness but still themselves fit into this aged population. Many of the aged carers, as I mentioned, are looking after younger people. So in terms of older carers, that's really just a recommendation for you to look more carefully at the issues associated with them.

The financial issues: 37 per cent of primary carers in South Australia rely on a

government pension and it's their main source of income and, because of that financial distress, carers in financial distress are isolated from the community and it creates social exclusion for them and is a very important issue to address within the scope of the report and the findings. How do we support people if there are going to be more carers? They are going to be financially disadvantaged. How does the aged care system address those issues for the future?

Many of the household incomes in our member survey were very low. 60 per cent of respondents' income was less than $30,000 per annum. We have done research on the utility costs that are essential for caring for somebody in the home and, due to the nature of caring needs, they have, from our research done some years ago, 14.5 per cent increased costs related just to electricity. So you can see that, besides their social exclusion and opportunity costs that they have lost, they have increased costs associated with the caring role.

Transport is an item that really does need to be addressed, and I know it is in your report, but many older carers, or carers generally, do rely on transport. It's surprising how many carers have very, very old cars; they can be 30 years old and still going. But some of them, to get to medical centres with the person they care for for treatment, can spend two hours on public transport - from the centre of Adelaide out to Flinders Medical Centre, for example. This has been consistently raised by us as one of the most fundamental issues existing in rural and remote areas, but not only that, within metropolitan areas, and it's quite surprising when you have a car how easy it can be but, when you don't have access to a car, how complex the transport issues are, and carers are responsible for getting people to appointments and so forth.

There are very, very limited options for transport in the rural and remote areas, so they do compound huge issues related to access to services and carers trying to get people to appointments, and transport services are really uncoordinated across private, public and community providers, and the transport may be very inappropriate for transporting older people. The other is that they often are unable to afford their own transport. So one of our recommendations is really to address the transport issues associated with providing care, particularly in rural and remote areas. On top of the cost, it's time associated, and the report The Tyranny of Distance highlighted some of the huge areas.

The other comment we really did want to make was about carer support services. Particularly in South Australia, we believe that quite a comprehensive model of carer support has been developed through the Home and Community Care Program funding, which is also supported by the Commonwealth Respite and Carelink centres and the carer advisory and counselling services within this state, which has created a layer of carer support across this state, but the local carer support programs are much more locally driven.

We would note the recommendation for carer support centres, but we believe that the commission could look at the model that we have, which is much more locally based in the regional carer respite centres, because they're connecting carers at a local level and building capacity within the community much closer to where they live. It's much more based on relationship and assessing them and linking them to local services. So we're happy to talk more about that. Carers need a lot of help in navigating the system. Besides just providing information, they do need that navigation assistance.

We've touched on rural and remote, but just finally, South Australia is particularly rural and remote. There are other states that are more rural and remote, but we do find that this is quite an issue when we travel around the countryside. The largest city outside of Adelaide is Mount Gambier, with a population of 23,500. Critical issues related to this, of course, are the workforce, supporting a workforce to support community care and aged care - very, very difficult; fragmentations of services; lack of capacity of services. Infrastructure and transport make the lives of carers very, very difficult in rural and remote areas. Also, rural and remote areas do experience an influx of retirees. There are more pressures on housing issues. They're looking for retirement funds. People are moving into the remote areas or seaside areas and we are finding the need to address those service changes in the country.

Three concerns in the country are: information and referral, services for the care recipient, which may just not be there, and the access to respite. The research shows that rural and remote carers experience higher rates of disability and/or chronic health conditions, have lower rates of employment, have experienced difficulty in accessing services and report that affordability of services is quite difficult. So the implications for the cost of aged care in the future are quite significant if carers and the people they care for are unable to afford them and what might be the implication for the family carer. That really sums it up.

MR WOODS: That's quite a broad-ranging presentation, for which we are grateful. You mentioned at one point - and a former president of Carers Australia keeps making the point as well - about carers in a situation where the person they are caring for doesn't wish to have services delivered to them: "They don't need it, they don't want strangers in, they want you to keep delivering the service and looking after them" issues. How prevalent is that? It goes to the heart of the issue of whether a carer assessment takes place in the context of the older person approaching or being approached for the Gateway for services. If that doesn't trigger the assessment, then to assist the carer to continue to provide the support, we need a different trigger. But what's your experience in terms of the actual quantum of the issue that we're looking at? We understand the type of issue.

MS WARMINGTON (CSA): In the older population, particularly in rural and

remote areas, it can be quite high. I'd just take a guess - 60 per cent of the people who we connect with, the carers in that category, may find that they're not really keen to have services in, and the attitude is that they want their wife or their family to care for them; they don't want anyone in, just as you outlined. I'd have to go back and have a look more clearly, but very happy to provide that information based on what we have received. We've received that information back.

MR WOODS: Yes. I mean, as broadly as you can reasonably achieve, but it would just be very useful to understand the quantum.

MS WARMINGTON (CSA): I think culturally diverse groups are much higher again. They're not so keen. Often men want their wives just to care for them and the family are more private about wanting people to come into their home. So it is quite a big issue. That's where we find a carer support model which supports the carer who really is delivering the service is so important, because it sits outside of what I see as the model that you're looking at. In some ways it starts sitting outside because these people are providing the aged care service but they're not going to really want to go through that formal structure.

MR FITZGERALD: I think the model - and we just need to clarify it a little bit. There are two ways to access support for carers. The Gateway is predominantly to assess the needs of the older person and the carer in combination, but if you have these dedicated care support centres - which we are recommending and you obviously support, because you have that model in South Australia which is effectively what we're proposing - people can directly access those support centres without going to the Gateway, so that in a sense what we are proposing - and it's not clear enough in our draft, clearly - is that a carer will be able to access the carer support centres directly and receive a range of services very much in the way you've described it here in South Australia, but in terms of the actual Gateway, that's really to pick up when you're trying to assess the needs of the older person and, in association with that, the needs of the carer in order to have a set of entitlements.

So I think we can enter it both ways, because in the early discussions with the Carers Association of Australia, straight after the draft, that was a concern; that the only way you could get services was through the Gateway. I think we've tried to clarify that. That would in some way deal with some of those concerns.

MS WARMINGTON (CSA): It would, definitely. Then that points to the need for some localisation of it, so it's really working more within the community.

MR FITZGERALD: Can I just take that up with you and then it's back to Mike. Whilst I understand you want localised services, we're not prescribing the number of centres. That's inappropriate for us to do so. But even if you had a regionalised model with hubs or sub-agencies, that still works if you've got the physical presence

in the local communities. So you can achieve that in a number of ways. The government can directly fund a huge number of centres or it could - if it so chose - fund a smaller number of regional centres who, in turn, contract with or work in partnership with smaller organisations. So one size doesn't necessarily fit all in that sort of model. Would you agree with that or not?

MS WARMINGTON (CSA): Yes. For example, Carers SA has 10 locations and they're in different regions and they're quite local, and there are other organisations delivering it and they are in regions where respite and Carelink centres are, so we all sort of work together. I suppose by "localised" I mean more than regional in terms of its presence and its location. There needs to be a sense that on the ground there's something there: they're not flying in and flying out. You just need to build that relationship in the community and have local people connected with it, because it's a word of mouth and the trust that builds the local capacity to support older people in the community.

MR WOODS: Robert has organised a wonderful segue to my next issue, thank you, and that is this question of having local resources, people you can trust. If we're looking at the provision of respite - and there may be slightly different models between planned respite and emergency respite - the question is, what should be the requirements for an approved provider? Should it go beyond the sort of current arrangements where they are organisations who have sought and are approved, to the extent that - and maybe especially for respite - they constitute neighbours who are on a schedule of approved providers? What sort of requirements would need to be gone through to ensure that they are fit and proper people, that they have basic first aid, and that they have an understanding of the needs of the person that they would be providing temporary care for? What are your thoughts about how broad should constitute the pool of providers of respite and what minimum requirements would you see would be essential in that? Would it extend to non-resident family members? Would it extend to resident family members? So the question is why - and the consequences of that. But where do you see that falling?

MS WARMINGTON (CSA): Very, very big question and I'm aware of the previous conversation and how big this is. Can I just reflect on some of our experience with family members. In the past, maybe five or six years ago, there was a much greater focus on using family members to support other family members in terms of perhaps giving them a contribution, just a minimal one, to help them to meet the costs of doing that. There are so many litigation issues and risk issues and taxation issues and requirements, it really squeezed that one. But for many Aboriginal families, culturally diverse families, families where their child has a disability, this was a very important source to them. But it's very difficult to manage.

In some senses, it's very easy to manage because the family organise it: "I want to go on a holiday. They'll come over. What are the costs? How do we help

them to do that? But on the other hand there's always this concern that it's open to abuse and you don't have those other things in place and someone has endorsed that happening. So they're the sort of challenge - - -

MR WOODS: Absolutely.

MS WARMINGTON (CSA): So on the one hand it's a brilliant idea. You want an answer to this. On the one hand, I think in a way it's incredibly important, but on the other hand it's incredibly difficult for organisations to know how to manage, and the only way I can think that you would deal with it is really you have to build this more into the social security system or the taxation system somehow so that the risk is taken away from the organisation, because they have to meet insurance requirements, and the standards are so strong around organisational requirement and coroner proceedings and things like that. You may need to find another system that recognises that. Taxation hasn't dealt with this to date?

MR WOODS: No.

MS WARMINGTON (CSA): I think the social security system, through things like the carer allowance and things like that, may be able to think of ways of doing it, where you're just saying, "Well, we recognise you do these things on an occasion. You've made a commitment to it so many times a year for so many hours that you will get a recognition in some way." That would be another way. The only other way is where you provide someone, through a discretionary arrangement, through the Taxation Department. I'm not giving this as professional advice; I'm very cautious about this. But there is some way of saying, "You're doing it on a voluntary basis. It's not a professional commitment and you can be paid a minimal amount."

MR FITZGERALD: Yes. I think the issue of the tax stuff is potentially able to be solved.

MS WARMINGTON (CSA): Okay.

MR FITZGERALD: The issue, I think, from my point of view very strongly is the other risk elements in this. The difficulty is as soon as a third party provides care in response to a payment of any description, irrespective of the tax issue, the issue is what happens when something goes wrong? Which it will, we know; we know absolutely, given the vast numbers of people we're talking about here. So on the one hand we want to increase the flexibility for the person that's ageing and their carer and to be able to let them have greater access to more flexible respite. On the other hand, you're absolutely right: we are absolutely perplexed by how you operationalise that, given a whole range of risks. Of course, if you've read the report into the national disability insurance scheme, there's a stronger position in terms of allowing flexible respite but no less clear about how you actually manage that system.

MR WOODS: So if overnight you're able to sort some things later - - -

MS WARMINGTON (CSA): Okay, I'll keep that in mind.

MR FITZGERALD: You're the experts.

MR WOODS: We're happy to have it by lunchtime.

MS WARMINGTON (CSA): Okay.

MR FITZGERALD: Can I just push that a little bit, just in terms of planned and emergency. I just want to test this with you. At the moment, it seems to us that planned respite would be something that would come through the Gateway and would be provided based on the entitlement - so Michael needs X planned respite; he gets an entitlement to do that - whereas we think that emergency respite, because of its unpredictability, is better handled through the carer support centres as part of the block funding. Now, I just seek your opinion on that.

MS WARMINGTON (CSA): One of the struggles we have in delivering carer support is that we have a model of supporting carers but we never have access really to enough of those things, like respite. So it can be really flexible about saying, "Well, we recognise we can provide you with some support at the local level," so we would support that. It would be a better marriage of the parts that are needed to support a carer in their own personal need, as opposed to the specific delivery of a service to the consumer, if you understand my saying, to support their own emotional health and wellbeing. That would be a better way of combining them together. It would provide flexibility. You could respond to the carer. It would be much better: the counselling, the information, the access to respite would really work better.

MR FITZGERALD: But, again, can I just be clear. I'm not sure. Are you saying that in the carer support centres emergency respite would be dealt with through that mechanism?

MS WARMINGTON (CSA): Yes.

MR FITZGERALD: What about planned respite?

MS WARMINGTON (CSA): Planned respite? It depends where it's really going to be provided, isn't it? If it's provided through a residential setting - - -

MR FITZGERALD: Some of it is; some of it is not.

MS WARMINGTON (CSA): Yes. Our experience is that it's almost impossible to

get planned respite in the home for an older person. I don't know anyone who really has access to that, other than in the residential setting or through family. They might get short bits of it, but to say, "Look, I really want to take a week - - -"

MR FITZGERALD: Very difficult.

MS WARMINGTON (CSA): We talk about it. It's becoming a bit - - -

MR FITZGERALD: Can I just raise one question. We've heard a number of carers organisations raise this, and that is for us to take particular regard of the fact that many carers are themselves ageing.

MR WOODS: They are.

MR FITZGERALD: And you've indicated that - both female and ageing. I'm not quite sure what that means in terms of what is the special regard you'd like us to have? I'm absolutely empathetic to the position, but in a practical sense what are you actually asking us to do in relation to that group?

MS WARMINGTON (CSA): Carers in that age group probably need more respite - access to more respite, to more services - and I suppose as well we start moving into the area of them caring for a lot of people with disability. So this is the nexus between aged care and disability. So in the aged care sector we have a better appreciation that an older person may be caring for an older person as a partner maybe, or in their home, and somehow we appreciate they change that role. But in the aged care sector we don't recognise that many older people are caring for a range of people and they're elderly in their own right and they can't actually enjoy their own health and wellbeing as older people.

I think it's that nexus between those two things that, although you might not see it fits easily into this commission's report and more into the disability one, there is still a need to address it. Does that - - -

MR FITZGERALD: Yes.

MR WOODS: And transport would be another - - -

MS WARMINGTON (CSA): Yes, and transport is another one.

MR WOODS: - - - issue relating to that.

MS WARMINGTON (CSA): There are a range of things within that. And probably more guided referral as well; more support to help them, guide them through the system, although if the system improves we would hope that would

change. But we find many carers very unwilling to approach anyone for help, so whatever system you put up, they're going to need the support for many of those older people, just to take it on and think about giving up the role or relinquishing it or getting help or getting assistance in. So they do need that support just to think their way through it.

MR WOODS: Excellent. Thank you.

MR FITZGERALD: Thank you very much.

MR WOODS: We appreciate your ongoing contributions to this inquiry.

MR WOODS: Can I ask Ethnic Link Services to come forward please. Thank you. Could you please, for the record, state your name, your organisation that you represent and the position that you hold.

MS TYRONE (ELS): Yes. I'm Angelika Tyrone. I'm the manager of Ethnic Link Services, which is a service that works with people of cultural diversity within UnitingCare Wesley Port Adelaide. And my colleague - - -

MS LOBBAN (ELS): I'm Rita Lobban. I'm the regional coordinator within Ethnic Link Services.

MR WOODS: Thank you very much.

MS TYRONE (ELS): With a specialist focus on the Riverland.

MR WOODS: Excellent. Thank you for your submission to us, which is very helpful. It drew our attention to a number of issues, but please take us through your presentation.

MS TYRONE (ELS): Yes. Thank you very much for giving me the opportunity to speak and for us to put forward our particular situation and views. We certainly acknowledge the need for reform, there's no question about it, and appreciate that you're tackling it in the way that you're doing; particularly about getting some of the ability to respond is very, very helpful and being able to speak to you.

The aim of our particular response is the intention in the submission that we provided to you; is the provision of aged care for people of cultural diversity and, in particular, the provision of aged care we're going to focus on here, in community care. We certainly recognise that you're trying to get a fluidity between community care and aged care and we really appreciate that very, very much. I think that makes a lot of sense. But our particular focus is community care for a number of factors. One of the primary reasons is the fact that people of cultural diversity tend to remain home longer in the community, rather than transit into a formal residential care setting. If you look at the numbers, the proportion, it's very, very high.

MR WOODS: Just on that one - and it is, indeed, true and we have in fact noted that in our report - to what extent might that also in part be a consequence of the CALD communities not fully understanding how to access residential care or not having enough information or being uncertain about what languages would be spoken in the facilities, or cultural awareness? There's the positive attraction of remaining in their communities, where they're known, respected and language and linguistic and cultural appreciation, but is there also a push factor, in the sense that they don't know how to access residential aged care?

MS TYRONE (ELS): I think to some extent the access would be a factor, not particularly for South Australia because we've got mechanisms to do that. However, there's still a preference, even with language support, navigation information, and you'll find that that will be the case.

MR WOODS: Yes.

MS TYRONE (ELS): I think that's reflected elsewhere in the world as well.

MR WOODS: We agree. I was just checking your views on that.

MS TYRONE (ELS): Yes. Our particular focus also is the situation in South Australia where there are particular situations that enable organisations like Ethnic Link Services, our organisation, and other services to be provided for people of cultural diversity that are ethno-specific style services which they prefer, and that preference is articulated by a number of other submissions.

Certainly the people of CALD background represent something like 20 per cent of the population - it's 21 per cent based on the 2006 statistics - and it's really important, imperative, that these reforms that are being undertaken actually acknowledge that. There certainly have been other recommendations from FECCA - the Federation of Ethnic Communities Councils of Australia - that have asked for the Commonwealth government to actually acknowledge the fact that this representation is so high, and we do support that as well; that that needs to be acknowledged and be a very important part of this particular change.

Certainly also the barriers: there are systemic barriers as well as operational barriers that are created. The FECCA submission, as well as the Centre for Cultural Diversity in Ageing, have a number of recommendations which we all support as well, which Ethnic Link supports, and I think that recommendation 2 that we've presented is that there has never been a regulation of care, service standard, policies or framework around providing service for people of cultural diversity, and that's one of the things that could be addressed with this reform - is to the development of those regulations of care, specifically for CALD.

Certainly the main issues and barriers are language issues. It's not about just obtaining an interpreter. That doesn't always solve the problem that is connected to what the service is about. Lack of information regarding services is an issue, but that's not the only factor. There are also cultural issues which are really important to have an understanding around and the other part of it is the difficulty of navigating the service system. That's been of particular concern. And with the aged, given that they're remaining home longer, there is the issue of the resulting isolation and other aspects interconnected with the language loss, and the situation is worse in the rural areas.

So with respect to communication issues and barriers, yes, the service right from the assessment stage should involve either an interpreter working with an aged care provider that has cultural experience - because otherwise it is very, very difficult to ascertain what exactly the person really wants and needs, and the building of trust that was referred to in relation to carers is also quite essential as well as that. So it's actually providing the service in a language they understand but in a method and a manner and a medium that they understand. So it's not just about having an interpreter, although they do have a very, very important role.

And not knowing the service system: that's of particular concern in South Australia where there are many small councils providing services. I'll go into that a little bit later. And the frailty due to age really does require that service be conducted in the home, and even right from the assessment stage, that service be conducted in the person's home to a large extent, because transport is also an issue, and the capacity for that person to actually even get a taxi; it's sometimes not possible. Above all, it's really looking at a client-focused approach to service and whatever the client needs.

In South Australia, given that this is the oldest aged state - it's something like 21 per cent based on the 2006 census, and that's increasing - in terms of people that are older than 80 of cultural diversity, that increase is double what it is for non-CALD. Graham Hugo's recent report looked at it. 22.5 per cent of the 65-plus are not able to speak English well at all, so that's another factor. Part of that is in areas like the Riverland, the isolation amongst the towns has meant that they just have never been able to learn English; also the fact that there were no English-language services really in place when they first arrived.

Hugo's other statistic is that those aged 75-plus, something like 30 per cent of the population don't speak English well enough. So, in terms of the spread, most people of CALD background are more likely to live in metro Adelaide. However, there are some regional areas, like the Riverland and Whyalla. Ethnic Link Services works in those areas, but there are also additional other areas.

Just getting now to South Australia, it is really different from other states in the dispersal of CALD across the areas, and also the fact that South Australia has very, very small local governments. There are some that are larger and there are some that have amalgamated, but it means that there are many small services and pockets of services. There are over 100 providers of aged care services, et cetera and so on, in Adelaide alone. Really, that's where Ethnic Link Services come in to actually provide some of those interconnections and relationships and connections with services.

MR WOODS: We liked your model-of-care diagram.

MS TYRONE (ELS): Did you?

MR WOODS: It's very helpful.

MS TYRONE (ELS): Good. I'm glad you could understand it.

MR WOODS: No, it was good.

MS TYRONE (ELS): So really, in South Australia there are other solutions that may not be as helpful as useful as, say, interstate. I know New South Wales has the MAP program and that sounds very, very interesting - the Multicultural Access Project. The other factor in South Australia is, the Office for the Ageing has actually employed a number of strategies around working for people of CALD background and has allocated funding to something like 17 to 20 CALD communities themselves that provide their own services, and they're ethno-specific; they provide people with the language.

I'll just talk about access to home care. That's being developed as part of an Access Points project across the state, and the demonstration project in the western part of metro, which is one of the culturally diverse ones, Ethnic Link has been working very closely with them in regard to people of cultural diversity that will require an assessment that cannot be done on the telephone. So it's really face-to-face, and that may be an alternative model to the Gateway one that is proposed in your inquiry and it has a number of components in it.

I'd like to just outline a little bit about Ethnic Link Services, which began over 24 years ago as a HACC-funded program, so it's as old as HACC. The model is specifically provided - it's quite unique in Australia and it's eminently suited to South Australia, given the nature of it, the breadth of services across the broader metropolitan area wherever there are culturally diverse people, including Whyalla and the Riverland.

The client profile is really the frail aged, the HACC target group, and over the 24 years Ethnic Link has been providing services to hundreds of thousands of people of CALD background who really require language assistance and advocacy in order to access any services, and that's the important criteria, and there are individual services. We have group programs as well and we actually broker our language workers out to other services, which has been quite successful. So it's what's termed an ethno-specific service, in that we provide the service of bilingual, bicultural workers who are from the culture of the person that's being provided the service, and it's one point of contact, and then there's an immediate person at the end of the line that is actually the person that cares for you. So there's an amazing sort of efficiency there.

We currently employ people with over 30 languages and they are trained in service delivery. We provide services to 45 different groups of different cultural backgrounds, including 30 communities that do not get any other services funded - ethno-specific services - from Office for the Ageing or HACC. So that's where really Ethnic Link Services fits in the gaps, and the model of care is basically that it's a navigator of the service system. Should the service system change significantly, where navigation is not necessary - but given that there are so many agencies in South Australia, this may be the most viable, cost-effective way.

MR WOODS: That would be wishful thinking to think that it could all go away.

MS TYRONE (ELS): Yes. So all of the things like providing language assistance, advocating on behalf of clients, providing information to clients, linking clients to services and, if they change or circumstances change, then really it's according to the client need. All they have to do is make a phone call to us or contact us in any other way and, due to the frailty, we provide service in their home or wherever it's needed. So it's really a holistic way and an equitable way for people of any culture. We do work with the larger cultures as well and we do provide some social groups for the smaller communities that have no other funding source. So those are the range of services that we have, and really we look at the client being at the centre and being the determinator of what they need in terms of service, and we assist to navigate whatever they need.

If I could respond to some of the specific recommendations. Chapter 9, catering for cultural diversity - unless you had some questions about the model or - - -

MR WOODS: No. I think we understand the model.

MS TYRONE (ELS): Yes. In terms of that, we certainly appreciate that there's consideration and there's a chapter on cultural diversity and that you've put a lot of different groups in there, which is I think one of the first times that that's been mentioned compared to other reviews, and considering that the aged of CALD background represent 20 per cent of the population, our view is just that there should be more specific attention to those groups.

We certainly appreciate that there are some other issues and recommendations that we've made and others have made that would be helpful to have in such an inquiry - certainly the Multicultural Access Project. The Migrant Information Centre in East Melbourne is another one that's produced some very important information as well. We appreciate the expanded use of in-reach service to residential aged care, because there was a blockage there, and also the single integrated flexible system of care. That sounds so much better than the - - -

MR WOODS: We're trying to fit the package.

MS TYRONE (ELS): It's fantastic, yes. It would make a major difference, because the number of our clients that are HACC-funded would not go onto a package because they would lose the language. So there are all sorts of blockages that have occurred that your recommendations will change. So that's good. Probably the competitive tendering may not be as helpful for people of CALD background, given that some of the smaller groups do not have the language capacity to sort of be into tendering. It's such an onerous task.

MR WOODS: Yes , we're aware of that item.

MS TYRONE (ELS): Great. Thanks. We certainly support the inquiry's comment on page 273 that there should be specialised models of care to cater for people of diversity who require additional care and culturally responsive services. We have actually put that into a recommendation specifically for that. In commenting - - -

MR WOODS: Sorry. Just on that one briefly, there are two issues there. One is the delivery of CALD-sensitive services and the second is what are the consequences of additional services that may be needed to deliver that? So not all diversity needs to reflect and require additional services, but there are some situations.

MS TYRONE (ELS): Yes.

MR WOODS: So as long as we tease the two out and keep both in mind.

MS TYRONE (ELS): And there are many CALD people, people of CALD background, that actually have - such as myself - enough of the language capacity to be able to negotiate systems. So we're talking about the ones that actually require it, so the recommendations should be around requiring additional care.

MR WOODS: Yes.

MS TYRONE (ELS): It's true that older people not proficient in English may require the additional assistance in navigating, such as is mentioned and identified by multicultural access projects and proven by our work over the last 24 years. It's precisely why the Ethnic Link model is so successful in navigating the pathways from the beginning with that person. Recommendation 8.1 regarding the Australian Seniors Gateway is described within the Productivity Commission report. It's our view that it will not be an effective and appropriate service entry point for people of CALD background, even if there is the interpreter service, because communication is more than an interpreter service. The Gateway could in fact create barriers. That's our view, and I've got some more detailed comments about why we think that it

would be a barrier.

Just going on, the commission rightly notes that language services are inadequate and it's much more complex in the context of care than having an interpreter, although there's no denying the need and importance of interpreter services. As noted by the multicultural access projects interstate, older people of CALD background who do have issues with trust, language, culture and so on will have a major problem with accessing a very large organisation that may not have the interconnection with themselves.

MR FITZGERALD: Can I just deal with this. How do people from CALD backgrounds access Centrelink? I mean, they already do access very large organisations in the government so, whilst I understand we've got to be very careful about the design of the Gateway absolutely, at the end of the day people do need to access the Gateway in order to get the entitlement, the same as they must access Centrelink to get a payment. So the question for me is not whether they will need to access it, they will, but what are the supports that will be necessary to enable that to happen? What are the design features in the Gateway that are absolutely critical to ensure that it works? Because at the end of the day you're not going to have multiple agencies handing out entitlements, but we are going to have multiple agencies providing information, advice, support, advocacy - all of those sorts of things - and, within it, absolutely, including services like yourself trying to work that out. So, in a sense, if the proposition is that they can't access the Gateway, that's not a plausible proposition. If we can say, "How can we make that work?" that's the question. And I use Centrelink not because Centrelink is a great agency as an example, but it's the one which people of all backgrounds must access if they want benefits.

MS LOBBAN (ESL): I suppose the critical point there is if Centrelink is going to give them the entitlement - - -

MR FITZGERALD: No, Centrelink is not. The Gateway will.

MS LOBBAN (ESL): The Gateway will through an agency perhaps like Centrelink.

MR FITZGERALD: No, directly.

MS LOBBAN (ESL): Okay. I suppose it's that income support. So you roll it out as income support or an entitlement support but that same agency is not going to be the one that's going out to assess on whether they can actually have it or how they're going to deliver it, so there is a separation there. Is that what you're envisaging?

MR FITZGERALD: Well, I'll unpack it just a little bit. The Gateway has a number of functions: information which can be provided through multiple services.

One of them, the second, is assessment. The Gateway can contract that assessment function or use any number of models to make sure that assessment occurs, but it's its responsibility. At the end of that assessment, as you know, Michael as the client will have a set of entitlements to services which will then may be provided by ethno-specific organisations or non-ethno-specific organisations. But the Gateway is the critical way by which you would get access to services.

MS LOBBAN (ESL): Right.

MS TYRONE (ELS): We work very closely obviously with Centrelink because it's one of the agencies that we work with, and when our clients get a letter from Centrelink, which is always in English, they actually start to get worried and call us straightaway.

MR FITZGERALD: Sure.

MS TYRONE (ELS): And we actually support the intersection. They do have interpreters - which are very, very good - to do that. Face to face, it is. Very rarely do our clients use any telephone interpreting. So we're that sort of interface at this stage when there's something that happens with an organisation.

MR FITZGERALD: Yes. So you provide a very important range of supports - - -

MS TYRONE (ELS): Yes.

MR FITZGERALD: - - - in order for people to be able to access and deal with Centrelink, and more than that. In a sense, I think that's what we see happening here: that organisations like your own would be critically important in support. The reason I'm being very particular about it is that there's no way of getting around the fact that at the end of the day a person of whatever background will need to be able to, somehow or another, get through the Gateway system.

MS TYRONE (ELS): Right. It will be harder if it's not - it would need a level of support; certainly advocacy and certainly another element. Perhaps the person would have to be alongside that person that's having the difficulty and, as long as that's sort of a separate role, that would work quite well, because of some of the issues that our clients have articulated when they do have - - -

MR WOODS: Yes. We're interested in having the Gateway have an interface with the CALD community through organisations such as yourself and other means, because it's important that people understand what their rights and entitlements are and can access them properly. So we're interested in your views on how to make it work as best as possible.

MS TYRONE (ELS): Could I just ask if you envisage the Gateway actually being specifically within Centrelink or separate from or - - -

MR FITZGERALD: No, totally separate from Centrelink.

MR WOODS: No, unrelated.

MS TYRONE (ELS): Okay. So it would have a different logo?

MR FITZGERALD: Well, can I just make a couple of comments. The Gateway - whatever the government chooses to call it - will operate at a regionalised level.

MS TYRONE (ELS): Right.

MR FITZGERALD: So that's the first thing: it's regional. Secondly, it will have the capacity to be able to deliver its services in whichever way it thinks appropriate, including contracting out or outsourcing some of those functions, or not doing that. So it's actually a regional basis for the very reasons that you and everyone else today rightfully have indicated: that it needs to understand what's happening. So that's the first thing.

The second thing is, within it it does have to have the capacity to be able to deal with the diverse Australian community and so that's why this issue that we're talking about today is so important. There may be a number of different ways to achieve that within the South Australian context.

MS TYRONE (ELS): Exactly. So in terms of assessments and so on, where would that necessarily take place? That's just one of the questions - - -

MR WOODS: Usually in the person's home.

MS TYRONE (ELS): All right.

MR FITZGERALD: If it's of a complex nature, or you're saying to us that in relation to some of the CALD community, even low-level assessments might need to take place on a face-to-face basis, whereas for other groups that can be done over the telephone or through the Internet or through another process. It's got to be able to respond to the needs of the older person.

MS TYRONE (ELS): All right. Absolutely.

MR FITZGERALD: As imperfect as all systems are, the design features of this are absolutely critical.

MS TYRONE (ELS): And it may not just be CALD, although that's the group I'm talking about that need a specialised service.

MR FITZGERALD: Let me give you one other example, if I can, just to explain. Homeless people, people experiencing homelessness, is a particular group. How do we enable that group to access services? How do we enable Indigenous people, who have a natural distrust of all organisations, to deal with these systems? So they're the sorts of examples we're looking at.

MR WOODS: Can I draw your attention to the time; if you could focus in on your remaining key points.

MS TYRONE (ELS): Look, that's basically it. It was questioning the base assessment screening tool and how that would be successful for people that can't express themselves in English and the actual questions; necessarily just interpreting them isn't the answer.

MR WOODS: No. Full interpretation doesn't work.

MS TYRONE (ELS): And the second, specialised care assessment service for more complex assessments, again that would make a factor. In terms of financial considerations, in any documentation there's generally a reference to just "interpreter service". Is it possible to actually use the term "language services"? That would broaden it significantly. I've done some consulting work with the state government in health and we've used the term "communication and language service" because it can then be a multiplicity of different ways, not just interpreting. "Interpreting" implies just a very, very strict and limited type of communication mechanism. The other part of the submission that we've had is around the financial considerations, being the interpreting costs, so much more than a bilingual worker; so whatever works the best is important, whatever is the best for the service.

MR WOODS: Thank you very much. You've covered a lot of ground and we're very grateful for that and for your written submission as well. Thank you very much for coming.

MR FITZGERALD: I particularly liked the Navigator. It a very clever idea.

MS TYRONE (ELS): We've navigated so far to get to Australia, so we now have to navigate the rest of it.

MR WOODS: In Australia.

MR FITZGERALD: That's true. Thank you.

MR WOODS: We're having a short break for 10 minutes, so we'll resume at 20 past.

MR WOODS: Could Josephine Swiggs please come forward? If I could encourage people to either sit down or take their conversations outside, please. Could you please for the record state your name and whether you are representing an organisation.

MS SWIGGS: My name is Josephine Swiggs and I'm here as an individual.

MR WOODS: Excellent. Thank you. Please talk to us.

MS SWIGGS: Thank you very much, and thank you for the opportunity today. I apologise. I actually got here late because I wanted to be here for the whole day, but I care for my mum and she had a health issue last night, so we were at the doctor this morning, and when I got here I arrived at the end of, I think it was the ANF, and I believe that the questions that I had you've probably already answered today, so forgive me for - - -

MR WOODS: No, just let's have a conversation.

MS SWIGGS: Thank you. So mine is obviously from that operational view, and looking at education and service delivery in the community. My questions are: will there be a national standard that all providers must meet and how will it be monitored to ensure that quality care is delivered? From my years working out there in the community and seeing some of the people who as personal care workers have done certificate III - some people have done it in five minutes; other people have done it over a period of time - the quality of service delivery has certainly been obvious from the result of that. So I guess what I'm asking today is will we have a national standard? Will we have something that absolutely everyone must meet?

MR WOODS: Could I just get a little of your background so I understand where you're coming from in this conversation?

MS SWIGGS: Yes, certainly. I was a registered nurse and I've been very much involved in health care for most of my working life; very much involved in teaching occupational health and safety; having an involvement with community care workers in the community, so that's what I've done in a working capacity; and have a good understanding of the services provided in the community; plus, I guess, caring for my own family as in my parents - yes, very much observant of service delivery in that role.

MR WOODS: Okay. Let's take the central issue that you've raised and that is the quality of delivery by personal care workers. To some extent that will be based on their education - you know, the skills and training that they've learnt, and the competencies that they have, which in itself is a product of both the quality and coverage of the curriculum as well as the quality of delivery of that curriculum by

different RTOs, but it will also be in part the professional development that they then receive on the job, and on-the-job training.

To some extent it will also reflect how long they've been in the industry, and where you've got high turnover it's going to be a diminution of quality, because everyone is learning all the time rather than having long-experienced people in the industry. So if we can break open the various segments of that, from your experience - looking at the issues of the curriculum that they learn in going through cert III as well as the quality of delivery of the cert III by the RTOs - could you expand a little on where your thoughts lie on your observations of that?

MS SWIGGS: To me, certificate III is just such an important education process, and the time factor, and then, as you're saying, the learning process gives people that experience, and in the involvement that I've had on the education side, with doing that certificate III in HACC or aged care, we have very specifically looked at the modules and people have been taught accordingly. It just appears to me that there are some situations where people obviously go off and pay or do that education process, but they don't come out with the same result. It seems to happen over a very short period of time.

MR WOODS: So are you generally satisfied that a well-taught cert III, given its current curriculum coverage, is adequate?

MS SWIGGS: Yes. And that is including the practical placement hours, which are absolutely vital.

MR WOODS: Sure. Yes, practicum is essential in that process. So the concern is more the variability of the RTO experience?

MS SWIGGS: Sure.

MR WOODS: Are you aware of any process by which inadequately delivered cert IIIs is taken up by the regulatory bodies? I mean, why is it that we're still getting these views? Is there no feedback mechanism that says, "Hang on, you can't churn out a cert III in five weeks with absolute bare minimum practicum and expect a fully operating person"?

MS SWIGGS: I don't know. I've never ever followed up in that vein.

MR WOODS: Okay. But the issue continues to remain. Then to the question of national standards: if again you can elaborate for me a little. Are we talking national standards of the cert III which is a national entity, or are you talking about the national standards of care that's to be delivered by a personal care worker, or a national standard of quality of care that the providers must ensure is delivered?

Where are you pitching your issues?

MS SWIGGS: The providers' quality of care.

MR WOODS: And are you not satisfied that the current quality accreditation standards, which are national for providers, are adequate? Are there failures in the system, or failures in the standards, or is accreditation seen as a, "Oh my goodness, it's coming up in a month's time. Let's get all the paperwork up to date and let's get through the accreditation process"? Where do your concerns lie?

MS SWIGGS: My concerns lie in the service delivery, in the actual care to the person. It's not that people don't care. It just seems from my observation that perhaps they just don't get that extra bit, little tiny things of following care plans, that actually make a difference to the quality for that person who is receiving it, and it might be a very small thing, but it does make a difference. It's very hard to explain, and I guess we will be forever working towards giving that ultimate quality service delivery. For me, talking as an individual, I'm very fortunate because I guess I have a background. If I pick up on something, then I obviously manage that, and it works extremely well, but it just seems in the teaching process maybe - I don't know - that it would be great if we could just add those little tiny personal things, because they are the things that our older Australians really value and enjoy in their life.

MR WOODS: Do you come across good providers who have got staff who do go that little extra bit, as well as poor providers who push staff to limits and they're just racing against the clock? Is there variability in quality from your observation?

MS SWIGGS: If I think about talking as an individual for my mum, the quality is pretty good - if you say that word, pretty good. Sometimes there are little things, but they're things that can actually - - -

MR WOODS: Be resolved.

MS SWIGGS: - - - be turned around, and they can be resolved. I guess I'm looking at our quality, our service delivery, as we're all working towards that better practice which, as you the commission know, this is all about. It's how do we actually give the best care to our older Australians, and the generations after us who are going to be caring for us, so it's about that continuous learning process and continuous improvement.

MR WOODS: So if there are some good-quality providers then it raises the question is it a resource constraint if, within the common set of resources, some providers can deliver very good quality and others deliver fairly basic quality? Resourcing is one issue but there's another ingredient in there somewhere. There's that commitment, that - - -

MS SWIGGS: Passion.

MR WOODS: Yes, that understanding that these are people who have lived their lives, that they deserve dignity and respect, and that they are still people with lives to live. I don't know that you can actually regulate that and it would be dangerous perhaps to try and over-regulate it, but there's got to be some balance in there somewhere. Any thoughts that you have on how far regulations should go to try and capture that would be useful, but also as a practitioner in the field, presumably you feel that there's sufficient regulation in terms of paperwork burden and reporting.

MS SWIGGS: Absolutely.

MR WOODS: So the danger is that doing more of that to try and chase down these issues may - - -

MS SWIGGS: I think, as in the draft report - you know, just thinking about that passion and working in the industry and wanting to care for somebody, to improve their quality of life is just absolutely vital. So I know we say dollars shouldn't make a difference, but just to be able to bring that workforce up to a salary equivalent of others I think may be a thing that supports there as well. But from a personal point of view - and I'm sure anyone here who perhaps has cared for someone you love - just to see that, to give that quality and to see their response is just absolutely joyful.

MR WOODS: They are so grateful to be recognised as people with needs and somebody has understood that.

MR FITZGERALD: One of the ways that one can monitor this in a different way is to ensure that consumers and their carers are in fact regularly surveyed as to the quality of care being received. Increasingly - and we talked about this earlier - the human service organisation and community service organisations are trying to get feedback on their services. In the services that you receive have you ever been asked your opinion formally?

MS SWIGGS: Yes, and I have responded - - -

MR FITZGERALD: Are you confident that that makes a difference?

MS SWIGGS: Yes, I have - well, I'm not confident. I did receive acknowledgment that an organisation did receive a questionnaire I answered but I hadn't anything followed from that, yes.

MR WOODS: Would feedback help you be more confident that you're actually listened to?

MS SWIGGS: Absolutely, yes, and it would be wonderful to participate in meetings and perhaps give some feedback in regard to that, and perhaps that's another way of working better to improve that quality.

MR FITZGERALD: I should just say that community based services - so the providers that provide community based services will in fact be required to meet new national standards and I think accreditation as well. So at the moment residential services have standards and accreditation.

MS SWIGGS: Yes.

MR FITZGERALD: And a similar but not the same system is going to be rolled out for community based service providers as well.

MS SWIGGS: Sure. Thank you.

MR WOODS: Thank you very much.

MS SWIGGS: And just one quickly in regard to home based assessment, but I think you've probably answered this earlier in saying that the assessment will be responded to for the person's needs accordingly.

MR WOODS: Yes.

MS SWIGGS: For me, I think that home based assessment has so much value and it's interesting. You know, a telephone assessment, somebody will say, "How are you?" "Well, I'm really well." "Can you manage?" "Yes, I can." By actually meeting people and sitting down and you get that face to face, you see the body language - - -

MR WOODS: You understand the circumstances that they're living in.

MS SWIGGS: You do, yes, and the occupational health and safety responsibilities to the workforce. So, no, that was great.

MR FITZGERALD: Good.

MS SWIGGS: Thank you very much.

MR WOODS: Thanks for coming.

MR FITZGERALD: Thank you.

MR WOODS: Can I ask Carole Royce to come forward, please.

MS ROYCE (ASC): Good afternoon.

MR WOODS: Good afternoon. For the record, could you please give your name and if you are representing any organisation.

MS ROYCE (ASC): I am standing in for Grace Jackman today, who was taken to hospital on Monday.

MR WOODS: I'm sorry to hear that.

MS ROYCE (ASC): She sends her apologies. Grace heads Advocates for Seniors in Care, which I've been part of for - that was born out of having a keen interest in getting care improved, one, for Grace's husband and, secondly, for my mother.

MR WOODS: Excellent.

MS ROYCE (ASC): And my name is Carole Royce.

MR WOODS: And you have some speaking notes?

MS ROYCE (ASC): It may be simplistic, but I think if the Nurses Federation could get involved to train staff, train personal caring staff. There's a lot of other organisations that put people through this training in three weeks, six weeks, eight weeks - I'm not quite sure - and they come onto the floor and they don't know how to move people properly. They don't know how to dress people. If residents need assistance with feeding, they're just a little bit nervous about that and nine times out of 10 if the resident goes like that they say, "Oh, they're not hungry," so that resident forfeits a meal.

MR WOODS: Do you have a professional background in this area, by the way?

MS ROYCE (ASC): No. My mother has been in care for seven years and sadly she can't speak and she can't move but my husband and I are there every day. This is the third facility she's been in and by far the best, so we've had some very torrid times over the years.

MR WOODS: You have some acute observations, so it's very good. That's very helpful.

MS ROYCE (ASC): Only because we're there. I went back on a file last night when Grace rang and said she couldn't attend today. The same things I hear today are what we were writing about in 2005. There's been no improvement and I think

that stems from the training. The other thing, I believe in high care they're more patients than residents and there should be more nursing staff on the floor. Sometimes a resident is sent to hospital and it could have been attended to at the nursing home. If you've ever been to emergency lately in a public hospital, it's six or seven hours before anyone is seen. I think if there were more nursing staff on the floor to attend to a resident quickly, that would be good.

MR WOODS: Yes, and we're exploring the issue there of how much of it is related to there being a nurse present and how much of it is related to the skills and confidence of the nurse to be able to perform those functions rather than send the person to hospital. So there are two issues there and we're exploring each of those.

MS ROYCE (ASC): I think that a nurse can direct personal carers if they see something. I see that in nursing homes and I visit other nursing homes where there's no supervision, whereas if there was a nurse there and they see something, that resident or patient could be attended to immediately. The thing that is lacking is regular toileting. I see that quite often. A carer will say, "We're just doing this or we're just doing that. We can't get to you." And I've seen residents that get very, very upset, very distressed.

MR WOODS: Rightly so.

MS ROYCE (ASC): You know you would yourself. The other thing I'd like to see is a carer to patient ratio come in. There's a lot of obese people coming into facilities now and instead of a two-person lift, sometimes they need three to four people to lift them. That's for the facility to work out when they get people like that but I'm just seeing over the last year that that is becoming quite a problem.

MR WOODS: And again, it's whether a simple carer to patient ratio would actually capture the subtleties of what is the profile, in a broader sense, of the patients so that at different times there would be variations in what are the needs of the patients, and whether a simple ratio that applies in all situations would capture that subtlety is a concern to us.

MS ROYCE (ASC): I think staggered working hours. You know, if four people are on duty, if they had a float person to just take up the slack. At different times of the day that's very important. Residents like to see familiar faces when they're caring.

Sometimes when personal carers come on, there sometimes is a bit of a language problem and anyway they need to find work. I guess that the reason that Grace gets involved with things is because the Department of Health and Ageing and ARAS - sometimes when you go to them and you fill out all the papers, you take photographs, you do everything they ask and they go back to the nursing home and

they say, "Well, they've fixed all of those problems, so there's nothing more we can do." People get very disappointed because they see the same things repeating over and over.

MR WOODS: No, that would be concerning. Other issues that you want to raise with us?

MS ROYCE (ASC): No, I've got my mother in a very good place now, where there's regular training of staff and counselling if things go wrong. Staff are counselled rather than treated not very well. I think they need more training and just throwing money at providers from the government is not helping.

MR WOODS: Excellent. Thank you very much for coming, especially at such short notice.

MR FITZGERALD: Do you receive funding at all for your service, the advocates for - - -

MS ROYCE (ASC): No.

MR FITZGERALD: No, I didn't think so.

MR WOODS: Purely a voluntary group?

MS ROYCE (ASC): It's all voluntary. We do meet and talk about the difficulties that we have amongst people in the group and Grace tries to sort things through and sort things out for the person concerned.

MR FITZGERALD: Good, thank you very much.

MR WOODS: A very dedicated service. Thank you for coming.

MR WOODS: Can I ask whether Masonic Homes are with us yet or the Independent Association of Retirees? Here they come. Come straight up to the hot seat; thank you for coming. Could you please, for the record, state your name and the association you are representing.

MR WEBSTER (AIRSA): Stanley Charles Webster, Association of Independent Retirees, South Australian division.

MR WOODS: Thank you very much. Please, speak to us, if you'd like to give your views to us about our report and raise matters with us.

MR WEBSTER (AIRSA): Our division management committee did put in a submission, which virtually is what we need to say. I don't know if you need me to read it into the record.

MR WOODS: No, we have a copy and it would be on the record; but if you just want to draw attention - you mention a couple of things such as user pays and the rural and remote issue.

MR WEBSTER (AIRSA): Yes. There is perhaps a slight addition to that, of which I've got a copy. As you are aware, the association has put up a national submission and we have the divisions in each state.

MR WOODS: Yes.

MR WEBSTER (AIRSA): In our submission we restricted our comments to the - as it would affect this state.

MR WOODS: Yes, and that's very helpful.

MR WEBSTER (AIRSA): That's hence why I opened up with a few more comments there. We refer to your original Productivity Commission report about needing to be fair to generations. We drew the attention to the need, because of the size of South Australia and the fact that we have large provincial cities - Port Lincoln, Port Augusta, Mount Gambier - servicing country areas a long way from Adelaide. I know aged care in that type of situation can be quite intensive and our need there that we stress is the need to have rural care. Somebody for instance in Tumby Bay, which is nearly two days' drive from Adelaide - - -

MR WOODS: Great place.

MR WEBSTER (AIRSA): They need to have provision somewhere else. That essentially is the starting point there of the difficulty of both the aged person into care and the fact that they're going to be separated by long distances from their family and friends and background; hence our comment there about the first one.

The second one of course is the transition to the user pays. In time to come, after a lapse of about 35 years - the national superannuation scheme has been going now since about the mid-1990s. I couldn't pick up the date exactly. So some retiring now won't have had the opportunity to build up the large funding in their superannuation. My comment there is that you'll need to have, to use the jargon, a grandfather clause or a transition arrangement. That was there. When I was preparing actually this morning for this - yes, South Australia AIR has emphasised those two points that I've got there.

MR WOODS: Yes, thank you.

MR WEBSTER (AIRSA): The user pays, the family assets: taking into account

the family residence in the asset, depending how it's done, could provide a very savage impost on the partner remaining in the home. Perhaps if I just refer here - if one partner goes into care and the whole asset base of the family includes the family home, presumably that asset base is used to calculate the bond. Then presumably what is left would be split so that one asset base provides for the care and the remaining partner has got the remaining asset. No way could they stay in the home that they've been living in, worked perhaps all their life to build up.

When you consider - retracting that point or going back over it - a big asset pool, take the bond out, halve what's left: the person remaining wouldn't be able to maintain the home and the lifestyle and in certain circumstances could be forced to move away from support even for them - such as in my case, daughters handy. I live at Henley. I'd be removed from this area and, I tell you what, half of my asset base less the bond wouldn't enable me to get accommodation which I'd be used to or even comfortable with within cooee of this area.

MR WOODS: We'll be able to assure you on that in a minute.

MR WEBSTER (AIRSA): In essence, what I've just said to you is almost a precis of just the additional paper material that I have here. On the assumption, and I haven't seen them, that national and the others have covered other areas, I think I should just stick to what I've said.

MR WOODS: Okay, thank you, and it's certainly not the intention of our reforms to lead to the outcomes that you were fearing.

MR WEBSTER (AIRSA): I've painted it pretty severely.

MR WOODS: What we are trying to achieve with our reforms is that we separate out the question of care from the question of accommodation and treat those as two separate things, and if I can deal with care first, being the most important issue. What we're proposing in the draft - and we're seeking comment on it but in the draft we're proposing a person gets assessed for their care needs, and if you are getting a middle level of community based care, the total cost of that per year might be, say, $16,000. If you are getting the highest most intensive level of care, the cost of that per year might be $50,000. There are two examples.

Separately you would then be assessed for your capacity to make a co-contribution, and they would range from as little as 5 per cent of the cost of that care, with the taxpayer picking up 95 per cent, or as high as - in the draft we've suggested 25 per cent, with the taxpayers picking up 75 per cent - most of the cost. In the case of you only picking up 5 per cent of the care, then your annual costs of care are quite low, and in fact we are proposing on the asset test that it doesn't start cutting in until over $300,000. So the asset cost - you can have a large value of

assets before you start moving up the ladder from the 5 per cent figure.

MR WEBSTER (AIRSA): Excuse me. In essence, you're saying there is a threshold which would be an equivalent to leaving the family home out anyway.

MR WOODS: Well, for a lot of modest family homes, yes.

MR WEBSTER (AIRSA): Yes.

MR WOODS: For your share of that family home.

MR WEBSTER (AIRSA): Yes.

MR WOODS: So most people are not going to pay anywhere near 25 per cent of the cost of their care. They're going to be in the 5, 10 per cent cost of care at most. In those two cases - I chose those because I can do the sums in my head, it's always useful - even if you were high wealth, high income and you were paying a maximum of 25 per cent of the cost of care and you were receiving a middle-level package of community care that cost $16,000 a year, your costs would be $4000 a year. If you were receiving the highest, most intensive level of care - and say it was in the order of $50,000 a year - you'd be paying 12 and a half thousand dollars a year for that care.

In addition, we're proposing that for your care costs over your lifetime you pay no more than a maximum of $60,000 in your lifetime for your co-contribution to care, so there's an absolute ceiling as well that once you've reached $60,000 worth of care costs as your contribution then you pay no more at all. The taxpayer picks up the whole lot. Now, very few people are actually ever going to reach that threshold. 90 per cent of people would never get anywhere near $60,000 over their lifetime in terms of their care co-contribution.

MR WEBSTER (AIRSA): Their share, yes.

MR WOODS: But it is there as a protection for those people who are on the highest income and wealth levels, who require intensive care for many, many years, so it is a protection that says, "If you get to that level then there's a protection for you and you don't have to pay any more anyway." So all of that has been very carefully structured to avoid exactly the sorts of situations that you were referring to. On the accommodation side, the issue then is that we've allowed - and we would be requiring under our reforms - that individuals can pay a daily fee or a weekly rental, rather than paying a bond. Their capacity to pay would still only be related to their share of the house, so if they did want to pay a bond it doesn't come out of the total wealth of the house. It only comes out of their share of ownership, and in most cases homes are jointly owned, and so we're only talking about half the value of the home.

But we would be requiring all providers to also offer a daily or weekly fee, and they would be published. At the moment when somebody goes to low care or extra service high care, one of the first questions is, "Well, how much money have you got? What size bond can you afford to pay?" That wouldn't be the first question. The first question would be by the person going into care to say, "Let me have a look at your published prices," and so the decision-making would be by the person going into care. They would say, "Well, sorry, I don't think your prices are good enough for the level of accommodation that you're offering. I'll go to a different provider." So we're separating out the question of care and accommodation. Now, being the Independent Retirees Association, most if not all of your members won't be part-pensioners, but some probably are.

MR WEBSTER (AIRSA): I would suggest quite a few would be now. Perhaps quick background - I won't go down the personal track - I've been retired over 30 years because of illness and for quite a number of years, which I don't think is quite relevant, as completely independent. Then about 15 years ago I got a small part-pension DVA. I think a high percentage of our members are in that area of small part-pensions because a lot of them are fiercely independent, I might admit.

MR WOODS: Absolutely. I understand the word "independent".

MR WEBSTER (AIRSA): We have one member, I know, in one of the country branches who's quite independent. Frankly, he's a bit like my father-in-law, wouldn't ask the policeman the time of day because he's somebody in authority and, yes, there is a hesitancy to disclose much. I think, from a survey we had a few years ago, about 64 per cent of our members would qualify for a part-pension.

MR WOODS: Okay. One of the other reforms that we're proposing is that people who don't want to remain in their current dwelling but want to downsize, move into a retirement village or an independent living unit, or are needing to go into residential aged care, at the moment they have an incentive to pay a bond to maintain their pension status, so that if they've sold their current home and they get a large amount of equity that they haven't reinvested, they lose their pension. We're proposing what we call an Australian pensioner bond which they could invest their excess equity in - - -

MR WEBSTER (AIRSA): Yes, I noticed that.

MR WOODS: - - - and that would maintain their entitlement to a bond, so it removes that incentive to pay a bond to keep their pension. I mean, that - - -

MR WEBSTER (AIRSA): We did notice that in our discussion.

MR WOODS: Yes. So we think that would be very helpful to people, particularly part-pensioners, but full pensioners as well, but there would be a lot of part-pensioners who are currently in a dwelling that's worth quite a fair bit but would like to downsize but don't want to lose their pension status, and so either buy something of equivalence or pay a large bond, or do something, or stay in their current home.

MR WEBSTER (AIRSA): Yes, one of the problems - and the branch to which I belong, which is Adelaide, have discussed this particular aspect, and our division incidentally has put up a submission to the state government to relax the stamp duty for a start.

MR WOODS: Yes.

MR WEBSTER (AIRSA): Because I can get a property up there - a nice round figure of 400,000. To downsize from the home that you've - you'd be lucky to get a smaller home for about the same price in, you've got to say, a compatible area. Historically, where I live at Henley Beach there is minimum of such aged care and a previous mayor, who I knew very well, said it was quite horrifying to see that people had had to move from their familiar area to places out of town - would get the bus down to Henley and walk around for the day.

MR WOODS: Just to be back in the local neighbourhood.

MR WEBSTER (AIARSA): Yes.

MR WOODS: Just to be back in the local neighbourhood and to meet a few old friends.

MR WEBSTER (AIARSA): Yes. It's not really part of your inquiry, but to sell a house at $500,000 these days, by the time you've paid all your expenses you'd be lucky to get a small one anyway in the same area.

MR WOODS: All right. But we are trying to remove that incentive to have to pay a large bond to keep your pension status, so we're trying to - - -

MR WEBSTER (AIARSA): Yes, I can understand that point.

MR WOODS: You did mention in your written submission the issue of rural and remote, and the fact of the ageing farmers and that a number of the small towns are ageing quite rapidly.

MR WEBSTER (AIARSA): Yes.

MR WOODS: So do you get feedback from your members about the difficulty in those more regional and rural areas in getting access to - - -

MR WEBSTER (AIARSA): I can only quote this: the secretary of our branch at Victor Harbor lived for many years on a station in outback New South Wales and she had a bit to do with that. Her comment to me the other day was that the age of farmers of now is going up and up because the younger ones aren't going on the land and, secondly, the properties are becoming bigger.

MR WOODS: Yes.

MR WEBSTER (AIARSA): And her comment was about the difficulties to obtain services, which at the time she was talking about were centred in Dubbo, which was a fair way from the station she was. So, yes, Victor Harbor of course is the retirement village down south, as you've probably heard.

MR WOODS: Yes, been through there.

MR WEBSTER (AIARSA): The feedback she would have got from others that have been on the land. Talking of other services there, those with disabilities: it was quite a problem - she was talking about in her past time on the station she was bookkeeper/manager for - to get the services. Dubbo was one place she did specifically mention. So, yes, there is feedback coming through, not so much from the Adelaide branch of which I'm a member.

Mount Gambier people are giving similar feedback. When they leave their farm property they go to Mount Gambier because that's been their working centre and, other than around their little village - I say "village"; I'll probably get my ear chewed for that - Mount Gambier is their centre. They would no sooner want to come to Adelaide than fly to the moon.

MR WOODS: No. But they would also have had other friends who have done the same and they would - - -

MR WEBSTER (AIARSA): Yes. That's the point: the rural support areas.

MR WOODS: Yes, exactly. So there's a community that moves into those - - -

MR WEBSTER (AIARSA): The community move with them.

MR WOODS: Yes. That's helpful. Robert?

MR FITZGERALD: No, that's fine.

MR WOODS: Are there any other points while you have us that you wish to raise?

MR WEBSTER (AIARSA): No. It was just the fact that that submission there - - -

MR WOODS: Yes, well, we can - - -

MR WEBSTER (AIARSA): - - - I just outlined that one this morning; in fact, I only printed it at lunchtime.

MR WOODS: Do you want to add that to the record? We can do that.

MR WEBSTER (AIARSA): Yes. There are copies here.

MR WOODS: Yes.

MR FITZGERALD: Thank you.

MR WOODS: Appreciate your time.

MR FITZGERALD: Thank you very much.

MR WEBSTER (AIARSA): Thank you very much for hearing me. It's a complex issue, we know that.

MR WOODS: It is. Yes, we realise that.

MR WEBSTER (AIARSA): I think our national people did highlight the fact of the percentages and those factors. We really didn't go down that track. We don't want to waste your time.

MR FITZGERALD: No. We've got all that, thank you.

MR WOODS: And we have had excellent cooperation from your national office. They've been tough on us but they've always been very fair and very objective in their analysis.

MR WEBSTER (AIARSA): Yes. It would have been nice if we could have seen theirs first and just picked the ones they didn't tell you. Anyway, thank you very much for the hearing, and I'll sit and listen for a while.

MR WOODS: Okay.

MR WOODS: Can I invite Masonic Homes. Could you please for the record state your name, the organisation you represent and the position that you hold.

MR STRAIN (MHL): Commissioner, my name is Doug Strain. I'm the chief executive officer of Masonic Homes Ltd.

MR WOODS: Thank you, and thank you for the significant assistance that you've provided to the inquiry so far, both in terms of your written contributions and in attending our various forums and being available and helpful to us. It's been greatly appreciated.

MR STRAIN (MHL): Thanks, commissioner.

MR WOODS: Do you have a submission that you wish to make today?

MR STRAIN (MHL): Commissioner, I'd just like to make a few introductory remarks, if I may. First, on behalf of Masonic Homes, our customers, staff and stakeholders, we certainly commend the federal government on the decision to appoint the Productivity Commission to conduct this important inquiry. It's felt that it was clearly time to undertake a non-partisan review of the system we have to care for older Australians, and we cannot think of a more qualified and impartial arbiter to conduct this work than the commission. Second, likewise we wish to commend the commission on the thoroughness of its draft report and the incisiveness of its findings. We believe the recommendations made give a once in a generation opportunity for government to grasp the nettle in this important area of social and economic policy.

To provide some context, Masonic Homes Ltd is a not-for-profit public benevolent institution, established in the mid-60s to provide accommodation and care services for what was then the emergent group of older Australians, principally widows of our First World War veterans. This was a group that were welfare-class defined by age almost alone, as at that time few older people had any wealth beyond the equity held within their homes, that they desired to own such to avoid the need for rental or mortgage payments on the very modest welfare pension that was paid at that time.

Gratefully, this has now changed and, whilst it is far from the case that all older people now have great wealth, it is a fact that the wealth of our community is slowly transitioning to be in the hands of the older demographic. Masonic Homes has now grown and evolved to be a major provider of accommodation services to middle-class senior parents of Australia's baby boomers. In doing this, we provide a range of adaptable senior housing options based within a seniors living community that offers integrated services to near preclude a person's need to ever gain access to a residential aged care facility unless they have a desire to do so or suffer an extreme

debilitation that will require such a transition. We certainly welcome the direction announced in various reviews, looking at a greater role for in-home community care.

I'd now like to comment on the specifics of the recommendations made by the commission and, in doing this, I wish to highlight our submission made to the original call from the commission and the submission made in response to the draft report. In our submission to the draft report we've made a number of overarching comments. The first is that the recommendations made in the draft report must be, in the main, taken as a total package. The risk is that government may seek to cherrypick the findings and allow those which are less palatable to go through to the keeper. For such to occur will only serve to compromise the whole.

Further, the need to establish a truly independent Australian aged care regulation commission is also paramount. As with monetary policy, we cannot afford for this important part of social and economic policy to be at the behest of political influence. Finally, the existing of customer or consumer choice must also be embedded at the heart of any changes made.

Regarding the specific recommendations, commissioners, I'd like to focus on three. First, recommendation 6.3: whilst supporting the five-year rollout of changes to the allocation of residential bed licences, it is our view that this time line should not be applied to the quarantining of community care places. The restriction on community care places should be lifted immediately and any controls on their use should be exercised through the ACAT process and the regulating of the standard of the care providers that are giving that care, rather than some crude backward-looking formula estimating a future need when that need exists now.

Second, recommendation 10.4: as a major provider of retirement villages in South Australia and the only provider in the Northern Territory, we believe that national regulation of this important seniors housing segment is warranted in time. It is acknowledged that the current focus of state and territory legislation is around consumer protection, which is warranted.

We need, however, to have a wider regulatory oversight that will serve to ensure that the housing needs of senior Australians is not subjugated to the short-term self-interests of local action groups that in time, as they age, will look to government to have had them do that forward planning. We face the ageing tsunami and planning must ensure that our built form and community layout are positioned to provide for this.

Third, recommendation 14.1: whilst supporting the need for transitionary arrangements, please do not recommend the applying of another grandfathering arrangement. Already we are impacted by three classes of fees and we would recommend that a transition be effected rather than us be lumbered with an extremely

inefficient class of various paying clients that is almost impossible to declassify.

Finally, we at Masonic Homes remain firmly committed to ensuring the best of accommodation and care is made available to our older Australians and we believe, in the main, that the recommendations made by you are worthy of wholesale adoption without any political interference. Commissioners, I'm happy to take any questions that you may have.

MR WOODS: Thank you very much. For the record, your submission also hits us over the head about the two-bed standard, but I take that as given.

MR STRAIN (MHL): Right. I would assume that would be a wholesale comment, commissioner.

MR WOODS: Yes.

MR FITZGERALD: Can I just ask about the retirement villages, because you're the first person today that's mentioned them. National regulation is beneficial, but obviously what's in the national regulation can be just as dangerous as state based legislation. I just want to understand your concern with the current regulatory arrangements in relation to retirement villages that gives you cause for concern.

MR STRAIN (MHL): Commissioner, I think it's in two areas. We operate in South Australia and the Northern Territory and have aspirations to go wider. One of the problems we have is the variation in just certain elements, sometimes quite fundamental, between the regulation that exists when we want to work across state boundaries. The second is that - and I'm not criticising this in its specifics. It is about retirement villages - is run for consumer protection and it isn't embedded to actually look at the issue of how do we facilitate a growth in the adaptable housing that we have. We do certainly note the recommendations made about COAG and their involvement in facilitating that, but we believe that in time there will need to be federal regulation to cover some of those matters.

MR FITZGERALD: I want to unpack, if I could, just one bit. There are those issues which are purely state based and local government based in relation to planning laws and what have you, in which the Commonwealth would not have any say, and then there are those issues that actually go to the management and operation of retirement villages. So your concerns are at two levels. One is in relation to the local level and how they apply, for which national regulation won't do much, but just in relation to the regulation as it affects the ownership and management of retirement villages, are there one or two issues that stand out? You say that they're more geared for consumer protection, which is true, than they are about providing adaptable and innovative housing solutions, but I'm not quite sure what you see is the main culprit in that.

MR STRAIN (MHL): I think the fear we have is around the problem of some consumers who may have concerns about the financial arrangements - the deferred management fee, for example - and a sense that there's something that may be occurring which is improper. Now, that's not actually the case in the main, and often it is about educating the market - and, may I say, educating the legislators - about what all that means. As Stan, the previous speaker said, one of the issues that we have is about older people affording to downsize.

Retirement villages, I believe, in all states aren't subject to stamp duty. That's one of the advantages of a retirement village option and, because those fees are back-ended, it also usually allows the person entering to have some corpus that they can take from exiting their house that they can apply to their living and then retirement village operators take their profit down the track. So it's in some of those areas where I think sometimes legislators or the bureaucrats can make short-term decisions which can have fundamental impacts on our social infrastructure.

MR WOODS: Picking up the other two then, starting with lifting the restrictions on community based service delivery in its new form rather than packages as such, presumably there will be operational restrictions just because of the quantity and quality of workforce, the management capacity to expand. There are a whole range of reasons why on day one after the reforms you wouldn't just have a massive new injection of community care services anyway, so when we plotted a transition pathway we were mindful that some gearing-up process would be required. The question is, in your view should we just allow those natural forces to allow an ongoing expansion, but might there then be a mismatch between the number of people who are provided with an entitlement to care and the capacity of the sector to deliver that care in the short term?

MR STRAIN (MHL): Commissioner, we operate quite a large service of in-home care here in South Australia and in the Northern Territory and we have a capacity to roll packages out very quickly. Our staffing in the main are part-time workers. They're looking for more hours. They want more services. We've got an infrastructure and a capacity which is underutilised. For example, in the recent aged care approvals round, we actually had our services ready to roll out in South Australia but unfortunately we weren't successful in getting allocated those, so therefore we had to pass people on to other operators who were successful who may not have geared up to be able to provide those services. So my plea to the commission is to say in this situation, if you open the numbers and allow us to deliver, then let us come up with the solutions to provide those services rather than - - -

MR WOODS: While maintaining quality.

MR STRAIN (MHL): And we will maintain quality, because we'd be saying a lot of those services would be already provided by qualified workers that we already have, operating within systems that we already have, and what we really need is to be able to provide those services. We have a bizarre situation, commissioners, where I can't provide a high level of in-home care in the Adelaide Hills because we have a line that's drawn in the Adelaide Hills that says it's actually Adelaide Metro East when actually they're in the Hills, and so I can't provide services into - - -

MR WOODS: You don't have a package on that side of the - - -

MR STRAIN (MHL): I do have them at Mount Barker but I don't have them at Aldgate. That's a bizarre situation and I just can't believe why we just don't unlock them and let the market forces go.

MR WOODS: It's certainly not in our interest to constrain. In fact, we want to encourage greater delivery, but we also want to ensure that it's an orderly progression so that there's a balance.

MR FITZGERALD: Can I ask a question just related to the provision of in-home or community based care going forward. In one sense our recommendations basically say that any provider that gets approval and, ultimately, accreditation can in fact provide any of these community based services. In one of the hearings in Sydney, they put the view that this was a very dangerous course; that in fact, whilst new players should be allowed into the market, obviously, there should be a controlled expansion - not of the number of services but of the providers.

I know you have a vested interest because you are a provider of some size, but I was just wondering whether you have any insights about how you open up the provision not only in terms of numbers - you know, the availability of services - but of providers in a way that makes sense. "Sense" to us means that you actually do allow both existing and new providers to enter the marketplace at some stage. You may not have given that any thought, but it is an issue that is raised and we have seen in other government arrangements where there's been a wholesale opening up of the market that has had some unintended consequences which, frankly, we want to avoid.

MR STRAIN (MHL): But, commissioner, I understand that issue and clearly, as I've stated, our commitment is to make sure we look after our older Australians. I think that around the regulation and clearly establishing who can provide those services, to make sure that's transparent, and whether it's done through a transitional arrangement of opening up some of those packages maybe to current providers, but I think there is something of an expectation that already through the aged care approvals round process, those who don't provide community care already find it almost impossible to get packages because you don't have the economy of scale; you

don't have the market; you don't have the brand. It is a very different business, despite what some would say, from residential aged care. There are a number of very different drivers, and certainly I understand the issue there, and Masonic Homes would be happy to work with any transitional arrangements, but I think to just put it off for five years is a very blunt instrument to apply.

MR WOODS: Yes. No, we certainly wouldn't just say, "Well, nothing will happen for five years." It's a question of an orderly ramping up of capacity, of proper vetting of existing and new providers. We certainly don't want people seeing this as a new you-beaut market opportunity with very little experience, and suddenly diving in and then having to mop up some consequences.

MR STRAIN (MHL): Commissioner, could I also say that I believe that there will be a natural brake applied. First of all, the vast majority of those who are receiving those packages would stay with their current provider.

MR WOODS: Sure.

MR STRAIN (MHL): The issue then is to say, "Well, theoretically the government through the ACAT process already knows what is the unmet demand, or potential latent unmet demand."

MR WOODS: Well, it should.

MR STRAIN (MHL): Should, or at least should be able to make an estimate of that.

MR WOODS: Yes.

MR STRAIN (MHL): So I don't see that there's going to be an uncontrolled demand. It will be a demand controlled by government, and I look at that and say I don't personally believe that it's an issue that should spook the government. I think it's an issue that will have a natural brake that's available to it.

MR WOODS: Okay. We'll take that on board and we may need to come back to you, but we share the common interest in getting as much community based care out there as quickly as possible, but provided it is orderly and the quality is maintained, and that the workforce is there and there aren't any unintended consequences. That then brings up the transition issue and grandfathering, and you've put a concept to us that others haven't. In fact, a number of others have preferred to grandfather what they have because that's what they've based their investment on, and they want some certainty into the future.

Although you're not proposing to pull the plug on that on day one, your

concept of rather than a blunt grandfathering but of bringing it all into a single transition package could be a tricky concept, but nonetheless is certainly very worth thinking through to see if that can be done. Again, we'll need to spend a little time working with operators and industry groups to just see to what extent that's possible, but if you've been doing some numbers on backs of envelopes as to how that might look, that would be useful input.

MR STRAIN (MHL): Unfortunately, commissioner, we haven't done any of the numbers but we do know the problem and whilst we accept that it's not an easy issue, the reality is we have to deal with it.

MR WOODS: Yes.

MR STRAIN (MHL): I therefore look at it and say rather than - I mean, to the credit of residential aged care, we still have people in nursing homes who were pre the change of 97, and when we have pre-97, then 97 to 04, then 04 to 08 and then now, it's just - - -

MR WOODS: The tails can be very long and very distorted.

MR STRAIN (MHL): And again, I look at the data that the department theoretically should have. They should be able to put some figures around what are the risks and what's involved, but at the moment we have to work all those different systems, which is just a nightmare and certainly drives inefficiency.

MR WOODS: Yes. There might be two issues there: one is protecting the individual resident for their financial exposure to make sure that they're not disadvantaged, but trying to wrap up the payments to providers in a way that allows your systems in a shorter period of time to coalesce into treating people as if they are under the new arrangement, so there might need to be an interface in that process.

MR STRAIN (MHL): And I acknowledge that.

MR FITZGERALD: I mean, we agree. You've only got to look at the Department of Health and Ageing's web site to try to figure out anything, and it's so complex, so we understand absolutely the complexity the providers and, I might say, consumers face already, and our aim is to reduce that. I think the one point we would make is obviously - and I think Mike has made it - that is, that there has to be a no-disadvantage rule applied for at least consumers, and I think we would say for providers as well, but beyond that, if you have any ideas - we'll certainly be talking to the department, but their answer up to date has been endless grandfathering.

MR STRAIN (MHL): Does that really surprise us?

MR FITZGERALD: No, it doesn't surprise us. We're getting through it. Can I just take another point, if I might. You haven't mentioned it but I think it's because you fully supported it on the sheet that we have. I just want to canvass with you the issue of entitlement to services in the community area. As you know, we've taken a building-block approach in terms of the assessment of need. The challenge we face is trying to actually say what does that look like in terms of the entitlement - the piece of paper that Michael in his old age will take to you, the provider. I just wonder whether you have a view about this.

We can go down a very prescriptive route and say it's two hours of personal care, and three hours of this and five point x of whatever, or we can go to a model that is basically lots of layers. You've got seven or eight layers and it's a band of services, obviously defined broadly, but a band of services and there's probably a thousand variations on that. As a significant provider, have you got a view as to what this entitlement needs to look like from your point of view? Now, there are different views about this, but from your point of view?

MR STRAIN (MHL): From our point of view, commissioner, we see it as the less prescription the better. We're dealing with everybody who's - they're all individuals. We certainly believe to empower the customer, and when we talk about consumer-directed care we sometimes get concerned that that's just another construct formulated by the industry just to confuse people. I think that in how we operate we need to be looking at each person as an individual so that we can balance out what their needs are, because some of them will have partners and some of them won't have partners. It's a very difficult one to prescribe down to quite narrow bands. I think it would need to be some broad principles that would be applied, and I look at the issue around quality control, both at the operator level and, dare I say, accreditation or assessment at the government level, to determine whether people are actually being best served.

At the end of the day we are a great supporter of empowering the customer, and if they have the ability that they're not getting appropriate services then they should have the ability to switch, even though that's an easier concept to take at our level; somewhat more difficult when somebody is actually receiving a service and has settled in there.

MR WOODS: One of the consequences of having a broad band is that given that people will be making personal co-contributions to that care, if they're paying for the care they're getting, and they live within a very broad band and they happen to be at the bottom level of that band but are paying the same as somebody who is at the maximum level of the band, if everyone is paying at the middle of the band and the band isn't too wide, then everyone feels there are swings, roundabouts, and at other times they'll need a bit more and sometimes they'll need a bit less, and life is fine. But if the band is too far apart, two people paying the same amount within that one

band, and one looks to the other and says, "Mm, how come you're getting so much more?" These aren't sort of goods that people naturally want to consume more of for most of it anyway, so there's not a lot of moral hazard happening in the consumption side, but there's a perceived equity issue that needs to be balanced in this.

MR STRAIN (MHL): Certainly we would agree with that issue. I mean, there's certainly the issue around - we already face that tension in our packages where some people are getting a lot more service than others. In fact, if we have somebody who's getting a large amount of service we actually have to offset that by getting somebody who's getting a smaller amount of service, bearing in mind that at the consumer level they're all paying the same, so that it's not their perception which is the problem. But already we do have some of those issues around as, again, individuals are at different geographic locations, and I certainly acknowledge the difficulties of trying to bring that into a narrower band.

MR WOODS: We don't want it so narrow that when somebody, in the normal course of the day, week or month, has a variation in need to which the provider then properly responds, that it triggers some other process and generates madness in bureaucracy. So these are all balancing issues that need to be identified.

MR FITZGERALD: Could I ask another issue - and again you try in your submission - we've heard a lot about respite. Firstly, are you a provider of planned and emergency respite?

MR STRAIN (MHL): We are.

MR FITZGERALD: Carers obviously and rightfully say to us that there needs to be greater access to both planned and emergency respite, and they want greater flexibility in the provision of respite. Our initial thinking is that planned respite would be an entitlement that comes through the Gateway; emergency respite would be provided or brokered by the carer support centres that we're recommending, and in South Australia you have those sorts of centres operating. I wonder whether, as a provider of respite, you have any particular observations that we should be aware of as how to provide greater flexibility in this space. I know you haven't raised it in the submission but I just thought I might ask it, given it's been raised a few times during the day.

MR STRAIN (MHL): Certainly, commissioner, respite is a very important aspect and it is something where sometimes services are available if people have actually consumed their entitlement. It's certainly an area that we have had some look at. I haven't got any specific comments, but certainly I'd be happy to provide further comment if you'd like.

MR FITZGERALD: Given that it has been raised in every hearing, particularly by

carers but more generally, it's just an issue that I think we want to do a little bit more thinking about. What we haven't had so far is very much input from providers about respite. So just take it and if you want to come back to us that would be fine.

MR STRAIN (MHL): Commissioner, if I take that on notice then I will respond.

MR FITZGERALD: Yes, thank you for that.

MR WOODS: Can I ask one last one, which again is not raised directly in your submission, but your views on dissemination of good practice. In this industry, when you go around the various states and territories, there are some excellent providers who are innovative, who deliver quality care and who sort of trial different things, pilot issues, evaluate them properly and then either adopt them in practice or decide that it wasn't delivering the outcomes they were looking for.

But there doesn't seem to be a mechanism, a process, a network. There are probably informal networks but it is surprising to us how little of that then gets disseminated and absorbed and incorporated into practice by other providers. Because some providers are small and don't have the infrastructure to be tapping into this, let alone the management capacity to adopt the practice, is it because the big providers - some of whom are doing the innovation - keep it to themselves as an edge and advantage in the marketplace? It's a very distinguishing feature of this industry. How can we overcome some of that? How can we free up the learnings from innovation?

MR STRAIN (MHL): Commissioner, I say that I think one of the problems we have with innovation is that we are such a fragmented industry that works on very tight margins and often is driven, in its innovation, by the ability to access one-off project funding from government and the conundrum of how long it takes for good practice to become normal practice I believe is actually extended because of that. I will be the first one to say that the industry is full of lots of good practice but we don't have a lot of those industry standards that we can roll out which - if you look at the retail industry, innovation will be driven out of the big retailers rather than the corner stores. I would say that the reality is in the main - for a lot of aged care providers, if not all - we're really all corner stores and we lack the large innovators who will drive that. We therefore look to government for that.

That's not intended in any way to downplay the good work that people do in some of those innovations but there's no doubt a need for a greater bringing together of the industry to start driving some of those innovations, and we do sometimes, in my experience - and I've been in the industry almost eight years now - we sometimes operate to try and hide those from other operators because that's what we see - is our ability to get to those conferences and go and do a presentation overseas rather than to embed that across the whole of the industry. I'm not sure that the way that the

government operates in some of its programs doesn't actually feed that sort of an approach.

MR WOODS: All right. Thank you. Are there any final points that you want to raise with us?

MR STRAIN (MHL): No, commissioner, but I will get back to you on that issue of respite.

MR WOODS: Okay, thank you very much.

MR WOODS: That concludes our scheduled presentations for today. Is there any person present who wishes to make a brief unscheduled presentation? We have one at the front and someone at the back. Please come forward. Could you please, for the record, state your name and whether you are representing any organisation.

DR BOOTH (ACLG): My name is Jenny Booth, I represent the Aged Care Lobby Group, and thank you for the opportunity to speak with you this afternoon, gentlemen. Briefly, my background is that some 17 years ago I started nursing my 90-year-old father at home, so I have some knowledge of caring for elderly people. He went into respite care and then full-time care in four different facilities. I was so unhappy with what happened to him that I got together a group of people who were similarly concerned with the care of their loved ones in aged care facilities, and that became the Aged Care Lobby Group.

We strongly support the separation of the policy-making and regulation sides of aged care. Incidentally, let us please not call it an industry. We're not boiler valves. I'd like "sector" or "aged care part of the healthcare system" instead. That perhaps might humanise old people. The basis of the aged care sector is the care of the aged. It isn't the number of bed licences. It isn't the number of providers or the level of their profit. Sometimes this seems to me to be very much forgotten. Whilst providers, of course, have to make a profit - otherwise they wouldn't be in the business at all - Prof Gray, when he did his review of the Aged Care Act, suggested that providers should be able to make 12 and a half per cent profit on their investment.

It would be interesting to know - but I'm not asking you at the moment - what you as commissioners feel in today's market is a fair level of profit. We keep hearing about tight margins and so on, and providers who went out of the industry. I'd love to know how many have because to some of us it almost seems like a licence to print money. Some years ago I was at a meeting at which the then minister, Julie Bishop, was present and addressed the meeting. She felt that pies and pasties were totally unsuitable things to feed old people. We heard this morning of one facility which gave its people, for tea, one-third of a sausage roll and a jelly.

Staffing issues are the crux of the aged care sector, whether it's residential or community care, and much more attention has to be paid on where those staff are going to come from and their level of training. Personally, whilst others here today have felt that the training in cert III is adequate, I'm not sure that it is. Only a few years ago was a dementia model added to the certificate III and at that time, if my memory serves me right, it was an elective. It wasn't compulsory.

Some anecdotal evidence suggests that aged care has gone to the level it was 30 years ago. A friend of mine was put into a facility. He was a lawyer, a very learned man. He assisted me greatly with my research at the time. He suffered two

strokes and couldn't speak. In one facility he was in he was treated as an idiot and because he had to shout incoherently to get any attention he was at one stage shut

outside the facility and was sitting there in his wheelchair crying. That to me does not equate with care.

Finally, I would suggest, as many others do, that the accreditation process is very gravely flawed because things are done on the days of the accreditation which you never see afterwards and you get a facility accredited, something goes wrong, and a few weeks later they've failed one-third of the outcomes and you think, "How did that happen?" So those are my feelings on aged care that I have time to tell you today, but thank you very much for the opportunity to speak with you.

MR FITZGERALD: Thank you very much.

MR WOODS: A pleasure, and if you want to capture further thoughts in writing in the very near future then we would welcome them.

DR BOOTH (ACLG): Thank you very much.

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

MS TAYLOR: My name is Lyn Taylor. I'm not representing any organisation. I'm here as a personal carer. I work in the industry. I have a great deal of interest in the aged care industries. For the last seven and a half years I have been a carer. I'm not a young person, I'm heading towards the sector we're talking about, and I went into the aged care business as a personal carer because I love old people and I love the aged care environment. I love dealing with those people and they deserve to be treated with dignity and respect.

Over that seven and a half years I've worked with - I've just recently changed from one company to another for the last six months and I've done a lot of extra training in the industry. I take an interest, so I do a lot of extra training. I've done an accreditation assessment course, I've done lots of manual handling and I've done lots of dementia training, and I'm here today because I have an interest. It upsets me that today the carers seem to have been given a bad lot in a lot of instances. I might say myself it's a hard-working job. It's a very difficult job.

Part of that job unfortunately is time management training. There's a time schedule. A lot of people and families don't understand the restraints - some do. Some take an interest and want to find out a bit more about it from the carer's perspective - what happens. I would say that 90 per cent of carers, and the ones that I work with and from what I've experienced, love their job, love looking after the elderly and would give anything to be able to do all the nitty-gritty little things that they want to do for them. But because of the funding and because of the time management constraints, that's not possible. You can have a resident who demands a lot of attention and you can spend an hour answering their call bell every five minutes, to the detriment of someone else that hasn't been toileted. These are the constraints of the aged care industry and the time management.

So unfortunately the poor old carer gets this, you know, "They're not doing their job," but they are doing their job to the best of their abilities. The only fall-down I see is in the last couple of years there's a lot of training been done at a very quick pace. My training took nearly two years and it included dementia and included every aspect of the elderly and the aged care industry. Today's training is five weeks - pushed through the door. Five weeks: you're ready to be an aged care personal carer. The people that are coming through now, they're there for another reason. They're there because the employment system has put them there and said, "This is an easy job to get into. Do your five weeks and we'll pay for that and put you in there. You'll have a job." They will move on to something else within a period of time. They will look to become an EN, if that's what they want to do, or they'll go into some other industry - child care. It's an avenue for people. Unfortunately, the ones that come in to go somewhere else don't have the same

feeling or care of what they're doing, so it falls down.

The abuse issues that I've heard today, about two or three that came into the scenarios, they're very unfortunate but I think in any industry, any industry at all or any workforce, there's always people that will abuse somebody or somewhere in some way, and those unfortunate incidents need to be dealt with efficiently and promptly, and if they need to be by the law, fair enough; that's how it should be. There's a lot of regimented systems in aged care and unfortunately that takes a lot of time - the paperwork that's involved in the carer's job. You know, I can start work at 7.00, I'm flat out until 2.00, but I'm still answering call bells at 2.00. But between 2.00 and 3.00 I have to sit at the computer and fill in all the paperwork for that day, so there's added problems. I tell the carers, "I'm not going on the computer unless those call bells are answered," because that's what I like to do. I'm there for the resident.

I'm not there for the paperwork side of it but the system dictates that we do that paperwork because of the accreditation standards. All the paperwork has to be correct and filled in. Sometimes it's filled in incorrectly to make it look good and that's an unfortunate error as well in the system, and it saddens me, but I do appreciate - I've gone through this report. Went through it wildly and followed most of it because I do have an interest, and I do appreciate that I think we need to put more into home care packaging - you know, home care side of things. Nursing homes are a necessary evil, to say the least, when it comes down to it because unfortunately not everybody can be cared for at home. So they're there and they serve a purpose but home care is the ultimate - I think the biggest - what we should be looking at.

I have a mother who's 85. She is independent, looks after herself, cooks, walks to the shop every day to get her groceries, but she had no idea of how to find out if she could get some home assistance to maybe do the vacuum or drive her to the shops. She had no idea until I explained to her what was available. I think the biggest percentage of elderly people have no idea where to even start looking and I think that's the main issue. We have to come up with some advertising or some system that puts it in their face. I do believe it needs to. The gentleman before from Masonic Homes used the word I was going to use. The aged care sector is fractured. It seems to be a bit here, a bit there, and it's not all jelled together. If some way it can be covered so there's one movement, one place to go when you're 85 or you're looking for something, go to one door and they will send you to the right direction as such, but I think - - -

MR WOODS: Hopefully our Gateway will do that.

MS TAYLOR: That's a really good thing and I appreciate that. That's good. But as far as personal carers, I think they're pushed. They're pushed to the limits because

of the staff ratio to residents, the type of residents. The lady from Alzheimer's, I agreed with her. Dementia wings: we have a lock-up dementia wing. They do need more staff so that they can give individual attention. You can't do the same for them as you can do for people with cognitive behaviour. They are a totally separate thing and they do need a lot more assistance in that area. So basically that's it.

MR WOODS: Thank you very much. We appreciate that.

MR WOODS: Gentleman at the back. Could you please state your name and whether you are representing any organisation.

MR PADMAN (PHC): I'm Viv Padman. I run Padman Health Care. I'm representing our own organisation but I need to declare that I sit on the board of the Aged Care Association SA and also the national board. Our organisation has been involved in aged care for just over a quarter of a century. In the last 10 years we have built eight new facilities.

All of our facilities have met 44 out of 44 outcomes and I listened with some concern about some of the expressions of care that is provided; and I've seen it happen in various facilities. I'm conscious of time and I would like a clarification on three or four points that have been raised in your draft report and they are around the accommodation charges, the pricing of care, supply and workforce. I have one question in each of those areas, if that's okay with you.

MR WOODS: We may pick that up out of session if it's going to take longer, rather than hold everybody up.

MR PADMAN (PHC): Sure.

MR WOODS: Let me just check: are there others who are seeking to make an unscheduled presentation? No? Okay, proceed.

MR PADMAN (PHC): My first question is in relation to the proposals surrounding bonds, accommodation charges and the Australian pension and bond scheme that has been proposed. Really what I'm seeking is a clarification of how you see the model working. It's my understanding that when a consumer places money with the scheme, it will be quarantined from Centrelink's assessment of their eligibility for the pension.

MR WOODS: For the aged pension.

MR PADMAN (PHC): For the aged pension.

MR WOODS: This is somebody who puts money into the Australian Pensioner Bond, yes.

MR PADMAN (PHC): Yes.

MR WOODS: And that's its only purpose, really. It's just a way of protecting their entitlement to their pension.

MR PADMAN (PHC): Yes, and it is my understanding that what has been

proposed is that if a person chooses to place such funds as they currently do with an approved provider, it will not attract that financial incentive. Is that correct?

MR WOODS: People can choose to either pay a bond to an aged care provider or pay a daily charge or weekly rental to an aged care provider or put funds from the sale of their home into the pensioner bond and pay a daily charge instead. That's how it would work.

MR PADMAN (PHC): So the clarification I'm seeking is: if a care recipient places a bond with an approved provider, does that bond get treated in the same manner as if they - - -

MR WOODS: It's part of their wealth for the co-contribution assessment.

MR FITZGERALD: The accommodation bond provided to the provider and the amount paid to the pensioner's bond are treated in the same way. They are not taken into account for the aged pension but they are taken into account for any means test. So it's treated identically.

MR PADMAN (PHC): Identically?

MR FITZGERALD: Yes, absolutely. What we're trying to do, and Michael has explained that earlier in the day, is set up a neutral space. You can choose to go periodic payment, you can choose to pay a bond, you can choose to sell your house and if you do you can choose to put part of that or all of that into this Pensioner Bond Scheme, so they are treated in the same way. They are not taken into account for the purposes of the aged care pension.

MR PADMAN (PHC): Right. So there is no financial disincentive by placing a bond with an approved provider?

MR FITZGERALD: No.

MR PADMAN (PHC): That was the clarification that I was seeking on that point because from reading some of the recommendations, I got the impression that that was not the case.

MR FITZGERALD: Our view is very clear that what we're trying to remove is the current incentive to pay very high bonds in order to retain their aged pension entitlement.

MR PADMAN (PHC): Yes.

MR FITZGERALD: So we're removing the current distortions in the system to

create a neutral position.

MR PADMAN (PHC): Okay, fine. I guess that's some comfort. In relation to the instrument that is used to determine the funding that a particular facility receives, that is a task that is currently performed by staff within a facility. Is it envisaged in your model that - it may be a different instrument - but is that task going to be performed within each facility, or by some external agency?

MR WOODS: That task initially for a resident would be performed on behalf of the Gateway Agency, so that at the moment where the ACATs have one instrument, and then the provider has a separate instrument, being the ACFI, the ACFI equivalent would be undertaken by the ACAT team or by the Gateway, and they would use whoever they use, and so that would be the initial assessment. Any subsequent material change in circumstance would be picked up in the first instance most likely by the provider and their staff, so they would seek authority to change the level of care. It depends on, in part, how tightly we defined the bands of care as to how often that would need to occur of course, because your responsibility as well as your intention is to provide the best level of care that is related to the needs of the individual as they change, both either increasing needs or reducing needs.

MR PADMAN (PHC): So you would anticipate that there would be an ACFI instrument or similar?

MR WOODS: Yes, there would still be an ACFI instrument, but it would be in the first instance conducted by or on behalf of the Gateway, and then any material change of circumstance would still use that same instrument, but in most cases for residential, by the provider in the first instance.

MR PADMAN (PHC): So the provider's staff will review as people age in place?

MR WOODS: Yes.

MR PADMAN (PHC): Okay, thank you.

MR FITZGERALD: The question that has been raised with your association today is at what point a residential aged care provider would need to go back to the Gateway on those reassessments, and we're just looking at that at the moment.

MR PADMAN (PHC): Yes.

MR FITZGERALD: What we don't want is a situation where you're constantly having to go back to the Gateway. On the other hand there would be some providers where a measure of oversight by the Gateway might be appropriate but, by and large, you'll continue to do what you do, to reassess the client on an ongoing basis with the

ACFI, and the processes of validation and audit would pick that up. But there may be circumstances where it would need to go back to the Gateway for authority, and we're just looking at that at the moment.

MR PADMAN (PHC): Yes, thank you. That clarification has been helpful also. The next question I had was in relation to supply. You have envisaged an unfettered growth in supply, particularly in respect of community services, and I guess I have an interest in ensuring that whatever facilities we have constructed are able to maintain a level of occupancy that attracts sufficient revenue to fund the operation of that facility. I'm somewhat concerned about what is to stop every retirement village becoming a quasi aged care facility without having to build the infrastructure that is required of an aged care facility through the certification process? As I see it, from what you have recommended, if I own a hundred-bed retirement village, I can become an aged care provider, a community provider to all of the residents within that facility. However, it may not be necessary for a retirement village operator to undertake the kind of expenditure that is required by an aged care facility operator. Could you comment on that?

MR WOODS: There would be a level of acuity that would require services to be delivered in a residential aged care facility but, up until that point, in fact you are quite right. We are deliberately encouraging people to the extent they are able and wish to remain in the community for the delivery of care, by freeing up supply both in community and in residential aged care. To the extent that they then wish to choose what accommodation they live in, whether it's their longstanding home, whether it's an independent living unit, whether it's a retirement village, whether it's a serviced apartment, that accommodation decision they make is a separate decision from what care they need. But at some point for a number of people - and it is at the moment only a minority and it would continue to be a minority - they need care to be delivered in a residential aged care facility because of the very nature of the care that has to be delivered, and that would continue. Those facilities would continue to have the accreditation and certification processes they currently do.

MR FITZGERALD: Just to put that into context - and these numbers may not be right - but our current estimates show that in 2050, if I can go out 40 years - I know that's a long way - 3.6 million Australians will receive aged care in that year. Three million of those will receive aged care services in their home or in the community. On current estimates 600,000 will receive care in residential services. Now, those figures may not be necessarily correct but whilst a very substantial portion will now receive care in the community, all the estimates we have is that the residential aged care will be an area of great growth going forward.

The real driver for that appears at this stage to be dementia. Very high needs associated with dementia would indicate that most people with very severe dementia will at some stage end up in a residential aged care facility. If we were to in fact

significantly change the impact of dementia, or in fact the condition itself, then those numbers change dramatically but those are our current projections. The industry has to form its own view so we see that both community care will expand dramatically. We also see that residential care will grow very significantly. That's our estimate.

Now, the industry is in a much better position to know whether that is likely, so whilst in the short term there is some substitution between community packages and our proposals going forward, it's very unlikely in the long term that that does anything other than create more community, but also a very significant growth in residential. That's our view. Now, you may have a different view. You're an expert in this industry, so we welcome - - -

MR PADMAN (PHC): I don't pretend to be an expert but I'd have to say that I think the community generally will welcome community care, particularly the growth in community care, because if people are given a choice they will choose to stay at home and everyone respects that, and I think it's a fantastic thing if they are able to do that. I also have heard this debate about the tsunami of aged care recipients arriving and I think the jury is out as to which year it commences. Currently there is a 9 per cent vacancy in residential aged care across the country and I'm not sure that this tsunami gets to us for another 10 years or so. I agree with your figures about what might happen in 2050. I have some concerns about where we might be, getting up to that 2050 date.

MR FITZGERALD: I think our report acknowledges, but we'll do so even more in the final, that that's right. The next 10 years is a different position to where we'll be in 2020 or 2030 or 2040. Having said that, I think the industry itself has to demonstrate to us that that occupancy rate that currently exists is likely to get substantially worse or substantially better, based on our recommendations, and we'd welcome that sort of feedback. The only other comment I'd make about the occupancy rates - I don't dispute the figure but you'd also have to do an analysis of what types of facilities have higher occupancy rates, and the supposition would be they are older stock, probably low-care stock, but older stock that is no longer attractive to consumers, but that's an assumption on my part.

MR PADMAN (PHC): I think you're right, absolutely.

MR WOODS: The other point of course is that our reforms would enable owners and operators of facilities to look at that facility as an opportunity to provide a wide range of care services so that it would be long-term dementia care, palliative and end-of-life care to the frail aged, sub-acute care, transition care, respite care. There are a multitude of opportunities. If you've got a facility and it is of an attractive standard of accommodation and if the care quality that is being delivered is recognised as high quality, then these reforms open up all sorts of possibilities for such operators to look at that business and say, "This is an asset I have. This is care I

can deliver in quality accommodation", to take advantage of that opportunity.

MR PADMAN (PHC): The last point I had was something I discussed with Commissioner Fitzgerald at length I think when you visited one of our facilities, and that was the inequity of the wage structure in our industry as it applies to the private sector versus the sector that has certain benefits, that is able to package. I was wondering specifically what recommendations have you made in regard to closing that gap because the thousand people who work in my organisation are at a significant disadvantage compared to if they chose to work elsewhere, because their salaries cannot be packaged. I mean, we're talking about a 30 per cent difference, and that is very significant.

MR WOODS: Potentially up to 30 per cent.

MR PADMAN (PHC): Potentially up to 30 per cent. So how does the commission envisage that this gap might be narrowed?

MR WOODS: We are conscious of the issue but we have also received a wide range of opinions on that particular issue. It was an important qualifier that it's up to 30 per cent because in fact a number of staff for their own arrangements don't take advantage of it, or only take advantage of it to a minor degree, so there is a variety of anecdotal evidence one way or the other that's not always mutually supporting of to the extent this is a significant issue. You've raised it today. We've raised it with others who are in the for-profit sector who have said that they don't find it a significant barrier if they provide a quality work environment for staff, that staff are very happy to come and work in their facilities, recognising whether they can or cannot package their salaries and knowing that they can't if they work there. So there's quite a diversity of opinion on this particular topic, and so we haven't come up with a specific recommendation that puts a priority on overcoming something that is a very contested area.

MR FITZGERALD: Can I just make a couple of comments? You would be aware that in the inquiry into the not-for-profit sector the commission did in fact make some comments in relation to this area. The Australian government, the Rudd-Gillard government, have indicated that they have no intention of changing the FBT arrangements for the not-for-profit sector. You'll be aware that the Henry tax review made recommendations and those recommendations were formally rejected by the Australian government in relation to this issue. Having said that, there is due to be a tax forum later in the year and life may change again, but I just want to put it in context that this issue has been raised by the commission previously and by the Henry tax review, and the government has responded as I've indicated. So we are still looking at it in the context of ageing but it may well be an issue that has to be dealt with in the broader tax reform agenda.

MR WOODS: And we put in our draft report that we understood the logic and merit of the Henry tax review position, and we were very comfortable with that outcome, but that's a broader debate than just in aged care.

MR PADMAN (PHC): In closing can I just say that in all of the years that I've spent in this industry, I have to say that yours is probably the most novel report. It's got real solutions and it's our sincere hope that it doesn't suffer the fate of the Henry review. Thank you.

MR WOODS: Thank you.

MR FITZGERALD: Thank you very much.

MR WOODS: If there are no further unscheduled presentations, we will adjourn these hearings and resume in Perth. Thank you.

AT 5.18 PM THE INQUIRY WAS ADJOURNED UNTIL
FRIDAY, 1 APRIL 2011