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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 PERTH ON FRIDAY, 1 APRIL 2011, AT 8.53 AM

Continued from 31/3/11 in Adelaide

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

I would like to express our thanks and those of the staff for the courtesy extended to us in our travels and deliberations so far and for the thoughtful contributions that so many have made already in the course of this inquiry. These hearings represent the next stage of the inquiry and the final report will be presented to government in June this year.

I would like these hearings to be conducted in a reasonably informal manner, and remind participants that a full transcript will be taken and made available to all interested parties. At the end of the scheduled hearings for the day I will provide an opportunity for any persons present to make an unscheduled brief presentation should they so wish to do. Could I call Aged and Community Services WA. Could you each please for the record state your name, the organisation you represent and the position you hold.

MR FITZGERALD: Stephen, would you like to start doing that?

MR KOBELKE (ACSWA): Stephen Kobelke. I'm the chief executive officer of Aged and Community Services Western Australia.

MR HARDING (ACSWA): Vaughan Harding. I'm the deputy chair of Aged and Community Services Western Australia and also the chief executive of Uniting Church Homes.

MR GLICKMAN (ACSWA): Good morning. My name is Ray Glickman. I'm the chairman of ACSWA and also the CEO of Amana Living.

MR WOODS: Excellent. Thank you for coming forth today and taking part in this inquiry and thank you severally and collectively for your support so far in providing information and visits and a whole lot of contributions to this inquiry. It has been very well received. You have a statement you wish to make?

MR GLICKMAN (ACSWA): Yes, thank you. First of all, thank you very much for the opportunity to address you and for going on what is basically a road show around the country. As you know, we are Aged and Community Services Western Australia, the peak body for not-for-profit aged and community care organisations in this state. We have a large membership and a very strong representation of smaller

and rural and remote providers.   Our team here is the chairman, myself as the deputy chairman and our CEO.

On behalf of ACSWA, we would like the congratulate the Productivity Commission on the generality of the report. We believe that it delivers on the radical reform proposals that are actually needed to make our sector sustainable and that there are a number of new directions contained in the draft report that are appropriate and much needed. So first of all, it moves our system, if you like, to an entitlement basis as opposed to one that is rationed by supply.

Secondly, it delivers on something which we all think is important, which is a greater degree of consumer choice. We think it does a very commendable job in trying to balance equity between consumers and the general taxpayers. Finally, it talks about an appropriate proportionality of regulation, trying to limit regulation to where it's really required. So in those respects, and in many others, we feel that it's a very creditable effort and starts to set the industry on a much better path. However, having said all that, of course the devil is always in the detail, and that's the really hard part.

We are aware of the fact that there have been numerous submissions made back to the Productivity Commission about this process, and you've been going around the country and you would have had a lot of feedback about the generality of issues and some of the detailed matters about which people are concerned. But the focus that we want to express today is very much on Western Australian issues as they affect aged and community services, and also we want to inject, as the peak body for not-for-profit organisations, a strong element of those sorts of interests.

There were three issues primarily that we wanted to talk to you about, and these really reflect very strong viability issues in relation to the WA situation. The first is about workforce. The second is about regional cost variations. The third is specifically on rural, regional and remote issues. So our game plan, if it's okay with you, is that I am going to hand over to our CEO to expand on those three major points and then Stephen, Vaughan and I will be more than happy to engage in general discussion with you.

MR WOODS: Excellent.

MR KOBELKE (ACSWA): Thank you. In a recent feature story in the Australian magazine the Premier of Western Australia said, "I don't believe that much of the rest of Australia, including the federal bureaucracy, actually understands this state and what is happening here." While our premier was talking about probably the resources and mining boom, we really want to share a similar story about aged and community care in Western Australia. There are many positive things about what is happening in Western Australia and what that is meaning for the rest of Australia,

but those things put strain on what is happening in the aged and community sector in Western Australia.

Perhaps the headlines that we see from Western Australia about two and a half thousand aged care bed licences undersubscribed extends far deeper into human resourcing, random building cost increases, the ability to house staff in rural and remote areas and escalating general costs. They're the story behind the headline stories that the press are using and what is really affecting us across the state. So our paper, of which you have a copy I think, just really highlights the key areas that Ray has just mentioned.

I'm going to go fairly quickly through. In relation to workforce, the simple fact of the matter is the state is not going to have enough workers. I know the report has covered it, but just to repeat it, there's $225 billion worth of resource infrastructure projects on the go at the moment in Western Australia, and we need 500,000 new workers by 2020. More importantly, we are going to be 150,000 workers short within six years. So we're talking a tight time frame. When in 2007 aged care labour agencies, who provide temporary workers, put up the signs that they no longer had staff either that they could send out to provides, that was unparalleled in the sector's history here, and unparalleled for anybody working in the sector.

So while there are skill shortages within our sector, 65 per cent of the industry aged and community care workforce are personal carers, and Western Australia is going to need to look to a new pool of workforce. Current regulations regarding overseas recruitment of temporary and permanent are not suitable for that area. The legislation doesn't extend to allow the carer to come in to work here, if that is what is required. Only last week our state minister Peter Collier for workforce urged the federal government Minister for Immigration, Chris Bowen, to relax several key immigration rules, the most significant of these being to re-classify Perth as a regional area for immigration, allowing a much greater flexibility for improvement.

So in this area what we're asking the commission to do is to acknowledge the significant variations in labour supply throughout Australia, particularly in Western Australia, and that the supply of aged care workers must be prioritised in critical labour-deficient areas through the temporary and/or supported migration program for unskilled, semi-skilled and skilled workers. Regional cost variations is the other area that Ray touched on. It's three and a half thousand kilometres from the bottom of our state, down towards Esperance, up to Kununurra, it's a big country, and we have more or less been in a boom economy for 10 years.

With long-term signs now confirming that to be the case, the major international companies are moving their world headquarters to Perth. That is the sign of a place that is going to be the lead for major resource projects for a long time. The big buildings you're seeing down St George's Terrace are going to be the

headquarters of some of the international offices. That's a sign that this state is in for a long-term, sustained shortage of staff. We are encouraged that the commission has recognised regional cost variations, commissioners, and has proposed the development of an independent regulatory commission to recommend to the Australian government that the appropriate subsidies be applied.

For Western Australia the significant challenges include the inflationary pressures which have outstripped the other states, particularly around land shortages and building costs through Western Australia where we have seen our industry in residential terms come to a standstill, in terms of building and the workforce issues I outlined previously. They are some of the key areas. The new system that you develop will need to reflect in a sophisticated fashion the variability in service delivery costs across the diverse state and across Australia if equity of service delivery outcomes is to be achieved across jurisdictions.

We recommend that the commission ensure that aged care services are funded with consideration of regional and locational variations that contribute to the cost of care. With regard to rural, regional and remote, our members, the not-for-profit providers in Western Australia, account for 95 per cent of the services across the state, both community care and residential care. So we, in a mission way, are delivering care across this huge state.

MR WOODS: Do you define across the state as non-metro? The 95 per cent relates to?

MR KOBELKE (ACSWA): Regional, rural and remote.

MR WOODS: Okay. Thanks.

MR KOBELKE (ACSWA): The challenges I flag around workforce and regional cost variations are compounded in those areas, particularly around housing costs and housing staff and those areas. Our federation 's response to you covers I think quite well that rural and remote, and I know you're looking for more information. But I just wanted to pick up on a couple of areas that I know that you've touched on in other states. Aged care providers in rural areas that operate within the MPS, the multi-purpose services area, advised that they must comply with a range of regulations that add cost to the cost of providing care.

Multi-purpose services here do not have to meet the same regulations, and therefore have a competitive advantage. Multi-purpose services are funded whether the beds are occupied or not. The current system does not facilitate a level playing field; there needs to be national consistency. ACSWA supports the notion that older Australians should be entitled to quality care as specified in the quality of care principles of the Aged Care Act. There is currently no requirement for multi-purpose

services to comply with the same standards that apply to Commonwealth-funded aged care facilities. There should be a common set of standards, to ensure older persons receive quality and care, regardless of location.

ACSWA also supports the concept of an integrated health model inclusive of aged care services. We propose that this model acknowledge the holistic health focus and not just the traditional medical model of care. In rural communities there is often limited access to health professionals and facilities. Health outcomes would be enhanced by increasing cooperation between these services and minimising competition. In Tasmania's model, the hub social enterprise model and the integrated health and aged care model at Brookton in rural Western Australia, where the community health centre and the aged care service operate from the same facility, the community nurse is readily available to attend to the health care needs of residents, preventing hospital admission and better outcomes for residents.

We recommend in this area that funding models for aged care services in rural and remote regions accommodate local cost structures to ensure financial viability in those locations. Linking in with all that is an issue that we feel has particular significance in Western Australia. We were concerned with the commissioner's comments about the fringe benefits tax. Not-for-profit aged care providers are following a mission for their owners, the churches, community groups and other charities. In Western Australia, even with desperately-needed extra government funding to pay our champion workers, Western Australia will still have to face competitive wage challenges, because the rest of business have unrestricted sort of access to increased charges, then apply that to wages; we don't have that in our industry.

So particularly in Western Australia - and for that matter, Australia - the fringe benefits tax for workers will always be important. We have outlined in our submission, which you have, some of the impacts in that area. Over here it gives us the opportunity to hold staff. In a state short particularly of service people in restaurants and in hospitality and retail. there will be a flight to those sectors if we can't continue to offer these extra benefits to our workers. Just finally on this point, surpluses generated by not-for-profit providers are reinvested in the business rather than paid to proprietors or shareholders.

Any reduction in the viability of not-for-profits will reduce this reinvestment and lead to the net reduction of supply. So ACSWA recommends that the commission reject the phasing out of FBT to ensure that not-for-profit organisations are not compromised in the provision of service to older Western Australians, particularly the more vulnerable and socially marginalised sector. So they are the four areas that we wanted to highlight for you. We support the Aged and Community Services Australia paper but highlighting that Australia is very diverse these days, and without banging on about two-speed economies, we definitely have

one here. Thank you.

MR WOODS: Thank you for that. We might take them in the order in which you put forward. So looking at workforce in the first instance and your commentary around shortages, which we both understand and fully accept, are there differences in shortages between PCs and RN, EN level or is it across the board - or are there differences?

MR HARDING (ACSWA): My experience would be that the greater shortage is with your general unqualified workers that are the mainstream backbone of our service delivery.

MR WOODS: So the third level, the personal carers, personal care workers.

MR HARDING (ACSWA): Yes. That's the major cost that you need to meet in terms of your total expenditures and it's where all of your mainstream services are delivered. The level of oversight and support for the PC workers is a more minor element of your total budget and a more minor element of the total numbers that you need to supply. So, yes, that is where the major push occurs.

Commissioners, just looking at the issue of workforce, you say that you understand it and I'm sure that you do, but just consider a scenario that as you leave Perth and head back to the eastern states, and the body of work that you've started to collect and the submissions that you have received, that the sheer workload between now and June when you are delivering the final report to government, that a third of your team back at base station is removed. They just go; they say that they're going off to work in the mining sector. You rapidly try and recover and move resources around to meet the workload that you have and six or eight weeks later about another third have gone. That's the scenario that we face at the peak of boom time conditions with workforce. We are trying to keep the ship afloat. We are trying to meet the needs of people who are incredibly vulnerable. Keeping that common face, common skilled person in front of the person needing care becomes an incredibly difficult task when this economy started to really move.

Looking ahead, most organisations now, looking down the track for the next 10 years, we virtually cannot see a good year ahead of us in terms of workforce. The predictions for the growing interest by the rest of the world in our resources probably means that for 10 or 15 years we'll be flat out trying to dig stuff out of the ground. That means the mining industry is going to soak up as many resources as are possibly available to do that. If that scenario is about right, that leads us into about 2025 or towards the top half of 2027. By then, just looking at the demography, the number of people available to come into the workforce through normal processes would have reduced dramatically anyway. So just looking down the track for our sector, labour intensive as we are and dealing with the vulnerable needs of people, the workforce

issue for us is front and centre of our future.

MR WOODS: There are a number of consequences obviously of that, including the extra supervision required for staff who don't have long experience, the impact on your residents of a constant turnover of people; there are a range of issues. Two that I'd like to just test with you a little further: what is the impact in terms of the quality of people who are coming into the sector and the training that they receive - that's one; and the second is what is the impact in terms of enterprise bargaining outcomes for that sector?

MR KOBELKE (ACSWA): So on the first of those, I guess there was a very strong impact in terms of the quality of people available. At the peak of the boom in 07, 08 it was a kind of joke around here in Western Australia that employers would take anybody who could present, and unfortunately that isn't too far from the truth. So in terms of being able to select people who have had the actual personal qualities or requirements to do the sensitive work that we do was a very difficult challenge. We also found that many of the people we were recruiting were from overseas with very different cultural backgrounds from the make-up of our client group and that in turn generated significant cross-cultural issues that had to be managed.

Just on the way through to answering the second question, I'd probably point out another level of impact that we haven't spoken of and that was the overall cost impact on organisations of being continuously in the recruitment and retraining business. For example, my own organisation, which is admittedly large, I calculated that we were spending about a million dollars a year on the turnover process. That was the impact of advertising, retraining, recruiting and the agency bills just to get anybody into the place to look after our residents and clients.

In terms of the impact on enterprise bargaining outcomes, I think the impact is clear, that there is significant pressure on cost structures for labour in Western Australia; that's clear. I think I can speak for most of our organisations and say that we have the greatest respect for our workforce and we understand that they are the key to success and they are the key to quality care and accommodation for our residents and clients. We would be delighted to have more revenue coming into the system in order to be able to pay higher wages and meaningful wages to the people who work for us. So the impacts are significant and significant on our cost structures. Those organisations that went through individual bargaining at that stage also felt that impact in terms of the outcomes. On the other hand we are squeezed in an impossible situation because we don't have the revenue to support higher wages, but if we didn't pay them it would just exacerbate our problems in terms of trying to get people to come and work for us. So it's an impossible squeeze, really.

Just finishing off on those comments, in your draft report I felt strongly that it was almost premised on the fact that there would be an availability of workers to

come and work in the system and I think our strong message to you from Western Australia is we are absolutely certain that that won't be the case unless some really radical change is made to how labour is brought into our state.

MR FITZGERALD: Well, can I just take that point. You made the recommendation prior to the draft and you're making it again in relation to freeing up the availability of migrant labour into this state and you've said today that you want to have Perth reclassified as a regional centre for purposes of migration of workers. What agreement do you have with the unions in your area and other like human service areas? In other words, one of the things that strikes me is that this is a chain that affects all aspects of labour, not just the aged care area. So when we talk to the unions later in the day, as we will, are they on the same page with you?

MR KOBELKE (ACSWA): There are some discussions at the moment at a national level around the workforce issues and linked back, I guess, to what the Productivity Commission is doing. However, in Western Australia those sort of discussions with the unions haven't developed. I mean, the unions have a current view that their key interest is in existing membership and the sensitivity around that area in relation to migration, but there needs to be more discussion, that would be clear.

MR FITZGERALD: One of the issues that the unions have raised with us everywhere, both the ANF and also United Voice and a number of other organisations, the Health Services Union and so on, is about workloads. So if there's an insufficiency of staff, that disadvantages in terms of disproportionately high workloads on the current staff. So it's not as if you're completely at cross-purposes in this area of concern.

MR KOBELKE (ACSWA): Not at all. I mean we want to be able to have every best chance to look after the people working for us. I guess that goes without saying, but we're up against it as well because when the pressure goes on - as it is coming back now, we're seeing the first signs of the workforce tightening again since the last boom - simply there isn't a work pool to draw from. So there needs to be some further discussions at a government level involving, in Western Australia, those peak groups about bringing people in. There are some discussions about that but they haven't - been more around the skilled area, so it hasn't really touched back down into this carer, unskilled, semi-skilled type of person because they don't fit the model to come in because of their wage level. So there needs to be more discussion, but certainly what we're saying is that a direction from the commission that would point the government and others towards this area is fairly important.

MR WOODS: Just one more on that third level of worker. With the recruitment that you undertake do you notice a variation in the quality of the cert III skills that they have? Presumably you try and focus on employing people with a cert III, but do

you find either that the content that is being taught or the quality of delivery by some of the RTOs compared to others is variable or is it all of a fairly common standard?

MR KOBELKE (ACSWA): There is a significant difference, and I know we've commented to a couple of inquiries recently about this, that in Western Australia we've had what we term the fast-track RTOs who are moving people through a certificate III within weeks and then they try to place them. Providers are really getting somebody who has had no on-the-ground experience and it's not working. Worse than that, that person then is not re-eligible for other training because they've been through it.

So at our own organisation level we are developing relationships. We have done some of our own internal investigation and we try to develop relationships with trainers so we can put our members towards them that do offer a more what you call holistic training program which involves a period of time where people are actually on site getting some on the job experience as they go through the qualification. Certainly there needs to be some tightening up at the government level about their rules about how the training is delivered. Certainly training needs to be over a period of time. That gives the person on the ground that sort of real life experience you don't get in a classroom for a couple of weeks.

MR WOODS: So in effect you'd be creating a sort of second filter of quality.

MR KOBELKE (ACSWA): Yes.

MR WOODS: These are you preferred RTOs and not others?

MR KOBELKE (ACSWA): Well, that's just a personal thing we do to try and assist, but it's part of the broader - I guess our organisation since the crunch in 2006-2007 have been trying to work around developing workforce pools and other training mechanisms so we can try and assist members as we go forward. We have limited resources but we are trying to do these things. Just recently - our next stage is recruit a specialist in immigration to work with us. We're trying as hard as we can, but we need your group and the government sort of pushing the same way.

MR WOODS: Well, we will be pushing.

MR FITZGERALD: I might say that I think the report does acknowledge the workforce shortages throughout Australia. In fact, one of the things we've been saying endlessly to the sector is that there are very, very long-term shortages in the human services area: aged care, disability, mental health and a number of others. There is nothing that indicates that they will lessen dramatically. Then we've got your special circumstance and Queensland and a few others. So I think we are very conscious that in all of the human service areas that we're looking at at the moment

this is a problem, and the magnitude of the problem depends on where you are.

But can I just ask this question. There's a limited number of things we can do. We can increase the availability of training, but that doesn't seem to be a problem in the sense that people can readily access cert III. You can increase the level of migration, which you've suggested. Then of course you can increase the level of remuneration, and we're freeing up some of that financial rigour. Beyond that there's not a lot you can do in workforce. Do you agree? I mean I can't think beyond those three things with one other exception, that is, actually making aged care an attractive industry in which to work, which is a significant issue.

MR KOBELKE (ACSWA): I think that's a very good point. The fourth one is - you know, every night on television we watch government promotions about an array of things to stop you doing this or get you doing that, get you healthy. Certainly I think the government could do more with industry and consumer groups to promote the importance of working and the honour of working in the sector. I think that's a fourth leg. Our organisation at a national level with our "Can't do without you" campaign and "Grand Plan" has tried to do some of that within a limited budget. But you could throw some government money at a campaign. That would be certainly another thing that would be important, I think.

MR GLICKMAN (ACSWA): Our strategic positioning in ACSWA has always been - well, in recent times it has been that there is a sort of what I call an axis of evil, really, which is inadequate funding, a poor image and inadequate workforce. They are all - those factors are all interlinked to play upon each other in a sort of vicious cycle at the moment that has made our industry very unsustainable over here. So somehow we need to break through those and work on each of those three elements, I think, to improve things.

MR FITZGERALD: Could I just ask one question or clarification before we move on to the other issues, and that is, is the workforce shortage in relation to the third tier, the certificate III worker an equal problem in residential and community or is one better or worse than the other?

MR HARDING (ACSWA): Can I just respond to that? The community sector is the one that is suffering most, I believe, because their own policy settings make it very, very difficult for you to offer sustainable work and income for the worker. The nature of the work itself, you're not working generally in a team, you're working by yourself. Going into people's homes has got variable responses in terms of what you might experience while you were there. The community sector has a lot of very particular issues that do need to be addressed and the weight of the problems with workforce, in my view, sits more with the community sector than with the residential sector. Given that this is really our growth sector and the future in terms of service development, it is critical that we get on top of this to give us any chance of creating

properly structured alternative models.

MR FITZGERALD: Thanks.

MR HARDING (ACSWA): Just before we do leave this area, just one of the issues that we have endeavoured to come to grips with in responding to you is what can we reasonably expect of the commission? What's the commission's role? What are the matters that we would like them to most influence? One of those matters which sit with other parties like government and those matters which sit with us is organisations that need to also create solutions for our own issues moving forward.

On the workforce side, for Western Australia, there is that shortage of people problem. I guess we look with dismay at the devastation in the eastern states, believing that for the next couple of years their need for workforce and resources et cetera is going to soak up some of the capacity that we have been utilising over here. So we would strongly recommend, if there is any chance of influencing current debate about the short and permanent immigration arrangements - that's where we think the biggest impact can be made. The work that has already started in the sector to improve its image - it's a journey. It's going to take us quite a number of years, I think, to make the sector a real alternative for young people looking at options for themselves.

At the very hard end of cost, we will never be able to compete with the mining sector, but we should at least be able to compete with the health sector, the retail sector, the hospitality sector. We should at least be able - we shouldn't be confronted with people stacking cartons in Coles being paid more than somebody responsible for care delivery for a very frail and vulnerable person. So at least we could deal with those sectors.

Robert, you asked the issue about what relationships or understandings or agreements we've structured with industrial unions in terms of what the future might look like. That certainly is work to be done. I believe the sector has been open to those conversations for some time in terms of how to move forward. However, we want to be convinced that the substance of the conversation really is about improving the outcomes for our sector than just improving the outcomes for a particular participant. So I think we stand ready for those conversations.

Some of the councils that now have been established - and I'm sure you're receiving feedback and submissions from them - in a genuine effort, have occurred in recent years to bring together consumer service providers' unions and other interested parties to create a more coherent voice in terms of what we think the future should look and feel like.

MR WOODS: Even though we have been in and out of this field for 12 years now,

there is a remarkable change in the mood of the various parties that come together and seek solutions which is very welcome. We don't have a lot of time left but in the regional remote space you drew attention to some of the MPS issues which I was a little surprised at but let's explore them. Do I take it that your model being driven out of the Health Department is sort of more similar to the New South Wales model than the Tasmanian model?

MR HARDING (ACSWA): That's correct.

MR WOODS: That then has consequences in terms of wages paid to staff because that would be public sector wages; the funding of the aged care component of the MPS is driven out of block funding or a mock-type model. You did mention a Brookton example. Is that a trend of new things or is that driven out of one of circumstances?

MR KOBELKE (ACSWA): I think it's probably one-off or not common. As I say in my initial statement, the providers and the small providers where there is an MPS, if a hospital has empty beds they're still being funded, so they feel that this whole system is really skewed against them. I noticed that at one of the previous hearings that you've had, you asked the question about prescriptive on this issue - should we be prescriptive about MPS models. We believe there should be some direction around this to get some consistency, and the Tasmanian model, which involves the whole of community model, presents quite good options, and that's really just bringing as much as possible of the community together so there's different levels. Without being prescriptive I think they would be keen to get some pretty reasonable directions so Australia is heading in the same direction in this area.

MR WOODS: Does it matter that it's heading in the same direction? I ask that because this is a case where given the different types of regional communities that exist, variations of the model may not be such an issue. I take the point that you said at a minimum you want the aged care standard to apply to the aged care component of the MPS. On the surface that doesn't seem an unreasonable proposition. But beyond that we note that who owns it, who manages it, who operates it, and whether it started as an aged care facility, whether it started as a health care facility, all shape the culture in the organisation. But I just wonder whether it is necessary to have the one model in the MPS area or not.

MR KOBELKE (ACSWA): I think that being totally restrictive won't allow for flexibility, but certainly at some level in terms of - particularly around the regulation, that hospitals doing aged care meet the standards. That would be something to cover off on. I think you've had a close look at some of the different models and I know you've had somebody especially working on this area. From what we have looked at, the Tasmanian model - there's been some good research done on it and it seems to be working. So without it being prescriptive that style of model looks quite attractive, I

think.

MR WOODS: That's quite helpful.

MR HARDING (ACSWA): Can I touch on some more of that because WA has some very particular issues in terms of a lot of small populations, and trying to get structure into these communities and make them sustainable is an enormous challenge. The current MPS model certainly created a very clear demarcation between - you're in the field and you've got treasury backing immediately in terms of your costs; or you're outside of it and you just survive on your own wits and backing within your own organisation. That's not a good model. It's not particularly sustainable. I haven't had a close look again at other submissions on this, but certainly for Western Australia we do need to have a conversation about the need to abrogate resources to meet the needs of community.

Some of our communities were a lot larger than they are now. The townspeople often still haven't moved beyond understanding that they can no longer support two sporting fields and two of this and two of that. They do need to come together and create some critical mass. Health departments tend to dominate a lot of these communities in terms of resourcing but they have financial backing and they have service models quite different to what we would think would be best outcomes for older people and to meet what we would see as minimum standards. This is actually a very broad conversation that we need to have about creating ongoing, sustainable support infrastructure for small communities.

We've got 1.2 million people in Perth, and the other million are spread all over the state, two and a half million square kilometres. It's a very difficult area to adequately service, whether you're talking about roads or food supplies or whatever. When people are frail and vulnerable they don't really have options. I just have a sense that a lot more work needs to happen. We do need to have a lot closer conversations with state governments concerning resources they're bringing to these centres to see where our sector sits with them to actually meet the needs of older members of those communities. Where we've got to now is not sustainable going forward.

MR WOODS: There are a number of other issues that we do need to have a conversation about but we have run out of time for the scheduled session this morning but, thank you. We know how to find you and we will continue discussions.

MR HARDING (ACSWA): Thank you very much.

MR WOODS: Can I ask Carers WA to come forward, please. For the record could each of you please state your name, the organisation you represent and the position you hold.

MR COATES (CWA): My name is Paul Coates, I'm the CEO of Carers WA.

MS TURNER (CWA): I'm Donna Turner, I'm a policy officer at Carers WA.

MR WOODS: Thank you for your submission. It has been very helpful and certainly sets out how you operate and what your issues are but please take us through your key points.

MR COATES (CWA): Thank you, and welcome to Western Australia.

MR WOODS: We come here regularly.

MR COATES (CWA): Carers WA, we've existed since 1996 but as you know we're part of a national network. I suppose the first thing I would say is that the stories you're hearing from the different carers associations, we're a close-working network, we endorse all those comments. So I'm not going to spend time going over and repeating the sort of issues that were raised, for example, by Carers Victoria. We endorse those. In WA we have 12,000 carers registered with an estimated 310,000 in WA. Of those 310,000, approximately 40,000 of those people are themselves are classified as older people but, of course, there's a large proportion of those people under that age who are caring for older Australians.

I listened with interest to the initial session, and there was a lot of discussion on workforce, on training, on pay, but I guess where I'm coming from is that I endorse and support what my colleagues in the previous session have said. But actually the largest number of people providing care for older people isn't those where you're concentrating on training the workforce, it's the unpaid carers. There's plenty of research which backs up that the majority - - -

MR WOODS: We fully accept that.

MR COATES (CWA): So that led me to thinking about the changes and what that might do to associations like ours and of NGO associations and their ability to support carers. My first concern was one of destabilisation. Without a coherent approach significant change within different sectors could possibly be competing, conflicting, and by different sectors I mean state and federal government, I mean Department of Health and Ageing, mental health, disabilities, the general health system. There's a lot going on and a lot of change and a potential for conflict. We believe some of these changes you have mentioned to be positive but they need to be

properly resourced and tested before they're introduced on a wide scale, and I recognise that that's noted in your report but it's very important.

When you think of the workforce - the paid workforce I'm talking about now - say, in associations like ours, we're currently coping with, because of the funding we pay people at lower rates, lower rates in government departments - significantly lower in some government departments - and that differential between the NGO sector and other sectors, as well as the commercial sector, is being recognised in the report for Community Services and Health Industry Skills Council and the government appears to be beginning to recognise that. The bottom line is it's a low paid workforce for carers' associations but people are doing it that because they're driven by other motives as well. Change can increase the possibility of instability, and the last thing we need is this fear of change, job losses to increase our already high turnover because that will flow on and impact upon services provided to carers.

The push for individualised funding is a positive concept but it may have a negative impact on some services. Currently the carers associations are block funded. What that means is that they're able to provide to carers free and accessible services which are vital to helping them identify and access support. Now, with individualised funding only those who have engaged in the services, who have accessed the systems, who have been through assessments would be potentially allocated funds to access carer support services. This runs counter to the need to increase the self-identification of carers and their participation in supports. Back to the paid workforce and carers; if you think you've got a problem with the paid workforce, if the carers are not supported, the next five to 10 years that paid workforce problem is going to double and treble because all the unpaid care is going to start to disappear rapidly. So I think we've got to be careful that what we're doing is not counter to the sort of spirit of the recent federal legislation which seeks to increase the support for carers. So I'm concerned on destabilisation.

The next point is coherence. Currently we've got two large Productivity Commission inquiries; this one and the one on disabilities. We've got consultations already by the DOHA officials about change. We've got mental health reforms, got health reforms, we've got the state government, we've got the federal government. Frankly, we're not clear what's happening in any of these sectors, I'm not sure the governments themselves are at this stage. So there's a fear there that there be lots of different reports, lots of different consultations and that the support for carers becomes fragmented.

I suppose a small example of that, how I can bring that to your report, is that there's talk about carer support centres. So is that a carer support centre for carers who are caring for older Australians, and what about all the carers who are caring for disabilities, mental health and general health as well as the aged? So if you think of Western Australia and you take Broome, does that mean that a carer support centre in

Broome only supports people who are carers of older people? Obviously that's not cost efficient, it's not practical. So there needs to be coherency in all these recommendations and we view this as absolutely paramount.

So I think there's a role for the Productivity Commission both in this report and in the disabilities to bring that point out, that all the recommendations that you're making need to be considered in the context of the Carer Recognition Act that was passed in 2010 and the proposed national carer strategy, which we're looking forward to viewing sometime in the middle of this calendar year. It's almost the cart before the horse if we start talking about things like carer supports if the whole holistic view of what's going on in government that I've outlined isn't taken into account.

Carer support centres: as I say, these need to meet the needs of all carers. If they're only linked to aged care many carers will not realise that the services that they provide are for carers in other spaces - in mental health, in general health. Carers Victoria have outlined the services that we believe should be offered in the carer support centres. I'm not going to repeat that. I'm going to pass on to Donna to comment on some of the specifics.

MS TURNER (CWA): So to follow on from Paul, one of the things that we've really been trying to understand is how the needs of carers will be assessed. So it's quite possible there will be cases where the person who's older chooses not to engage with formal services or, to take this a little bit more broadly, someone with a disability might not be eligible under the proposed scheme. So what happens to the carer and what's their pathway for being assessed and then eligible for services in their own right?

It's quite possible, if there is no separate pathway for the carer, that they could be, say, caring for an ageing parent, caring for a child with disability; neither falls into eligibility for formal services; and so how does the carer then access services for themselves? So they might actually be carrying a heavy enough caring load to be eligible for a Centrelink payment such as the Carer Allowance but not actually be able to access carer services if there's not an independent pathway to be assessed and to be eligible. So that's one thing that we're trying to get our heads around; how does that play out in these recommendations.

I'd like to talk a little about aged care services and what some of the recommendations might mean to family carers. Often carers will tell us that entry to residential aged care is a real barrier to continuing family life. So carers continue to be involved with the person they're caring for even if they're in residential care. Particular examples where that family structure is not well catered for now would be, say, a partner caring for a partner with dementia or physical disability, mental illness, or older parents caring for an adult child with disability.

So what we were hoping, I guess, in some of the recommendations would be some innovation in residential care where that family could be maintained. There are examples. I guess a lot of people will be quoting the situation in the Netherlands where there are independent housing units where families of different levels of health can live together and where services come to them. So we'd like to see some kind of, I guess, exploring of how families can be maintained and how that caring relationship can be maintained even when one partner needs more care than the other. Following on from that, the comments about residential care providers being able to trade places within region, that caused us some concern. If a person who needs a supported place is less likely to be able to remain in their community, that's a huge loss. So we'd like to see some assessment of the caring situation and the family situation when decisions are made about where a person can be placed.

We looked at some of the role of the proposed Australian aged care regulation commission and it showed complaints mechanisms, I guess, for service providers and for residents but there was no role there for carers to make a complaint. Now, that's an area that's been under review and is concurrently being reviewed at the moment and we've put in some comments to that review. We've seen that the Carer Recognition Act, the federal legislation, requires care providers to acknowledge carers. So within the AACRC there needs to be some mechanism for carers to be acknowledged and also some features built in that will actually help providers and the government to measure progress against the goals of the carer recognition legislation.

MR WOODS: Good.

MS TURNER (CWA): With regard to palliative care our carers would agree that a lot of people would prefer to die in their home rather than in a hospital setting. So that's a transition that most people would agree needs to take place, but it does create another role for family carers. What we're thinking of is how is it that staff who now will be - as in palliative care staff who will now be working more in the home to deliver this care - how will they get the skills to work with a family who are carers as well? So we're thinking as part of the national palliative care strategy - there was some mention in there of supporting family carers, but I think your recommendations could strengthen that, could focus more on that.

One of the things that we do in Western Australia as part of Carers WA is a prepare to care program. So that's a hospital based program where our staff train hospital-based staff in how to meet their requirements under the state Carers Recognition Act. That has proved really effective. So we're wondering if that could be considered as a worthwhile program to expand into palliative care. They were the comments that I was going to make.

We did mention - and the comments before about workforce made me think of

this again. In our submission we talked about the carer visa, which is under the family migration program. Now, we don't know why there was a cut to that category of visa, but our concerns arise from complaints we have received from families, mostly CALD families, who - they can't get any other local support - are able to have a family member from overseas apply for a carer visa. So with the cut to that, that just seems to be totally contrary to all the other concerns we have now about shortage of workers. But also for CALD families who are struggling to have someone come into their home to care for someone who might be quite vulnerable but who can't speak the language and doesn't understand some of the cultural features of that family a cut to the carer visa seems to make no sense. So we're still waiting for a reply from the government on why that cut occurred and also what plans they had in place to assist those families who can no longer have a family member come in to assist.

MR WOODS: Yes. No, that was quite a useful addition.

MR COATES (CWA): So then just one final comment.

MR WOODS: Please.

MR COATES (CWA): This is about the use of the family home to pay for aged care services and the impact on inter-generational equity. It may seem self-evident that it's fair that if people have the assets and resources that they be applied to paying for the care. But the situation with unpaid family carers is different. You think about the carer who has moved back into the home to care for their parents or the adult child with a disability who could remain in the family home with support when the parents themselves enter residential care.

Carers, whether they're partners of those imminently going into residential care or adult children who have returned to the family home could have the homes placed at risk. We believe that more modelling is required to determine inter-generational impact to take account of the circumstances. Sometimes the fact that the older person has assets could arguably be a function in many cases of the fact that that person has had the benefit of unpaid care from the family and friends for a number of years. If those supports weren't around say for the previous 20 years, those assets would have had to be used to provide that care for those 20 years far quicker.

So I think more modelling needs to be done on the opportunity cost of care. I think those opportunity costs should be netted off the assessment of assets, because whilst we sort of talk in economic terms, opportunity cost, costing exercise, we're talking about real people's lives. Many of these people have devoted a substantial proportion of their life to providing support for the loved one. Then to say, "Right, at the end of that your loved one is going to go into a care home. We're going to take your home away from you. You're not going to get any superannuation, by the way.

We realise you haven't been trained for the last 20 years but we're not really bothered about that either" - is a bit of a kick in the teeth.

MR WOODS: Certainly there are no proposals of ours that would take the home away from the person. In fact, the whole aim of the reforms is to provide a range of ways in which care co-contributions can be met, including a range of protections and stop-losses and the like. So we're not at that end of the spectrum in our proposals and it only relates to the asset base of the individual, not of the partner. There would be no sort of taking the other partner away from the home or the home away from them. I think if we go through it carefully you will see that our proposals don't lead to those sorts of outcomes.

MR COATES (CWA): I think my argument, Mike, is in the assessment of those assets. Those assets, in many cases, exist because of the opportunity cost of the carer.

MR WOODS: Yes. No, I understand that point.

MR COATES (CWA): That would have to come into the calculation, I guess is where I'm - - -

MR WOODS: I understand the point you're making on that one, but I was just reacting to some of your other descriptions. But before we run out of time there's just a couple I'd like to raise. Robert might want to deal with the carer support centres, but one that I would like to address briefly is your reference to models of sort of social housing, congregate care opportunities. In fact, our reforms are aimed at allowing many more people - in fact allowing all those who wish and their situation, their medical and health needs and carer needs situations allow, to remain in the community for as long as possible. So we would envisage by separating out the care issues from the accommodation issues that in fact a range of accommodation options would develop, including sort of small social housing groups, other congregate care models, serviced apartment and unit-type models, so that the sorts of innovations that you referred to from the Netherlands, and there are other examples as well, could flourish. By pulling these two functions apart let's concentrate on what is the right care that people need and be delivered to them and let the housing options and where people live be a much more diverse range than currently exists. I don't know if you have any - - -

MR COATES (CWA): I'll speak first and then Donna will. The problem, when you talk about housing of any description, is in Western Australia there's a waiting list of 24,000. There's a massive amount of competing demands for housing.

MR FITZGERALD: This is social housing?

MR COATES (CWA): Yes, social housing.

MR WOODS: Yes.

MR COATES (CWA): Therefore aged care carers get in the queue with a whole range of other people. So I guess my only comment to that is I think that this is to be applauded, your own views and comments to be applauded, but it's only meaningful if resources are put into it. So I guess what is missing compared to the old - caring for older people report, say to the disabilities, is some form of commitment for a significant increase in resources. Sorry, Donna, jumped in there.

MS TURNER (CWA): Just a question: so do you see under your recommendation that a family where the needs are mixed - so one of the people is say an adult with disability but under 65, and the parents are older, so over 65 - do you see that they could end up having some kind of supported accommodation together?

MR WOODS: There is no reason why not, because you're focusing on what are their care needs. Where they live is a separate but related issue. There can be all sorts of accommodation models that allow for multi-family relationships and community relationships. I know certain of the CALD communities in fact are looking at our report and saying, "Well, this is really good, because we're not having to rely on being able to get 10 CACP packages or 20 EACH packages." What we're talking about is an entitlement to care. We will then work with developers and others to develop accommodation options that support our communities. But the same can apply in relation to disability and aged care.

MR FITZGERALD: I think we need to see some really innovative and evolutionary-type approaches, both in the disability and the aged care system. If you look at both reports we're very conscious of the impacts of those - and I'll come to that in relation to carers when Mike has raised his other issue. You'll see that we've been very conscious about how they come together, but one of the most exciting features of this is going forward that by separating accommodation and care you actually allow a whole range of new accommodation options to open up into which carers they have provided. So you will see the providers will be providing accommodation for people with disabilities or older Australians for people in need of social housing, into which disability care comes, aged care comes, and other services.

So if you look at the long-term impact of both reports, you'll see that the types of accommodation we will end up with will be considerably different and more flexible than what we've got because we've separated accommodation and care. The difficulty - the point you raise - however, for those of limited means there is an issue about resourcing, absolutely. All the models in the world won't actually deliver more housing unless there's more resources, so that is an issue and we're going to be doing

a little bit more of that in the final report.

The actual options available I think will be much greater than we have got now. Accommodation is one issue and care is another issue, yes, absolutely. But your point is more fundamental: "Well, where are the resources going to be, particularly for that social housing?" We agree.

MR WOODS: We've only got a few more minutes.

MR FITZGERALD: I read your submission and your presentation but I think we can actually put you at ease in a number of areas, and it's important we do so - and please interrupt me if you want. The first thing is that carers will have two fundamental entry points. In our model the carer support centres will do exactly what you've said; that is, they will be centres that will provide services for people by caring for people with disabilities, aged care, mental health and medical. So it's one set of services.

Taking your concern about the situation where the older Australian, the older person being cared for, doesn't wish to access the system. The carer just accesses that care support centre directly, just like they do here in WA now, directly. Now, you've got this access point but that's okay. That centre, whether it's run by your association or not, is not of issue to us at the moment - and I'll come back to that. So you have direct access into the carer support centres. If you want a particular hub like you've got in WA, that's fine. It makes no difference. But the second point is very important: if the person that's ageing needs to access aged care services, they will need to go through the gateway. When their needs are assessed, the needs of the carer will also be assessed in conjunction with that individual. Arising from that will be a set of entitlements, for example, planned respite, or a referral to the carer support centres for a range of other services.

In our model the carer support centres are, as you want it, block funded. A planned respite would be subject to an entitlement. So in the disability system, the same thing: their assessment process for the person with the disability, they will assess the needs of the carer in conjunction with the person with the disability. That will lead to a set of entitlements or a referral to the carer support centres. So in fact the system is very easy. It's much easier now. It's considerably easier than the current state. You either access the carer support centre direct or, if it's in conjunction with the person that's ageing, you enter the gateway. End of story. There's two access points. Much simpler.

MS TURNER (CWA): Can I walk my way through this proposal?

MR FITZGERALD: Briefly, yes. So I'm a carer of a child with a disability and an ageing parent, so I will go to the gateway to be assessed at the gateway in relation to

my ageing parent.

MR WOODS: If the ageing parent needs care and support then you do.

MR FITZGERALD: If the ageing person needs aged care services, yes.

MS TURNER (CWA): Yes. I go there and I'm assessed there at the gateway. Then for my child I go to the proposed NDIS.

MR FITZGERALD: Yes, correct. If they require disability services, yes.

MS TURNER (CWA): Okay. I'm going to be assessed there as well. So I've been assessed - - -

MR FITZGERALD: The one thing you would have to deal with is, the carer would access the carer support centre for any needs they want, but in relation to the person that's ageing they will have to come through the aged care gateway. For the person with the disability they will have to come through the disability gateway. There's no way we can combine those, and can I say it's quite simple. At the moment if you want a disability service it's very difficult to access disabilities services, extremely difficult, in most states. WA has the best system. If you want to access services for aged care you've really got to go through the HACC process or you go through the ACAT rounds or you go through a whole range of different things. Both systems simplify this enormously.

I read your submission. We actually meet with all of your objectives, absolutely. One thing I have to be very clear about, it is not possible to combine the aged care and disability assistance together. It is possible to have a consolidated carer support system. That's what we're doing. That's what the carer strategy is about. That's what the carer recognition legislation would lead you to.

MR COATES (CWA): So is the carer support centre a gateway as well. Is that what you're saying?

MR FITZGERALD: A carer can access that, absolutely.

MR COATES (CWA): An independent carer.

MR FITZGERALD: Absolutely.

MS TURNER (CWA): So assessment of the carer could be done at the aged care gateway, at the NDIS, and then at the carer support centre?

MR FITZGERALD: Can we go back a bit. You're missing a very important point.

If you are caring for an older Australian who needs aged care, his or her needs need to be assessed.

MS TURNER (CWA): Yes.

MR FITZGERALD: His or her needs will be assessed at the gateway, but we're expanding what happens so that we actually take account of what's happening to the carer, the carer's capacity to care, and the carer's own needs. So it's an added service.

MS TURNER (CWA): That actually happens now in WA.

MR FITZGERALD: Yes, I know that, but I'm trying to talk about the national system. The same thing will happen to disability; it's a significant improvement. For the first time ever - in 90 per cent of Australia - the carer's needs will be assessed in conjunction with the individual. That does not happen in most states. But independent of that, totally independent of that, the carer support centres, run by your association or other organisations, become a direct access point. You don't have to go to the gateway. You can access it directly. This is a significant improvement on most of what exists around Australia. I acknowledge WA has done certain things, but if you look at the national scheme - I just make the point, when I went through your submission and your comments we're actually very closely aligned to the needs that you've identified, but there may be issues that aren't.

MS TURNER (CWA): Okay. My question would be about that: is there some way - and it's what we do now - of the assessment being shared through some kind of information-sharing protocol between agencies, because for carers it's that repetition of the assessment that is a concern.

MR FITZGERALD: Well, you have to be clear: are you talking about between the aged care gateway and the disability gateway? Anything is possible. Neither exists yet. So in the development of those they can, but one of the things I just need to repeat again, we looked at, as a commission, whether we could combine the aged care and the disability systems. It is not possible. They are fundamentally different systems. They fund it differently. The expectations and aspirations of the groups are different. So in the end, rather than trying to create a camel, we said, "Let's just be fair dinkum about this. Let's get the aged care system right and let's get the disability right, but let's then make sure we've got to consolidate it for the carer," and that's what we think we've done, but we might be wrong.

MR WOODS: I'm going to have to draw this - - -

MR COATES (CWA): Just one comment: but, Robert, that all sounds great for disability and aged, but I guess in the opening remarks - are mental health on board with this and health on board with this?

MR FITZGERALD: From the carer's point of view, we can only deal with what we can deal with. If the national carer strategy adopts a common approach; that is, national carer support centres conducted by your other organisations, and we all agree that carer support centres provide services for carers of people with mental health, aged, disability and chronic medical conditions, and then separate to all that we work out how to fund it.

MR COATES (CWA): Okay.

MR FITZGERALD: We're not doing an inquiry into mental health, we're not doing an inquiry into medical conditions, but it makes sense. At the end of the day, governments like sensible solutions. The big issue for government will be, "Well, who funds it?" That's the issue. That's a different issue.

MR WOODS: I am going to have to draw this to a close but thank you for not only coming today but also for your contributions, not only in terms of your own submission but through the national framework.

MR COATES (CWA): Thank you.

MR WOODS: Can I ask St Bartholomew's to come forward, please. Could you please, for the record, state your name, the organisation you represent and the position you hold.

MS KINGDON-BARBOSA (SBH): Good morning, commissioners, I'm Sally Kingdon-Barbosa. I'm the aged care manager from St Bartholomew's House.

MR WOODS: Thank you, and thank you for providing a very clear description of what you do and what your mission is and your views on it, but do you want to take us through your submission?

MS KINGDON-BARBOSA (SBH): Yes. There's just a number of points I would like to highlight. One is the growing number of older homeless people presenting. In gathering evidence one of my other concerns - and it's also a concern of the Homelessness Australia Council - in representing the needs of older homeless Australians is that there is a general lack of research and evidence. We are aware there's scant evidence of older Australians occupying caravan parks, boarding houses. So the title of my paper, The Gap People, clearly is identifying this trend.

Obviously through services such as our assistance with care and housing for older Australians the caseload, the increasing caseload is on-the-ground evidence of this trend of older people and also prematurely aged. It's those prematurely aged and the people that are presenting that are aged - they have mental health issues, they have physical health disability, alcohol or addiction issues, so all this mix, your complex people. Generally what we do find they do fall through the gaps because they are troublesome, they are hard to deal with. So the recommendation is that specialist service providers do attempt to meet their care needs. In doing so we need an integrated approach from health, from ageing, from mental health and alcohol and all disability services. So government needs to be integrating the service approach, and we strongly urge this; both at a ground level in terms of service but also at a policy level there needs to be that approach.

So that's in terms of care needs. Then in housing needs we're needing - and I know the commission does pick up on it. Other housing models - quite often prematurely aged are too young to go into residential care, they need that supported accommodation. Sometimes that support can be intensive, particularly in the case of a mental health person. They have episodal times of being unwell and then they're back on track and everything is going kind of okay, but the care needs to be responsive to when you need to be just there to hold them and stop the crisis because what - and this is where we need further evidence, certainly.

I don't believe you'll have the evidence that people that I'm describing are presenting at emergency, but we don't have the figures - sorry, we do, Paul Flatau has

the figures in terms of the cost to emergency services. But in terms of numbers presenting it's unclear. As I said in my submission, a Geraldton social worker rang, "Do you have accommodation? This person is costing at least $1000 a day. We have nowhere for them to go." So I think that's a good - well, certainly a good argument back to government is you're paying here, it's a hidden cost. However, if we were proactive and put in place supported accommodation models for these people as well as appropriate care and integrated care then we would seek to address the issue. The white paper on homeless and the government made a clear policy decision that by 2020 there would be no more homeless.

MR WOODS: Good luck.

MS KINGDON-BARBOSA (SBH): Yes. So that's primarily the key issues. The other one for specialist providers such as ourselves are care staff, whilst they are trained in aged care are not necessarily trained in mental health or addiction. I would certainly recommend that with the investment in training for aged care that for specialist providers there is forthcoming subsidised training. There's various ways that can be done in those areas, so a holistic response can be provided; also decreases the risk to staff as well.

MR WOODS: Yes.

MS KINGDON-BARBOSA (SBH): I have here - and I would like to add to my submission - this is just a recent paper that was added - recommendations from the Council for Homeless Persons Australia. It's hot off the press. They actually go into more detail. They are recommending - their key advocacy positions are that: 220,000 new dwellings of affordable housing is provided by 2020, so that's going towards addressing that policy statement by the government; that there's a standard template for local environmental plans, which should include provisions on accessible housing, so that at least 10 per cent of all new multi-unit dwellings are adaptable and all new multi-unit dwellings are visitable with the intention of increasing the supply of adaptable housing over the next 10 years. I know Julie Johnson and I know she put in a submission. She is a representative in the Kimberleys. She was saying a lot of the housing built in remote communities isn't adaptable for older people, and so this is what this is also saying, not just in the Kimberley but as a standard.

Given the growing number of older population at risk of homeless due to housing stress, we seek 10 per cent of all new built social affordable housing to be allocated to this target group in line with homeless prevention strategies as identified in The Road Home. Aged care funding is allocated to specialist homeless services to provide ongoing support tied to housing allocation for a small but significant group of older homeless people with complex needs.

The final position and recommendation is to establish a strategic working group to strengthen the partnership between Department of Health and Ageing, specialist homeless services and aged care services to deliver the best possible outcomes to older people who are homeless. So essential we are really advocating for a much more integrated approach to addressing the needs of homelessness for older people.

So going into the residential care part, one of the recommendations for the commission was shared rooms. As a provider of accommodation for people who are at risk of homeless and homeless people, shared accommodation when you have complex people doesn't work.

MR WOODS: You probably don't need to elaborate too much on that one. We understand that point.

MS KINGDON-BARBOSA (SBH):   Definitely we don't support that recommendation.

MR WOODS: No.

MS KINGDON-BARBOSA (SBH):   Definitely not.

MR FITZGERALD: Sorry to interrupt. Can I just clarify this: what is the sort of accommodation that you provide? Do you provide one bed with one bathroom, or do you provide single bedrooms with a shared bathroom?

MS KINGDON-BARBOSA (SBH):   We've got a mix. We have shared rooms with one bathroom and we have single rooms with a bathroom attached. We have received funding for a new development in which we do have all single rooms with an attached bathroom. We have had quite a lot of criticism that, "How come these homeless people should have such luxury?" That's sort of an aside; it's really about meeting the care needs of people who have on top dementia, you know, wandering tendencies. Social isolation is very much a common element of people. I mean, I don't like to categorise but - - -

MR FITZGERALD: No, sure. Can I just ask, the funding for that - when you say you've just been funded for that, who's funding that?

MS KINGDON-BARBOSA (SBH):   Federal government capital funding.

MR FITZGERALD: As aged care?

MS KINGDON-BARBOSA (SBH):   Aged care, yes.

MR FITZGERALD: Thanks.

MS KINGDON-BARBOSA (SBH): The other concern I expressed in my submission was about the gateway, and again it's a great concept. I think in developing that concept further for this particular target group and, again, indigenous people - I was at a consultation recently when we started sort of taking it a bit further, what it would look like and how people would access. I guess when people are already marginalised, particularly our indigenous population and our homeless people, there needs to be consideration how that may take place. Obviously remote communities there's not necessarily a telephone, which can often be a first point of call. The face to face works well but that's very intensive and how does that happen. Paper communication, again doesn't always get to the people. So it's a challenge in ensuring that people are directed in and how that is, and obviously other languages as well. So that's a challenge. I think that just about covers what - - -

MR WOODS: Let's go through those. If I pick your last first because I think we can deal with it fairly simply. In terms of the gateway we would envisage it working very closely with groups who outreach to certain sectors of the community. So you would provide an interface, you would provide the support. You've got workers out in the field working with people, homelessness and related issues, and so you would assist them in the process of transacting an assessment of their care needs. The gateway wouldn't, sort of, cut off your relationship with that client group. If I can pick up the broader issue of integration of services, we can see an argument for the specialist providers - and there aren't a large number of you but they're fairly identifiable who they are and we've visited a number of facilities and talked to a number of your colleague groups - that there is an argument that block funding might be the most appropriate model for delivery of integrated services where it is a specialised facility or set of services.

The issue becomes more complex when we're talking about providers who might have a cluster of homeless people as part of a total client group that they're servicing, either in the community, through community work or through a facility, or where there are one or two people who come from a homelessness background but are part of a mainstream servicer. Those two groups - the clusters and the isolated one or two people - are a slightly more difficult issue to deal with, but we'd certainly welcome your views on whether a block funding model that would still sort of have an underlying ACFI or related-type framework applicable either for residential or community care - whether that would be a better solution for the specialist providers and for dedicated facilities.

MS KINGDON-BARBOSA (SBH): Yes, definitely I think the block funding would work but I also take your point of smaller and regional areas and the issue there where - - -

MR WOODS: You mentioned Geraldton, Broome and - - -

MS KINGDON-BARBOSA (SBH): Albany, I know. Again, it's about that unmet need, that unknown need in many of those cases. Also the growing trend too in terms of homelessness now with younger people being homeless, whether the intervention strategies - you know, prevent them from being older people too - in planning for the future and what that will look like. I don't like to say, "Yes, it will work for us but sorry about the other providers that are providing services" - and what that would like, how an allocation can be made - whether you have a growth strategy there for - I mean, you really don't want that either because you're hoping to address the need and I guess it's really about intervention.

MR WOODS: In our consultations with your colleague groups and now with you as well we encourage you to work collectively on what a block funding model for specialist homelessness providers would look like. So that's your homework.

MS KINGDON-BARBOSA (SBH): Yes.

MR WOODS: I mean, you know who the other groups are and you can collectively have a dialogue amongst yourselves on that. Can I just briefly ask about staffing, and you made the valid point about the need for training in a wide range of matters, how are you finding recruiting adequate staff both at the personal care worker level and at the RN, EN type level, and the quality of the training that they are getting and whether there are suitable modules that can be added to sort of a basic cert III that deal with a wider range of issues?

MS KINGDON-BARBOSA (SBH): The biggest issue for us with the training is the backfill, paying for the backfill. The other issue at a carer level is, and which is under review with the Fair Work, the level of pay. Because we are 100 per cent government subsidised the pay levels are appallingly low and embarrassingly low. Because we're quite a unique service provider often staff are attracted to come to work at St Bartholomew's not because of the pay; so we have been quite fortunate. We have had, though, in that, when there was the first wave of the mining boom real difficulties in recruiting appropriately, and myself a classic case. I came into the sector no background in aged care, however background in community development and management. Other staff have been brought in with skills in other areas, retrained on the job.

Some of the training feedback from staff, the self-paced learning does not work. Staff really enjoy the interaction in a situation with peers and colleagues. So that's the training model that they prefer. It's too restricted. I mean, it would be good if there was train the trainer as part of subsidised funding, the cert IV in train the trainer, and certainly the certificate III in aged care, whether it can be extended to include some of the community service models of mental health, addiction or you

look at what already is out there through other providers and have the funding to actually buy in that training or to be able to go and do that training.

MR FITZGERALD: Can I just ask a question about premature or early ageing of homeless men and women. Currently how are you finding that? You've got both community care packages and residential and I suppose I'm asking the question how do you find it now, but guidance for us - we've got this thing about people being pension age but then we also acknowledge a whole lot of people who have premature ageing or age-related conditions that happen earlier. Your guidance about how we should handle this issue for homelessness because you have very young homeless people but you also have old, but not so old, if you know what I mean.

MS KINGDON-BARBOSA (SBH): Yes.

MR FITZGERALD: So what's your guidance on this area and how do you deal with it now?

MS KINGDON-BARBOSA (SBH): Well, I guess one of the overarching challenges if for a prematurely aged person who has written on their ACAA "impairment" and there is no actual diagnosis. One of the biggest challenges then is having mental health or older mental health who picks up and we are often at loggerheads. So the biggest challenge for us is the advocacy and really saying, "This is your duty of care to somebody," but the buck get passed.

MR FITZGERALD: Just let me clarify that as an organisation that provides support and advocacy for individuals you have to really fight to ensure that the person is included in the ageing system because the guidelines are very - in one sense they are very good because they're very flexible and in the other sense they're very unclear.

MS KINGDON-BARBOSA (SBH): The success really depends on having established good partnerships with external providers and when that isn't existent or the external providers are overworked then there is an issue, there is a big issue, yes. But certainly those partnerships - - -

MR FITZGERALD: The other issue and this relates to what Mike was talking about before, one of the issues is how does a person expressing homelessness come through the gateway and we've talked about those supports which are very important. But just one question is about the community based programs, the community packages that you currently have. As part of all of those packages, would you say that you provide either care coordination or case management? Is that an intrinsic of dealing with people experiencing homelessness?

MS KINGDON-BARBOSA (SBH): Case management, yes, and the care is both.

It's totally integrated. It's a very fluid arrangement too both in terms of how much time you give to a person and so sometimes you will go well over the allocation of six hours a week but it's necessary at that time and then back. Also looking at, "Who else can pick up?" and that is always the difficulty because people - not all but quite often, particularly when particularly are unwell - can be rather difficult. So often you've developed a relationship or a rapport of how you deal with that but, yes, definitely the care.

We're constantly faced with ethical issues on that too, particularly when people make lifestyle choices that we would not agree with. So that whole dignity around choice and decision-making and then how far do you go? Are you enabling or - - -

MR WOODS: On that one briefly, I assume you don't try and disentangle the times when you are providing care being the advocate and being the case manager, that they just are part of the things that you have to do to help that person. But do you get different funding streams for different types of roles and do you just try and push them all together?

MS KINGDON-BARBOSA (SBH): No, it call comes under - that's under ACAT.

MR FITZGERALD: Just my last question. The home population is fairly mobile but by the time they come into your services and receive any of these aged care packages, either the community care ones or the residential, do you find there is much movement, people moving in and out of your service at that point or once they get to this point they're fairly locked into your organisation?

MS KINGDON-BARBOSA (SBH): Yes, they do, they stabilise with regular food and just having somebody being there definitely. The moving out is maybe excessive drinking in recent times but not always either. What can happen, and this is where I guess we're integrated, it can be eviction because unwell, there hasn't been a timely response from mental health services so then pick up and start the whole process of trying to find housing again for a person. But there isn't too much movement once the appropriate supports are in place.

MR WOODS: Thank you. That has been very helpful. We are acutely conscious of the role that you and related organisations play in this area and we look forward to your further thoughts.

MS KINGDON-BARBOSA (SBH): Thank you. Thank you for this opportunity.

MR WOODS: We will have a brief break and resume at 11 o'clock.

MR WOODS: Can I ask the Aged Care Association Australia to appear. Could you please, for the record, state your name, the organisation you are representing and the position you hold.

MS ARCHER (ACAA): Anne-Marie Archer, the CEO of the Aged Care Association Australia WA.

MR WOODS: Thank you for coming. Talk to us.

MS ARCHER (ACAA): First and foremost I just want to acknowledge that ACAAWA welcomes and strongly supports the aspirations and intentions that underly the framework of the draft report and we also recognise the work that has gone into it today. Our federal office has actually put in a submission which you would have.

MR WOODS: Yes, we do.

MS ARCHER (ACAA): I don't intend to reiterate the majority of that but there are some key points I will raise in relation to Western Australia. Before I go into some of the key points for Western Australia in regards to the recommendations put forward by our federal office, one of the really key components that I'm sure you are aware of is the regional cost variation in Western Australia. Unfortunately our state has a building development demise title, which is not a claim to be proud of, but unfortunately due to the fact of construction costs, workforce, indexation, in regards to the operational costs, the capital access and also some of the recent capping of - well, issues around extra service allocations et cetera, and these compounding the capacity for the industry to develop in Western Australia, and as you are aware there has been a diminishing take-up on beds in this state, notably more than other states, and this started occurring in 2007.

We did forecast to both parties at the time that this would be an issue given the cost of construction and the operational costs in the state, and unfortunately this has escalated every year from being a 64 per cent take-up in 2007 through to this year, when we had 1564 beds available, to only have 314 allocated. So that's a major concern, that this decline is happening. Next year we've got 2485 prescribed to be available and we really don't know who will be putting up their hand for that allocation at this point, given the situation. So this compounds the fact that this reform is absolutely paramount for Western Australia.

In regards to the recommendations themselves, the association supports the separation of funding for aged care services into the four major cost components of personal care, health, everyday living expenses and the accommodation. We also welcome the immediate removal of the distinction between high care and low care

places and we're also mindful of the fact that there needs to be a careful transition of the planning and management to ensure it becomes sustainable for those who are already in the existing facilities. We also support the removal of the restrictions on the accommodation payments and the cap on the accommodation charges, particularly in high care. In addition, the issue around the extra services restrictions, that's one of the driving forces in Western Australia and unfortunately there are some major areas in a large component of the state that is actually - metro - now unable to apply because they can't put an extra service license in place with the 15 per cent that was applied to regional.

The access argument that was put forward is absolutely and fundamentally flawed because unfortunately if you actually deny someone the capacity to build a building because they can't normally access the financial resources, or service alone accordingly if they can't get a bond in high care, they will not build the building. That will then deny anyone who is actually then a supported resident who would have potentially got a percentage of those beds. So therefore you create a more competitive market that will actually impact upon everyone and particularly those people who were supported.

We also would support the recommendation on the removal of the ratio between the residential and the community care. It just does not reflect the demographics. In regards to the rooms and the provision of a twin room, we actually support the notion that it should be a single person with a shared en suite as a minimum. I know you've received a lot of feedback on that one. Otherwise it just sits below the market expectations.

In regards to the supported residents, one of the areas that I'd like to flag is the fact that we have some regional planning issues that need to be addressed, I'm sure nationally, but for WA specifically we have regional areas. Say, for example, I'll use metro east. You actually have within that region areas that are quite affluent, you have north Perth, for example, and within that same planning region we have members who are trucking in gas because we're outside of the grid. So it is so diverse, some of those planning regions, and yet the application of the process has been applied across that board and those regions. So the planning regions need to be reviewed; realistically probably need more of smaller planning regions that actually could reflect the demographics.

The numbers for supported residents would be better assessed as a census number that would actually reflect the actual true demographics. We know there is a shift where people moved where they prefer, where families are, accordingly, but currently the 40 per cent that's in place is yet to be explained. It's not reflective of the community and the services, and also the demographics that it's in.

MR WOODS: So just picking up as an example for metro east, are you familiar

with the sort of boundaries of what that looks like?

MS ARCHER (ACAA): That's actually an interesting question. I've been trying to get some more detail on the break-up. That's a large area.

MR WOODS: I mean, the fact that you're including north Perth in it suggests that we're coming in a long way to start with.

MS ARCHER (ACAA): We are.

MR WOODS: Then heading out - - -

MS ARCHER (ACAA): You're heading right out past the hills, sort of. That corridor is big. When you've split, say, for example, Perth, into predominantly four quarters and you have your corridors north and south, sort of thing, it makes it very challenging when you're trying to apply blanket approach to areas when they are so diverse. So therefore the planning itself needs to be reviewed as to how that's allocated. That's going to become absolutely paramount when you start looking at your supported resident percentages. I appreciate there's currently a regional target within those areas, but when you look at the regions and their make-up they are so diverse.

MR WOODS: We'll come back to how we can better define those in a minute.

MS ARCHER (ACAA): In regards to the supported residents there needs to be an appropriate level of accommodation funding that would actually reflect the market forces, which then in turn would reflect those planning regions or those areas which would obviously be more expensive to build in accordingly et cetera as per the changes that would be afforded for bonds accordingly. In regards to the price setting of that process there may be a role there for the commission to actually review these targets for the supported residents themselves. Where there's a reasonable price-setting supplement it would actually be more attractive to accommodate supported residents in areas so they actually weren't forced to move from their own community. It would also be likely to ensure that the regional and remote providers could actually meet the demand for services in a sustainable way, if there was a genuine review of the accommodation charge.

MR WOODS: We'll go through that.

MS ARCHER (ACAA): The other elements we would like to see is the Commonwealth contributions towards supported residents, the increasing of that be introduced very early in the implementation process, in stage 1, and during the transition phase that all supported residents be at the higher rate, regardless of the fact that it is a target rate because those figures currently, as just mentioned, aren't

reflective of the real regional targets.

MR WOODS: We'll add that to the discussion.

MS ARCHER (ACAA): In regards to access for capital, it could be a consideration that the capital funding be afforded to providers through the pensioners bond scheme at an interest rate that's set appropriately, similar to what is happening with zero real interest, just to ensure there's a capital access. In regards to the assessment process that there be a review capacity, once people have come through the gateway, for providers to actually review the care needs. This could just be managed in very much the same way it is with the current validation process.

Workforce is certainly something that was discussed earlier and possibly sort of underlies one of the greatest problems we've got here in the west. The position that ACSWA put forward in regards to WA being considered a regional centre in an immigration sense, we would definitely support that. The immigration processes and the impact that has had upon our state is tremendous, particularly in regards to the elements around the residential care officer. We've had reviews from the federal Immigration Department that have unfortunately reassessed that for metro and we can no longer access. We've had quite a few people removed as a result of them not having disability services in that environment. The 457 base rate - just unobtainable and impossible in Western Australia because of operational costs. That was covered earlier. Unfortunately providers are having to be focusing on a student visa. The training visas come under a state review and unfortunately aged care is not on that list either. So we do have some definite shortfalls.

One of the other elements which was raised was training, and the backfill is also a huge issue. There's a lot of funded training access, but unfortunately a provider can't fund both the person to attend and backfill at the same time when their funding is so restricted. So some more creative or innovative ways of training mechanisms would be important, and the image, of course, you mentioned earlier. One of the elements is we are looking for major reform so we can create some stimulus and growth, but the reality is you could have a business case but you actually need a human resource case to actually manage that delivery of care.

In regards to service delivery, dementia is - as you aware, accounts for up to 60 per cent of residential care falls, so therefore it is becoming core business for a lot of aged care providers. Dementia carer is now becoming a mainstream service within the residential environment and I'm sure also in the community care environment with greater demand. We would like to put forward a request for a recommendation that the funding model should also include specific supplements for those caring with dementia and also some consideration towards barrier being shifted from mental - the breakdown between mental health and aged care services so people with severe behavioural symptoms can receive the care they need. It could be a

model mix that involves more psychogeriatric services as an outreach model similar to what has been recommended with the palliative and end-of-life care. So we just need to make sure that in future we can manage those provisions of services that will grow in time.

In regards to the gateway model, that will also become an issue when you've got people who are ageing who are - the cognitive impairment and dementia. That will have an impact. It needs to be taken into consideration in regards to the assessment and the support for those people in that environment.

In regards to the transitional arrangements overall, we would potentially like to see that the aged care implementation taskforce definitely is supported, be independent of potentially the Department of Health and Ageing and/or they have good, strong representation from industry to make sure it can have a good process.

The only other key thing that I would like to flag is in regards to the actual final release process. I would like to ask that the industry, consumer groups and stakeholders, actually have access to the report in the early stage, because this is such an important reform process that we just can't afford to be in a situation where we're unable to respond to the media. Unfortunately I know there are particular processes in delivery and release of documents but this is not something - because the people who will be the broader consumers is an ageing population, and that's an enormous demographic out there, we can't afford to have them misled or alarmed because people can't make informed comments.

I know that that's sort of - I would hope that that - and that's not a recommendation you can necessarily make but hopefully that will be considered in the process; because we want to make sure that this is supported by, obviously, the political processes and most importantly, we want to make sure that people are making an informed decision, particularly consumers, who will be having to change the way they invest in their care.

MR WOODS: Just on the release. The release of the draft was something under our control, and we made sure that people were aware as quickly as possible of what its contents were for when it was publicly released. But the release of the final will be up to government, not up to us. We will pass on your comments, and quite clearly when they make a decision and then choose to release the final it is in everyone's interest to know what is in that report. So we will do what we can to encourage their awareness of that.

MS ARCHER (ACAA): We know journalists have had deadlines and they have news cycles and unfortunately if we can't get the document until 10 hours after their news cycle - - -

MR WOODS: Yes. No, we understand that point. As I say, the draft we could control but the release of the final is up to the government, not us. Couple of issues, if I can raise, and then Robert will no doubt have a few. Supported residents, couple of issues there. One is in defining the regions. Although we won't create a new map that will have regions there are several considerations. One is that we're obviously very conscious of the proposals for the development of Medicare Locals and local hospital networks. We're not predicating our reforms on that they will be (a) up and running, and (b) wildly successful, although that may occur in both instances. But we are developing our reform such that were that the case that then either a merge or a collaboration could most easily be developed. So we're aware of what is happening in that space but we're not holding up our proposals on aged care reform to see how those develop.

But there is the separate question then of what should be the appropriate regions. We won't rewrite the maps but we will look to see whether we can offer some principles of what would constitute good regional planning and how those regions should be developed. So if you have particular principles that you think should be taken on board and for us to consider for inclusion in the final report, that would be helpful. We have asked that of your colleagues in other states and territories as well but if you could pursue that and either collectively or individually - preferably collectively - come back with some ideas on what should be the underlying principles for defining the regions, that would be helpful.

In terms of pricing for accommodation, we are recommending in the draft - it would stay in the final - that the cost of providing accommodation for supported residents is transparently assessed and recommended to government. So there are two issues: (a) what is the standard. Yes, we do understand yours and many other's views on a two-bed versus alternative standard. But second then is the question of what is the appropriate cost of developing that, because from our point of view there needs to be transparency in that process; that you have a capital strike, as we are witnessing at the moment, if the subsidy that is provided is insufficient to meet the standard that is prescribed. So that's a simple proposition and we totally understand that one. That's why we're proposing that the regulatory commission would undertake a transparent pricing process to identify what is the cost of delivering accommodation at the agreed standard. I think that will - I mean the decision then is finally for government, but there will be a transparent assessment process and recommendation to government.

MS ARCHER (ACAA): I think there needs to be built into that though an ongoing review process as well.

MR WOODS: Yes, so it's not just a one-off.

MS ARCHER (ACAA): No.

MR WOODS: It would say, "What is the current relevant price?"

MS ARCHER (ACAA): That's where it comes into the planning issue where you've got regions. So if you've got the price where I have just described metro east and you've got north Perth and you've got people up in the hill - I mean the disparity is so apparent.

MR WOODS: Yes.

MS ARCHER (ACAA): So that's going to impact upon that process. So in some ways it does dovetail into the planning or the region allocations.

MR WOODS: Yes, absolutely. The next issue in the supported residents was in relation to the transition. I noted your plea that whatever is the new price, and it wouldn't be $28.72, it might look more like $40 or whatever the price is - it's not going to be us who sets that price - whether it should apply to some of the old stock that patently doesn't meet the current standards and particularly old stock that has basically been written off over time and is just waiting to be exhausted and knocked down, I wouldn't see why they would get the higher price.

MS ARCHER (ACAA): That wasn't necessarily what I was suggesting. Potentially, I suppose, you may put a benchmark or a line in the sand that goes within the framework of current model of the Aged Care Act or you may have a provision there that those who are meeting the current legislation, bill standards to date, that might be y our mechanism. I'm not sure, I can't prescribe that for you. But that potentially could assist those people to continue to build up those numbers so then when we have a transitional process - it's very difficult for those - and I'll use Western Australia, of course - who have a target and a regional target that is just absolutely unattainable in their areas, yet they still want to make sure they accommodate supported residents. It might only be 10 per cent in their catchment area but they would like the opportunity to be able to do so. But it's a disincentivised process currently financially for them to do so which shouldn't be the case, they should be encouraged. So we need to probably put that on its head to become incentivised for those - well, for those, say, it might be within the framework or the Aged Care Act.

MR WOODS: Provided there is a sufficient return on the cost of providing that accommodation.

MS ARCHER (ACAA): Yes.

MR WOODS: One or two providers have suggested to us also that it would be nice to have the new price extend backwards to all of their current - - -

MS ARCHER (ACAA): That would be nice, I'm sure.

MR WOODS: We didn't quite see the merit of that proposition. The other one that I will just raise briefly, in terms of assessments clearly the gateway has to be the front end for people who require services to have an assessment and it wouldn't be done necessarily by gateway staff, there would be a whole range of services that they would draw on to conduct the assessments. But you then raised the question about reassessments where there is material change of circumstance and from our point of view, if we take residential care, those who know and understand the situation facing the resident are the care staff who provide for them on a daily basis and they would be the first line of alert that there is a significant change of circumstance.

As at the moment with providers then doing that follow-up assessment and reassessment process, we would think that would be largely unchanged but with obviously a risk management process, validation process et cetera in there to ensure that it was a proper constituted assessment. So apart from notifying the gateway and being authorised to move to a different care level of funding, the assessment process would occur.

MS ARCHER (ACAA): Much of this will be diffused if you do remove the distinctions between high and low care and that's unfortunately where some of the problems lay with the ACAT assessments accordingly.

MR WOODS: The ACAT equivalents, the gateway would be using the tool at the front end that is the tool that then gets used all the way through and in community so there - - -

MS ARCHER (ACAA): There would be one tool.

MR WOODS: Pardon?

MS ARCHER (ACAA): It would be advantageous particularly when they're doing the behavioural assessments and to make sure that they're using the same tool which is very challenging at the moment when you're assessing on two different tools for the same - - -

MR WOODS: Yes. With community there is a question of whether that does need a slightly different process because it is a slightly different situation where you are coming in and out on a daily process but not actually providing 24-hour care and support for somebody and whether the gateway needs to adopt a slightly different process for authorising and validating significant changes in care needs is an opportunity question and if you have views on that, that would be helpful to us.

MS ARCHER (ACAA): I think that would be something probably coming from the community care sector.

MR WOODS: Absolutely.

MR FITZGERALD: Just an issue that you haven't raised but I just want to get a view. ACFI and its relevance in relation to residential care. I just want to get a sense from y our members, if I can, as to what they think is the right way forward. Later in the day there will be a presentation by a substantial provider that will call for the ACFI to be changed to a levels approach, that you can substantially move from 64 classifications down to a much lesser number of levels. It is also relevant to what we are trying to do in terms of the entitlement to community care and what would the entitlements look like, are they in fact bands or are they more prescriptive identification of services. You may not have a view on this at this stage as to whether or not your members have a view about the way in which the ACFI operates and the way in which the entitlements should operate for the community care.

MS ARCHER (ACAA): Predominantly our membership has a residential focus so in regards to community care we haven't received a lot of feedback on that. In regards to the residential care and environment and ACFI the greatest number of comments we receive is in relation to behavioural and therein lies our problem. So if you don't have a diagnosis for dementia, you don't get the funding for the care provisions. There is a big gap there, particularly then when you - just following on from St Bart's you actually have an issue of a lot of people who have cognitive capabilities or there are issues there that they are not getting funding for, yet they are young, they're strong, they're physical and they're difficult to care for without the care funding coming with them.

So that is a market that a lot of providers are now having to struggle with and those people aren't able to fit into the state systems and they are coming - that is one gap that we are identifying and that will actually probably exist also in the community care to greater extent and that will probably dovetail into what the carer's concerns about.

MR FITZGERALD: The second question, you raised this issue about greater linkages between the mental health system and aged care and that could be said of the health care system. In our report we have encouraged the government to look at further in-reach services into residential care but also aged care specific health teams that would operate both in the community and in residential. I was wondering whether you have any particular models that your association thinks are pursing in this area.

MS ARCHER (ACAA): I will certainly investigate that for you and if there is something we can get to you in the near future I certainly will. I imagine there will

be a few different views on how that could work but an in-reach that you have actually already suggested would be a preference at this point.

MR FITZGERALD: Okay, that's fine.

MR WOODS: Just on the workforce and we have heard a number of other views on issues relating to obtaining an appropriately qualified and skilled workforce. What's your particular perspective on this both in Perth metro and in regional areas?

MS ARCHER (ACAA): Our members are predominantly Perth metro but I would have to mirror the messages that were put forward in regards to access to staff and, unfortunately, as you're probably aware, we actually have a couple more major developments of mining operations in the process of developing and opening. The industry is already starting to raise concerns as to how we are going to manage that and the point was raised this morning that the challenges on trying to get staff when you can't compete with Coles or you can't compete with any basic other service, let alone the mining industry, it becomes very difficult. That's not just for care staff, that's also senior clinical staff when they can earn considerably more on a mining site and to come back and do occasional shifts so they don't have to do a re-reach, that's very challenging when they've actually got the increased cost of living in Western Australia.

So you have to bear in mind for our care staff where people want to live and receive care is in the areas where potentially the cost of living extraordinary. So you're not going to get people who are going to bus in 40 minutes to an area where someone would like to receive their care to get $18 an hour. So that creates a greater challenge as well because facilities are intentionally built where people would prefer. So that in itself, this locality and the cost of living also inhibits access to staff and also in regards to the fact that there is some - I know the unions have voiced that they want staffing ratios, that is just unrealistic, it doesn't reflect the resident mix and we have to be in a situation where it's about the provisions of care, not just heads, and for Western Australia we need access to people who are appropriately trained and they need to be the appropriate people and that in itself is very challenging.

The training you mentioned earlier in a previous session, unfortunately, providers, given the shortages have had to just accept people who have come in with what they would consider very little training and a minimal amount of on the job, knowing full well that not only do they have to bring them on board, they are going to have to start their whole training process from scratch because they need to make sure that person is competent and is delivery good quality care. The challenges that are provided here are not only just the access but the duplication of having to then fund for training, so that all comes into play, but we just don't have the people in the areas where the facilities are.

MR WOODS: So what actual strategies are you employing, I mean, apart from trying to be at the industry level - an industry of choice, but at the individual provider level, presumably, trying to demonstrate that each facility is a good place to work in, in terms of the total package of remuneration and other work issues, the provision of PD. I mean, what strategies, given this dire shortage, are you finding the most successful?

MS ARCHER (ACAA): Well, it's very challenging. We don't have a lot of resources to actually access a lot of options but I suppose flexibility has become one of the major components, and because we have, unfortunately, an ageing workforce and predominantly female, and we have a lot of people out there that aren't attracted to the industry as younger people. That in itself reflects potentially - technology, the environment, the image, they all reflect the challenge. In regards to activities that people do, I mean, each provider has their own mechanisms that they try within their areas, but flexibility has certainly been one of the very few. You've still got to make sure that you've got the appropriate people on at certain hours.

MR WOODS: Anything else that you want to raise with us?

MS ARCHER (ACAA): No, I think the only thing I'd just like to reiterate is the issue around the percentages and the process of the supported residents. That to me is probably one of the really key issues that needs to be recognised, that those supported resident dollars needs to be at market value for those regions. The issue of the trading of licences et cetera, I mean, I know it has been of concern, but the reality is you could almost avoid that situation. If you're put in a position where there was triggers to reassess the value of the accommodation charge and also making sure that that's assessed regularly, you would effectively then have people seeing it as a good opportunity and people should be clamouring to actually then have those residents because it would be an attractive position, as opposed to being in the situation we're in now.

So you therefore wouldn't have people necessarily trying to trade, to offload it. You would actually have people wanting to desperately attract as many of those residents as possible. That's one area I think that really needs to be viewed, and also I know that there was issues around tendering, but that still once again comes down to the real costs.

MR WOODS: Okay. Thank you very much. We appreciate that, that was very helpful.

MS ARCHER (ACAA): Thank you.

MR WOODS: Can I ask Baptistcare to come forward, please. Thank you very much. Could each of you please, for the record, state your name, the organisation you are representing and the position you hold.

DR MORRIS (B): Dr Lucy Morris, chief executive officer, Baptistcare.

MS STAMPALIJA (B): Toni Stampalija, director of strategy and innovation, Baptistcare.

MR BAKER (B): Ken Baker, director of life services in Baptistcare.

MR PRESTON (B): Harold Preston, director of business services.

MR WOODS: Thank you for your most recent submission which very helpfully actually goes through recommendation by recommendation which made for very easy reading so we could focus in on the specific issues and your views on them, so it was very helpful submission. So whoever wrote it, or collectively, please thank them for it. Speak to us.

DR MORRIS (B): Okay. Thank you. We welcome the opportunity to talk to you today and I just want to give a very brief summary about Baptistcare so that you get the context within which we're going to pick up a number of issues. Baptistcare has been around for nearly 40 years. We operate both rural, regional and metro Perth in WA. We employ over 1300 people. We are faith based and not-for-profit, and we are also an organisation that does provide services to people who live with disabilities and mental health illnesses, and it's residential, community and home based. So we've been able to take quite a broad perspective in thinking about some of these challenges that are facing us.

Overall we very much support the visionary approach that's been taken by the commission and welcome it, and certainly in talking to my colleagues in other organisations, that's been the same view. We are also very concerned to make sure that the message is passed on to the government that this particular report and the recommendations are dealt with in total as a whole package that the government is not tempted to cherry-pick. We think that would be a mistake, and we would hate to see a response that was similar to the Henry review. We don't think that would be a good idea.

What I wanted to do was to talk about a number of issues. If I can start with funding sustainability. The current recommendation 6.4 as it stands doesn't provide sufficient capital for the sector to remain viable into the future. The risk is that such a significant loss of capital to the sector will be that providers will not be able to repay bonds over a transition period and they will not be able to handle any transition

process from the payment of bonds system because of the loss of capital. We think it has the capacity to wipe out residential providers in the short space of time. It reduces the revenue stream from accommodation bonds and charges, and there are no other funding sources identified in the report, other than that of supported residents. So we would suggest that 6.4 is not implemented until an alternative accommodation revenue scheme has been identified and is implemented concurrently. Similarly with 6.6 - - -

MR WOODS: Just before you progress on to 6.6, normally I encourage people to put forward the whole presentation before we start but this one, when I read through your response, puzzled me and I'm wondering if it's some misunderstanding and because it then affects your views on some of the others - if you'll pardon me taking the liberty of discussing that one first. What we're proposing is that when a person needs to move into residential aged care that they have a choice. Put aside supported residents. Supported residents would get whatever is the transparently recommended and set by government cost of providing accommodation at whatever the standard is and, yes, I did notice your views on the two-bed, and we probably don't need to spend too much more time on that one.

But for non-supported residents we're proposing that providers offer either a daily or weekly or some form of periodic charge and if they so wish also offer a bond alternative, or you could have some combination of the two. The charge that you set is set by you in accordance with what you think the market will bear and the standard of accommodation you're offering, but there's no prescription as to what that charge is by government. This is for non-supported residents. So you'd construct the standard of accommodation, you would look around at what's the average house price in the local region, what's the capacity of people, and what are the other providers doing, all of those things, and what you need to generate a return on capital and you would set the price. That would be, provided you offer as one of the options, a periodic charge, a daily fee or a weekly rental, you can then also offer a bond and you must publish what they are. So you don't get the choice of saying, "How much money have you got? Let's try and work out what bond would be appropriate."

We're also removing the incentive for people to pay a large bond in terms of retaining their access to the pension by having the pensioner bond scheme there as an alternative for them, so that they can put their money there and access it for whatever they want. It's their equity and they can use it in whatever form they want. But that does allow them to make the choice. But I don't understand in that circumstance your comments about not having an alternative funding source from bonds. I'm wondering if it is an understanding. The rest of the economy operates on the concept of going to a bank with a business case that says, "Here is our expected income stream. Therefore we think we can service debt of X." I know debt is an interesting concept for the aged care sector but the rest of the world operates on it. So the

particular issue really is, from our point of view, one of transition, where some people choose - some people who exit and had bonds then you were going to - if the next person chooses to make a periodic charge you're going to have to replace bond money with debt money on a bankable proposition. But the charge that you set would be set by you. It would be up to them then to decide whether what you're offering is better or worse or different from somebody down the road with a different proposition. But was there a misunderstanding or is that still not meeting your - - -

MR BAKER (B): Perhaps if I can respond. There may have been a misunderstanding there but certainly as we were reading it we saw that the bonds were likely to be capped to the cost of providing accommodation. We saw the fact that with the choice between a periodical payment and a bond, and especially when it's stipulated that they have to be the same over a period of time, that also had the potential to deny us the lump sum. There was - it sort of provided a disincentive, if you like, for people to want to move to a bond. So we would end up with a trickle feed rather than having access to that amount of money for the duration of their stay with us.

MR WOODS: We don't want to create a disincentive for people to have bonds. What we're trying to do is remove the current disincentive for people to pay a daily or weekly rental. They are currently on offer but in your case less than 5 per cent would pay that, probably?

MR BAKER (B): Most would probably pay bonds.

MR WOODS: Yes, exactly.

MR BAKER (B): It would depend on the actual facility.

MR WOODS: Sure.

MR BAKER (B): Some of our people - we have very high concessional ratios - - -

MR WOODS: No, putting aside the supported.

MR BAKER (B): Putting aside that, yes.

MR WOODS: But for the non-supported residents virtually everyone pays a bond.

MR BAKER (B): Yes, it's almost entirely bonds.

MR WOODS: But that's because there's an active incentive to do it, from their point of view, to keep their pension entitlement.

MR BAKER (B): That's right.

MR FITZGERALD: So what we're trying to do is create neutrality. If a person puts a bond with you or puts money into the pensioner bond, they're treated the same way for aged care pension, they're treated the same way for means testing for the care charges, so they're identical. What we do think will happen is the very high bonds that bear no relationship whatsoever to the accommodation on offer will in effect reduce, as they should. This is a very odd market where you pay an extremely high level far and above of what you're actually getting. We think that will change, but there's no capping.

MR BAKER (B): Then there may have been some misunderstanding on my part with regard to that because we did see this reference to limiting the price that could be charged to the cost of providing the accommodation.

MR FITZGERALD: But I should also make the other point. The cost obviously includes return on investment.

MR BAKER (B): Okay.

MR FITZGERALD: There seems to be some - I don't know why this happened in the aged care industry but when you use this term we're obviously talking about costs including a reasonable return on investment for capital.

MR WOODS: But it's you who set the price. So for non-supported residents you set the daily charge you set the bond. As long as you publish it so that people know in advance and can choose between your facility and some other facility - and we've also removed the restriction on the number of beds that you can build or offer, so that if you're successful in the marketplace and people actually like the care you're delivering and the quality of the accommodation, they go to you. If they don't, they move away from you.

MR BAKER (B): But in the seeking of the neutrality, which I think is a good thing, there still needs to be some sort of incentive to actually encourage people to want to take up the bond offer.

MR FITZGERALD: No there doesn't.

MR WOODS: Not from our perspective.

MR BAKER (B): Not from your point of view? I suppose what we're saying - - -

MR WOODS: We don't understand why that needs to be the case. We don't understand why a debt proposal to be bankable by your financial institutions is

different from bonds. You've grown up with bonds, we understand that, and that's how you're currently organised. But as long as there's an orderly transition - and it's not for us to want to disrupt the market. The fate of individual providers is up to them but the overall sector has to remain viable and operational.

MR FITZGERALD: But it will depend on your assumption as to whether or not people will continue to pay bonds for your service. Now, most providers so far have said to us two things. One is that they like the notion or accept the notion that consumers choose a periodic payment or a bond and it's their choice, not the provider's. The second is most say that they still think that a fair percentage of consumers will pay a more modest bond more reflective of the costs. They think that will happen. What none of us know is what that percentage is. What we do know is that it will vary from organisation to organisation. We are not projecting forward any particular figure on that. But so far most providers think that a fair number of people will pay a bond as well as contributing something into the government pensioner bond scheme, you know, on the sale of their home if they choose to sell their home. Is that your view or you have a different view to that?

MR PRESTON (B): I understand the banking industry has been asked to make a submission.

MR FITZGERALD: Yes.

MR PRESTON (B): We've had some discussion with some representatives. Your discussion that you've had so far is fine for existing facilities - understand you can pay the debt or whatever. But to build new facilities the banking industry has generally been prepared to lend 100 per cent of the land and the construction of a new facility, knowing that they will have the balance of the bond payers coming in when the facility is constructed and open. Under this process they will no longer be able to manipulate the position so that there are more bond payers than say co-contribution payers. Therefore the banks will probably not be able to accept a buy, build and construct proposition for the future, which is going to be a massive challenge for both the government and the industry in its ability to provide the accommodation in the future.

MR FITZGERALD: I don't understand that. Why do they fund motels or hotels? Why do they fund private hospitals where there's no guarantee at all of occupancy rates?

MR PRESTON (B): I'm not sure whether they provide 100 per cent, whereas in aged care they are prepared to provide 100 per cent of the funding for those sort of situations.

MR FITZGERALD: That's because they've got bond security.

MR PRESTON (B): Yes. They know that once the facility opens there will be a flush of funds coming through the front door which will reduce the debt down to a level that can then be managed by the profitability or otherwise of the facility.

MR FITZGERALD: Sure.

MR PRESTON (B): So there's a balance about - I understand the argument, what you have put forward about the neutrality for existing facilities, but for the construction and implementation of the ongoing need for more facilities, that will be challenged.

MR FITZGERALD: Well, again it depends on the projections you make in terms of how many people would pay bonds.

MR PRESTON (B): Absolutely. But then you have to sell that story to the bank.

MR FITZGERALD: I must admit, I'm - well, we will be talking to the banks but I must say that I would be very surprised if it has a huge and significant change in the way in which they're prepared to deal with the aged care sector. That would be unlikely.

MR WOODS: But we hear your views.

MR FITZGERALD: Michael has raised the issue but we are very conscious of the transitional period where a provider may be reliant on incoming bonds to pay outgoing bonds.

MR PRESTON (B): Yes.

MR FITZGERALD: There is a cash flow issue there, we absolutely understand that issue. So we're looking at that at the moment. So we do appreciate that position.

MR PRESTON (B): Just to add to that. I mean, for example, Baptistcare, we've recently built a new facility. It cost $23 million or something. We're in a debt-reduction process with our bank now, because every time we get a bond, any bond uplift - overall upward movement in the bond position - we have to pay to the bank. This will go on for anybody who is in the transition with their bond payment if we go to the new position, depending on what the transition process is to move from the existing to the new.

MR FITZGERALD: But you're also broadening your base on which you can actually charge a bond as well. So the other factor is it's not the same stock, you've only got low-care and extra service care if you provide that. Now you've got a

broader range of options - sorry, a broader base on which both periodic and/or bonds can be charged. So the equation is quite different to what is currently arranged.

MR PRESTON (B): I assume you're referring specifically to high-care being able to pay bonds?

MR WOODS: Yes.

MR FITZGERALD: Yes, absolutely. Well, the proposals, I think - - -

MR WOODS: Yes, and there won't be high-care.

MR PRESTON (B): And the politics of that?

MR WOODS: There will be accommodation that you offer and there will be care that you deliver.

MR FITZGERALD: Well, let me make a comment. If there is no removal of the distinction between low and high care and no removal of the distinction between ordinary and extraordinary, effectively it will be all the proposals in relation to residential care will fall over. So I mean this is not - you made the comment about cherrypicking.

MR WOODS: It's interlinked.

MR FITZGERALD: You made the comment about cherrypicking and your residential one they're absolutely interlinked.

DR MORRIS (B): Yes.

MR FITZGERALD: If you don't do most of them, it can't happen. The community care stuff is different. But this one, yes, they all come together or they don't.

DR MORRIS (B): Certainly we would be very keen that the transitional arrangements there's a working party that includes providers and sector representatives on it to work on these details.

MR FITZGERALD: Sure.

DR MORRIS (B): Can I continue?

MR FITZGERALD: Yes.

MR WOODS: I just thought because of the importance of that one and the way it permeates through several others it was better to stop and deal with it and then move on.

DR MORRIS (B): Our next issue was around workforce. We would say very clearly that WA, as in most things, is very different to the other states. We have recently made an offer to our core care staff of an almost 6 per cent pay increase to move us into the top five wage providers in WA as part of an overall strategic workforce plan that also includes ongoing improvement in terms and conditions of employment, investment in training and professional and personal development and strategies to reward and recognise our people. This has been and is a significant risk for Baptistcare when we contemplate the government's inadequate current and past response to the CPI increases and the need for fair and equitable wages.

We also think there has been minimal recognition of the people that sit and do these particular core services. They are invisible. They have been undervalued and unrecognised for far too long and that has had a flow-on effect with care of our older Australians. This has meant that we are drawing on global markets to attract staff as we try and also match the diversity in our residential and community populations. What we are finding is that not only are we providing the usual skills training and development for the staff, but we now need to provide cultural training across the full range of services and life expectations for the recently arrived staff from overseas.

This means we have to raise awareness about the attitude required to older people through to the use of communication, ranges of communications and practice, intercultural issues, essential work practices, equipment use, legal and social obligations all to ensure that we have a workforce that bits the culture and a homely and de-institutionalised care and life environment for people who choose to live there and that's for residential and community and home based care. We think this is significant. It has been underestimated and for WA, as we face the workforce challenges, does need further work. Rural and remote service provision - - -

MR WOODS: Sorry, just on that one where you say "needs further work" what specifically - I'm trying to remember what you dealt with in your written report. But where in particular would you direct our attention?

DR MORRIS (B): What we find is that the staff who come and work for us the type of training that has to be provided is not simply based on skills development. There is a much broader range of training and cultural training that needs to be provided, particularly when we have staff from different continents or different countries who won't talk to each other, who carry particular cultural issues through into the workplace in Australia.

MR WOODS: But in terms of a specific operational direction that we can focus on,

what would you propose that we embed in here that actually manifests itself in some sort of improvement in that situation?

MR BAKER (B): One of the things that would be of assistance would be the recognition that the additional training for almost non-traditional areas for developing our staff, such as the cultural areas, additional funding for that would be essential for us to be able to make sure that those cultural issues didn't arise so predominantly in the workplace.

MR WOODS: But is there a vehicle for delivering that training? By the sound of it you do most of that in-house working with your newer recruits as to how best to deal and to interact - - -

DR MORRIS (B): But we're also talking to multicultural agencies in Perth as to what sort of supports that they can provide, what sort of training that can be provided and how that can be done in both rural and regional WA, as well as in the Perth metro area.

MR WOODS: So working with the CALD agencies.

DR MORRIS (B): Yes.

MR BAKER (B): I would add there that on-the-job training, not just classroom training, would be a very important factor of that so that they can be shown and learn in practice rather than just in theory.

MR WOODS: Okay.

DR MORRIS (B): Rural and regional services, probably in excess of 60 per cent of our services are done in rural and regional WA. We face higher costs in that service delivery. Some of it is through transportation, staffing attraction. We're finding we have to provide accommodation. Staff often travel long distances to come and do a couple of shifts before they go back. Getting allied health professionals to come and deliver services can be very challenging and particularly when we have staff who may travel three hours to go and deliver a community service type support and then have three hours to travel back. It is complicated and difficult and often some of our locations are so remote, it does make life very interesting for us.

MR WOODS: We will come back to that one in a minute.

DR MORRIS (B): We have got a model that has been working really well two hours out of Perth. We work with Brookton Shire where we have a nursing home there.

MR WOODS: That's the second time they've come up today. So are you involved in the MPS?

MR BAKER (B): MPS is delivered out a set of buildings whereby it's all co-located with the residential aged care we provide under management to the Shire of Brookton and we also provide the nursing post for the general community. We are working with the shire to actually transition that to be, whilst still community linked, but to have access to more professional structures so that the whole of the health services for the community and the area can be delivered more efficiently out of that one location. All the other services besides aged care we're very dependent on as well. The ability for them to attract people is difficult so we have been offering our services to assist in that area.

The program itself is currently set up with a strong local committee but as what often happens in small towns, the local committee tends to age out and get a bit tired so they are looking to be able to bolster that at the moment and make a stronger relationship there. But nevertheless the whole system basically provides quite a good cross-section of services to the committee. There is a bit of triaging done inasmuch as if there's no hospital there - they closed their hospital down to set this up - and so the nursing post provides the initial consult and if they need to, they ship them out by ambulance to a nearby hospital. The funding is a combination with aged care of federal and also of state for the nursing post, but if all of that was able to be supported in these sorts of reforms, it could be set up to work much more effectively than what it is already.

MR WOODS: I know I keep on interrupting you but if I could just pursue that a little further. Do you operate any facilities or community care support in other areas where there is a more medicalised MPS operating by the state Department of Health?

MR BAKER (B): In many of the locations that we are at there are small hospitals around. We look at the Brookton model and see that it provides a much better - especially the area that we are directly involved in with residential aged care - quality of service because a number of the smaller hospitals are actually sustained by having half a dozen aged care beds. Our observation - without being disrespectful or overcritical - - -

MR WOODS: The verandah out the back.

MR BAKER (B): - - - they're not subject to the same rigours as we are and so the standard of care is quite different.

MR WOODS: So what are the dynamics that led to Brookton evolving and do you anticipate that that then can progressively roll out to some of these other locations?

MR BAKER (B): We would see that as a very viable model for a number of areas around the place.

MR WOODS: Yes, but it takes three to tango in this one; it takes you, it takes the state government, it takes the federal government. Where are the other partners? Are they dancing their own dance or are they starting to sign up to your card?

MR BAKER (B): Sorry, could you repeat that.

MR WOODS: So the state and federal government is interested in developing these facilities in the broader - - -

MR BAKER (B): I know that they have shown some interest in the Brookton model. The Brookton shire is very keen to hold it up as a possible solution. We have consulted with them on a number of occasions to assist. Where it does become difficult for them is actually attracting the allied health professionals - the doctors - and even the management level professionals to a small town. We have again suggested possible solutions for that and even indicated that we'd be prepared to work with them to try and solve it. So to some extent the final model is still a work in progress but the signs that we're seeing we are very confident that it would be a good model to look at across many of the country and rural areas. Possibly part of the complicating factor is again it's a mixture of state and federal money, which has different drivers and different political issues associated.

MR WOODS: Do you have documentation on Brookton? Have you written it up, also with a vision of where you would take it?

MR BAKER (B): Probably not to the extent that you would like but we could certainly work with Brookton to provide you with something.

MR WOODS: Without going to too much more trouble, but if you can piece together some bits of the documentation.

MR BAKER (B): We saw it as such a positive opportunity that we made sure we made specific mention of it in our submissions to you.

DR MORRIS (B): The only other thing I would want under this particular point is that we're often amongst, if not the largest employer in many of these smaller towns and so our engagement actually goes beyond just providing residential aged care or community aged care. Our decisions have a significant impact and our engagement in the community development is actually quite critical and that's something that we see as part of our role as a not-for-profit service provider.

MR WOODS: Yes.

DR MORRIS (B): We do have some fairly pungent comments about the quality system, most of them are in our report and I would say that I don't think the current accreditation system has created a person-centred service, it's created an institutionalised form of care and is one that we would urge does need changing. We're concerned in the report about the transitional arrangements and that they need to be worked out with the sector and with representatives of the people who will be receiving these services, and would urge that very strongly. We also, with regard to community services, would urge that residential care mistakes are not transferred across into the community sector. Community care is not necessarily the panacea for residential aged care and I think it has its own similar and different challenges around staffing. What we have in many instances is a time and motion type of care that is not particularly helpful, and again person-centred care is not always evident.

I'm concerned about the gap or the lack of discussion between older Australians who might have a disability or a mental health illness, particularly if the Productivity Commission's report on disability that we are currently involved in doesn't get up, then what's proposed in that has an impact on this particular report and I think that area needs further work. In terms of building we certainly like the recommendation to simplify the building codes but one of the things that still stymies us is the capacity to build flexibly within the communities that we have. Local government authorities are very inflexible about their zoning regulations so our desire to build communities and have child care, cafes, pharmacists, GPs, all the rest of it, on site and build community and have community integrated doesn't work under the current system and I think there needs to be more attention there.

MR WOODS: Are you making headway on that back through state government as well?

DR MORRIS (B): Not noticeably. I have conversations.

MR WOODS: Just no outcomes?

DR MORRIS (B): No outcomes.

MR WOODS: Got it.

DR MORRIS (B): Thank you. My final comment; I said at the start that we're a charity and we're not for profit and we're faith based. We deliver services in a marketplace that is not necessarily the same as the marketplace that you're describing and that you're creating. We agree that there needs to be a radical revolution rather than evolution but we do think differently. We will continue to think differently as a not-for-profit provider. We operate in places where it's not possible to break even sometimes. That's our commitment; we work with people to grow their capacity,

grow community. That's not covered. The settings for this particular marketplace are predicated on people having a particular capacity, or advocates on their behalf to have the capacity to mediate and operate within that marketplace. I don't think there has been enough taken into account for the people who live on the margins who will never have the sufficient capacity, and I think your throwaway line around the FBT - which we do not support your recommendation on that - actually points to a deeper belief system that the commission holds around this particular area of being in civil society and we are at odds there I think. I thank you very much.

MR FITZGERALD: Well, if I can take the last point first. As you know we canvassed that particular issue about FBT concessions for the not-for-profit sector in the inquiry into the not-for-profit sector and it was also canvassed by the Henry tax review. The current government's view is that there will be no change. Nevertheless there is another tax summit coming up towards the end of this year. Can I just make one comment to clarify: the commission has never held the view that there shouldn't in fact be support for the sector, even to the extent of that particular benefit, which runs at about a billion dollars a year to the not-for-profit sector. What it has always argued is that the means by which that benefit is being provided is inappropriate through the tax concession. So anyway I just want to make that comment: there's never been a view the commission has taken that the not-for-profit sector more broadly shouldn't receive the support, but it has had longstanding views about that particular concession. All that aside, the government has decided so far not to make the change.

I want to take your last point, not in relation to the FBT but more generally. We would think, and we may be mistaken in this view, that what we're proposing in relation to aged care gives you and organisations that are committed to those on the margins much greater flexibility. In other words, by unpacking accommodation and unpacking care in a sense we would see that the number of innovative models coming forward, both in terms of housing and in terms of care, would be substantial because effectively we're not creating the boxes. There is no longer a box called "low care", there is no longer a box called "high care", there is no longer a box called "CACP packages". Now, there are risks in that.

I would have thought, and I'd be interested in your general view, that this is a more flexible arrangement that allows service providers who have a special skill or a particular interest or mission in a particular area to more adequately move into those sorts of areas. That's our view, and whether it's in the CALD communities, whether it's in the indigenous communities, whether it's in the area of people experiencing homelessness or whether it's more generally people on the margins, we think that this package makes your ability to create what you want to do more easy. Maybe we're wrong. The bottom line of this is we're trying to remove the government as the designer of every aspect of the system.

DR MORRIS (B): I think that's being achieved with the package that you're doing. I do see it being freed up and being - I'm not sure that I would call it a deregulation.

MR FITZGERALD: No.

DR MORRIS (B): I would say it's a re-regulation and a re-scripting. I think there are still inherent dangers in the way we value the people that this is being designed for and our notions of person-centredness and access and choice. I think the concepts are quite slender and thin in places in the report and haven't got a lot of substantiality. I am concerned that - I mean obviously the commission comes from an economic paradigm but - - -

MR FITZGERALD: Some of them do, yes.

DR MORRIS (B): Some of them do.

MR WOODS: We're a caring organisation.

MR FITZGERALD: Some of us are.

DR MORRIS (B): I would just say that our world is bigger than the economic.

MR FITZGERALD: Yes.

MR WOODS: Indeed.

DR MORRIS (B): I would want to make sure that the discussion is more broad-ranging and that there is more room and that people aren't squeezed out in the way that this is being described.

MR FITZGERALD: Can I try and operationalise that concept, because at the end of the day we're trying to design a system. We have to work out how does it actually work in practice. One of the issues that has arisen in the hearings so far, and this is day eight or nine of those hearings, is that we haven't clearly articulated the role of the social supports and the supports of vulnerable consumers, people that are ageing. So we've got the formal aged care system, coming through the gateway. One of the things we want to build up in the final is how do you support people to navigate the gateway and how do you support people once they're through it? So there's that whole issue about supported decision-making, which includes advice, information, advocacy; the whole issue about social supports, many of which are delivered through peak bodies, many of them are delivered through specific-purpose organisations. So that part of it we recognise and that we haven't done a good enough job in the draft on that.

DR MORRIS (B): I think there is also the mainstreaming and making people visible within the communities so that the invisibility of old Australians doesn't continue. Often we construct systems and actions that are very job-specific, and actually the work that we do is embedded in community. Am I making sense here?

MR FITZGERALD: Yes.

MR BAKER (B): Could I ask the question about the flexibility that you - and I can see how you've tried to build that into it. But I would assume that part of those flexible arrangements is the capacity to trade supported consumers.

MR FITZGERALD: Well, we'd be interested in your view about that. Can I just make one comment? Firstly, we absolutely recognise that if you have tradeability of those quotas and obligation, the defining of the regions becomes absolutely critical to the issue of equity. Having said that, there are a lot of people that don't believe tradeability is appropriate, or if you do it shouldn't be in the way we've described. So your views would be welcome.

MR BAKER (B): My view is it's a fraught proposition. It's fraught with the establishment of - not wanting to use inflammatory language but ghetto-type arrangements where you have, you know, "Oh well, that's the poor people's residential aged care facility," yet it's not necessarily going to be allowing us to build the communities that we want, have that egalitarian view that Australians like to be so proud about. It has that potential of creating the have and the have-nots, which is a bit alien to our particular ethos and values.

MR FITZGERALD: We accept that.

MR WOODS: Anything else?

DR MORRIS (B): No, that's it.

MR WOODS: We have run out of time, but given your particular regional service delivery there are a number of issues that we would have liked to have canvassed further. For instance, you supported our recommendation in relation to delivering care to indigenous communities, but I'm sure there's a richer story to tell in terms of advice that you could give us on how to enhance what we have there at the moment and where further we could go.

DR MORRIS (B): Would it be helpful if you let us know the bits that you would like some more information on and we can put something in writing to you?

MR WOODS: That would be good. So Mr Raine at the back there will communicate with you - - -

MR FITZGERALD: Can I just articulate without going into it now?

MS MORRIS (B): Yes.

MR FITZGERALD: One of the issues for us is we absolutely recognise many of the issues that confront smaller regional and rural communities and also remote communities. At this stage we've been very broad, we've indicated that many of those services could be provided through flexible funding arrangements, block funding and so on. But I have to say this is still fairly lightweight. So any concrete proposals, given the nature of the WA demography and the high percentage of people of indigenous backgrounds in this state, we welcome your insights into that. Again, I don't want to - we're not trying to prescribe this system, but I think we've got more work to do in particular in relation to those issues. Some more specificity - like we were talking about the multi-purpose centres, and those sorts of things - would be helpful; but we recognise that.

MR WOODS: Thank you very much.

DR MORRIS (B): All right, thank you very much indeed.

MR FITZGERALD: Good, thank you, it has been terrific.

MR WOODS: Can I just clarify is Diedre Timms from - you are present? Thank you. Could you come forward, please. Thank you very much. Could you please, for the record, state your name, if you are representing an organisation.

MS TIMMS (VT): Diedre Timms, CEO of Volunteer Taskforce.

MR WOODS: Excellent, thank you. You've provided us with a few brief speaking notes, but I'm sure you've got a more extensive statement to make. Please.

MS TIMMS (VT): Yes, thank you. I'd just like to give you a bit of background on the organisation so it puts my comments in context and myself, personally I've worked in community development for most of my working life, including Aboriginal health, women's health, disability support services and for the last 10 to 12 years in community care both in rural and metropolitan environments. Volunteer Taskforce is a not-for-profit organisation delivering HACC services across metropolitan Perth. We've been delivering community services for 40 years and currently provide basic support services to approximately five and a half thousand clients a year with paid staff and volunteers. We have approximately 65 staff and 570 volunteers.

Our priority is to support financially disadvantaged clients. We have a range of basic services: gardening, home maintenance, transport, domestic assistance, social support, meals on wheels. My comments are focused on community care, not residential care. The report devotes a lot of space to residential care and I notice many of the presentations are from residential providers and yes, they have serious sustainability issues. I believe community care, and more specifically the Home and Community Care program, is a major component of the aged care continuum of care. As the modes of care triangle suggests, this is about little support to many. It's also about support when it's needed and about early intervention.

I cannot emphasise strongly enough the importance of these very basic services that support people in their homes. It's also, in the main, what older people want. If we get this right people can stay at home longer, and not everybody needs residential care. I think the numbers speak for themselves on that one. The assessment is a very important part of this process and I don't believe a telephone or a simple self-assessment will identify client needs. Many will underestimate needs and some will overestimate them. It's sometimes hard for people to actually ask for help. It's also important to take into account the environment in which people live. This also has an impact on their ability to remain independent and on the type of support that is required.

Basic assistance with gardening and home maintenance is more than creating a safe environment for people who may be at risk of falls. It also has a profound effect

on people's wellbeing. Transport is another vital component of support, not only important for medical appointments but also for shopping and social engagement. I'm sure if you think about how you use transport you can easily see how important that service is.

My other point is about volunteering. As an organisation, as our name suggests, we're active supporters of volunteering. The value to clients and the community is enormous. Volunteers actively engage in their communities, and that's a positive contribution to their wellbeing and that of the community. Support to clients also links clients to their communities. Volunteering does have associated costs with support, training and retention and reimbursements but it's a real win-win situation for clients and for community. There is much evidence to indicate the value of volunteering: it builds communities, it builds social capital.

I would like to recommend that there were some incentives for organisations that support volunteering and that volunteering is vital to a sustainable aged care system. I'd also like to make a point about carers and support for carers. We talk a lot about the need to support carers. We even have legislation in this state to do that, the Carer Recognition Act. But I believe we do just that; we talk about it a lot but we don't actually do very much. Carers don't have access to a full range of the HACC program services. They can access respite, they can access information support and advocacy.

I believe they should be supported with eligibility to the range of services. Sometimes a care recipient will deny a service because their carer can do it; it's usually their wife, and the wife is failing under the strain of the caring role. If we could actually support the carers who have given up careers, they have given up social engagement, family participation, a range of things, if we could support them with basic services to extend their caring role, I think it would be better for everybody.

My final point is around implementing change. The report contains a raft of recommendations, and can I please stress the importance that the changes are trialled and they're evidence based. Processes need to be tested before they are put in place because it's the client that gets lost in the changes often. The way changes are often implemented in government-funded programs can have a detrimental effect on the sector. It provides uncertainty for staff in organisations. Frequently a program will run for a contract period, then be changed, re-tendered, new providers start, build new systems and then again on it goes.

There's an enormous amount of effort that goes into starting all over again. I believe we lose valuable people from the sector due to uncertainty of continued employment and we are already struggling to retain and attract staff. Thank you for the opportunity. Those are the extent of my comments.

MR WOODS: Excellent. A couple of questions, if we may. One is, you've given your extensive involvement in delivering HACC services. We're proposing a gateway approach and you stress the importance of face-to-face assessment. We understand that. How do we extend the current arrangements so that we could be more confident that those who do need support and help, they know that support and help is available and don't feel that there's some institutional barrier to being able to apply and be assessed and access it. Where are those barriers and what can we usefully do about it?

MS TIMMS (VT): I think the major barrier is that people don't actually want to know about community care until they need it. I mean, people don't think, "I must find out about community care, I might need it 10 years down the track." So it's at the point of something has failed, a support has fallen away and then they actually need it, and then no-one knows where to go. I think maybe the Carelinks are providing some information around that. We're trialling a system at the moment, that being the access point in WA. It has still got a long way to go, it's in the early days. It will be interesting to see what the outcome will be. But there's been quite a systematic relationship between referrers, as in social workers and GPs and allied health professionals directly to service providers, and that new arrangement was cut across that, so I'm not sure how that's going to go.

MR WOODS: So those who come to you and you then do the assessment and see whether you can fit them within your budget, what's your most effective ways of making your services known to those who potentially need it?

MS TIMMS (VT): We do a significant amount of advertising to attract volunteers which actually means that more people know about us than would otherwise know about us. Our services - particularly we have a huge gardening and home maintenance service and it's visible. The sign is on the vehicle. Someone sees someone down the street getting the service. Someone wanders up to a gardener and says, "How does this work?" and then they would be referred back to the office. Pre the assessment framework at the moment, we would go out, do an assessment and then see what services we could provide and then see what other organisations would also need to be involved to support that client wholly if we didn't have those service types.

MR WOODS: A final one from me: in the funding of community based transport which you do, and potentially - I'm interested in your views - the Meals on Wheels function - do either or both of those more warrant a block funding approach rather than an entitlement approach, or is there some difference between the two of them?

MS TIMMS (VT): Well, I think they both do, for different reasons. The assistance with Meals on Wheels is actually about coordinating the service and getting the meal

to the person, and that requires a reasonable amount - you've got to have the meals, you've got to have that team of, in our case, volunteers to actually provide that service. Our transport service is a little different in that we use taxis so we can provide - - -

MR WOODS: So it's voucher based.

MS TIMMS (VT): No, it's not voucher based. We have a contract with the taxi companies and negotiate rates - it's not a flagfall system - but we batch them so one person just doesn't get to go in the taxi on their own. So we batch them for efficiencies and it's 24 hours a day, seven days a week, which complements a lot of other services.

MR WOODS: With the Meals on Wheels we've noticed in some cases that it's sort of gone from having the friendly face that drops in each day and delivers the hot lunch and the cold collation for dinner but also says, "How are you," and checks whether there's mobility issues and the like to, in some cases, "Here's your week's meals. See you again next Monday." Are you also aware of those sorts of developments, and what can be done about it and how do you value that daily interaction?

MS TIMMS (VT): I don't think the daily interaction is necessary and there are other mechanisms to achieve that but I think the interaction is important. I guess one of the things I was criticised of by a volunteer when I started with this organisation was that I was turning it into a business, and that's exactly what we have to do. We can't afford to drop in every day, have a chat and give a meal, but that doesn't mean to say we can't be respectful and value the comments that come back from those service delivery people when they actually interact with a client, and we have communication forms particularly for that: "The volunteer dropped off the meal. Mrs Smith didn't look the same today." So that then alerts some further interaction and follow up.

MR WOODS: So you have a feedback mechanism that at least keeps that flowing.

MR FITZGERALD: Just a couple of comments having received your comments about carers. WA is in the process of developing these access points. In many senses they are in fact what the gateway will look like and at some stage they, subject to negotiations between the Commonwealth government and the WA government, may all be merged because it's the same sort of concept, which is a central point, information, some basic assessment, referrals and/or entitlements to services.

You've raised one issue which is interesting beyond that. There's a whole range of carer services that we see as absolutely essential for the carer themselves; part of that is particularly emergency respite, peer support, education, counselling,

advocacy. You've said that the carer should have access to other HACC services. Now, I suppose the way in which most of us think is that the HACC services going forward - they may not be called HACC but they go forward - are there for the person that's aged or the person with the disability, not necessarily for the carer. So just explain to my what you think that means, or what are you actually trying to achieve within that.

MS TIMMS (VT): I'm trying to achieve the sustainability for the carer because you often see their health declines before that of the care recipient, under the burden of caring. If we were to give them some support earlier on, the basic support, early intervention - it might be that they need the domestic assistance, the care recipient says, "Oh, no, I don't need domestic assistance, my wife does it," and that service is based around the care recipient. The carer could have the domestic assistance, they could have the transport assistance, they could have social engagement support, you know, those sorts of things.

MR FITZGERALD: So you see an unpacking between what we see at the moment as the principal client being the older person, to also allowing for the principal client to be the carer in his or her own right?

MS TIMMS (VT): Yes. People would still have to be eligible and it would be on a needs basis but that is money well spent, in my opinion, because it's very much about early intervention, and if we can support the carer longer, the longer they will remain in their own home.

MR FITZGERALD: Just in terms of volunteers, the commission, as you know, well recognises the value of volunteering. I mean, in the not-for-profit inquiry we spent an enormous amount of time looking at that issue and valuing it, and as you know it comes out at about 14 billion dollars per year in terms of contribution by volunteers in the not-for-profit sector. When you get beyond that to actual practical things it's actually quite difficult, so we recognise it and obviously recognise the importance of volunteer centres and those sorts of things. We've also recognised in this report that we need to reduce any barriers to in fact engaging volunteers and we've made some modest recommendations around that. Beyond that it's actually very hard to come up with substantial recommendations that encourages service providers to use volunteers more effectively.

MS TIMMS (VT): Well, one of the things I was thinking of was it could be something in your tender submission or whatever where a preferred provider actually engages volunteers and has a program for retention, training, support, all of those sorts of things; certainly not another plaque on the wall.

MR FITZGERALD: Thanks for that.

MR WOODS: Excellent. Thank you very much for your time. That's very helpful; appreciate that.

MS TIMMS (VT): Thank you.

MR WOODS: We will adjourn for lunch and resume at 1.30.

(Luncheon adjournment)

MR WOODS: Thank you, ladies and gentlemen. Welcome, could you please, for the record, state your name, the organisation you are representing and the position you hold.

MR KELLY (UV): Good afternoon. I'm Dave Kelly. I'm the WA secretary of United Voice. I'm here representing the union today and with me I have - - -

MR WOODS: If they could speak for the record themselves.

MS JORGENSEN (UV): My name is Cath Jorgensen and I work at Carinya Nursing Home.

MR DEPIAZZO (UV): My name is Aaron Depiazzo. I work for Hall and Prior out at Tuohy Nursing Home.

MR WOODS: Excellent, thank you. Please.

MR KELLY (UV): Thank you very much for the opportunity to come and address you this afternoon. United Voice here in Western Australia represents a range of staff in the aged care sector, enrolled nurses, carers, cleaners, caterers, orderlies, maintenance staff. We're the largest union here in aged care in WA. You've heard a lot, the commission has already heard a lot about the low pay that our members receive in aged care. I don't intend to go into that in great detail because I think you've already had that. Both Cathy and Aaron will both speak about that. What I would like to speak to you about this afternoon is really if there is more money in aged care, how is the best way to have it translated into the pay packet of the workers?

One of our concerns is that there will be reform in the sector which delivers more money into the system but it will go to employers on the assumption that some of it will, if you like, trickle down to the staff. Now, in our experience that is not the case. The history of bargaining in aged care here in WA - bargaining is a long and difficult road. We, as a union, made a decision about 10 years ago that we were going to try and improve the wages and conditions here in WA through a bargaining campaign, the way unions in a lot of other industries have achieved increases. A lot of people said it will never work in aged care, too many employers, you can't take industrial action in the traditional way. We decided we would give it a crack.

After 10 years we have managed to get agreements with probably the 10 biggest providers in WA but that has virtually left almost half the sector still award reliant but even those employers where we do have bargains, the outcomes have been fairly modest. People are above the award by two, three, maybe four dollars. After a decade of quite intensive efforts to bargain in this sector the outcome

is meagre, only half the industry is covered by agreements and those that are, the wages are still low. Individual campaigns are long and protracted. It's not unusual for us to take 12 to 18 months with a single employer to try and get an agreement. So with a multitude of employers it is just extraordinarily difficult.

We have representatives today. Cathy works for a small provider, Carinya Bicton, where we are in the middle of an enterprise bargaining dispute that has lasted over 12 months. Aaron works for one of the big providers, Hall and Prior, where we have actually negotiated two agreements. So they are both going to talk about the experience that they have hard - firstly what they do but the experience of bargaining in this industry. I suppose the main message today is we think the commission understands how low paid these workers are. The concern we have is if - and looking at your report there is going to be more. If the government adopts your recommendations employers would be free to charge for additional services, there would be more money coming into the sector, our concern is that just saying, "There needs to be competitive wages without the commission having a clear understanding as to how that is going to happen the employers will see the benefits of the increased funding and the staff will not have that translated into their pay packets.

So I have probably said enough. I might ask Cathy who is, as I say, a carer at Carinya Bicton, to now address the commission.

MS JORGENSEN (UV): I have worked in aged care for over 30 years so I have seen a lot of changes over the years. We used to have funding specific for wages when this was changed to introducing bonds which made the industry clean up their building and have single or two-bed rooms. But pretty buildings don't equate to good care. Staffing levels are poor in most nursing homes. Some staff having to shower and care for nine residents each. No-one takes into account what care any particular resident needs, like, a full hoist and shower trolley which are all the more time consuming. Workloads are too high and we do more than our job description because quality of care is important to us and because if we don't do it, it doesn't get done.

So let me tell you how a morning shift goes, starting with handover which takes about 10 to 15 minutes. Then we go on the floor to sit up in bed or chair, changing residents if need be ready for breakfast. Try and get a shower or two done before breakfast at 8 am. So running trays then doing feeds. There are currently 44 feeds in our facility. So this is very time consuming and would take between an hour and an hour and a half. Then we have to collect trays to go back to kitchen. Then we start showering in our sections, usually doing the single residents first and making beds as we go. Then we do all the doubles, meaning needing two staff which would entail using either a standing hoist or a full hoist putting into shower chairs or trolley baths. These residents are the most hands-on so they are either put in Regency chairs which are a float-back chair or back to bed. These people are often

now second daily showers because the workload has become so heavy.

We are often showering right up to and after lunch and sometimes having to go back and shower people again if they have had an accident in between showering. We are also trying to toilet people and give out morning tea and feeding those drinks to the people that need to be fed. We are also supposed to do ward tidies as well as making sure linen is stocked. We are often without equipment such as pads and flannels and towels, lack of personal clothing, which is also time consuming looking for. Then about 11.40 feeds come down so we have to stop showering and start feeding. Some girls will go to lunch at this time while the rest will continue on. Those that can walk to the dining room and those in wheelchairs are taken by staff and then trays and meals are given out. Then when finished are collected up, residents taken back to their rooms, toileted and then those that would want to lay down do so. Then we do another round and hopefully finish any showers outstanding.

Some girls will finish at 1 pm, some stay on until 2 pm or 3.30. So from 1.00 to 3 pm minimum staff who still have to do afternoon teas, feeds, toileting and bed rounds before knocking off duty, as well as other cleaning things like pan rooms et cetera. There have been times over years when workload has got too heavy that when, and if, they manage to get morning tea break they are shaking and crying because there is not enough time to give quality care, to spend the time to talk to residents. Girls are leaving the industry in droves because of workload and poor pay. I'm on $18.66 an hour, so I work weekends to up my pay. There are a lot of single of mothers in our industry who rent and the average rent now is between 400 and 470 and with utilities going up and up.

We need to have funding specifically to wages. We have currently been in negotiations with our employer for two years trying to get an EBA in process. In that time of the EBA, the first meeting that we had we were kicked out so we had to go to the commission to be allowed back in. So then we were allowed into the meetings and we went through them all and eventually they came up with an EBA. Not to our liking, I might add, so we put it to a vote. 70 per cent of the staff rejected the vote and she wanted to go back to the modern award. They have taken a week of our holidays off us. We're in a highly stressful job. We need our holidays. We wanted a dollar an hour up. They wanted to give us only 30 cents for the second and third year. They also took that week holiday, as I said, so we took strike action. Then they locked us out for seven days. The commission - - -

MR KELLY (UV): How long did you go on strike for?

MS JORGENSEN (UV): I think we had three, three sessions of four-hour strikes so to affect the residents as little as possible. It was a big thing for us to do. Anyway, we were locked out for seven days. The commissioner overturned it saying

it was an illegal lock-out so we were allowed back to work after days and back to the negotiations. So we have come down to 10 per cent over three years and they have offered our holidays back. But they want to give us 8 per cent over three years. They say they don't get enough funding so they can't give any more. But they have made a very tidy profit over the years. They had an extension put on only three years ago which they said cost them about nine million.

So please look at the funding specific to wages and staffing levels in relation to number of residents and how much care they need. We need the best of care for our loved ones and remember, we may be there one day too.

MR KELLY (UV): Thanks, Cathy.

MS JORGENSEN (UV): I wanted to finish off with a story of a man that I was looking after in Rockingham who was a headmaster and I work in the transitional care. He used to hear our voices coming down the passage and he would get excited about seeing us coming and he'd say, "Oh, not you two again. Great, I've got you again." In transitional they're only there for 12 weeks and then they go either home or into other care and he said on the day that he had to leave that he would like to throw himself down and break his other leg so he could stay another 12 weeks with us.

On an ending note, I have a daughter. If she asks me to go into aged care, I would encourage her against it most vehemently the way it is at this moment. It is not good.

MR WOODS: Thank you. There are a few things coming out of that we'd like to discuss but Aaron first.

MR DEPIAZZO (UV): My story is much the same as what Cathy's is. Basically we are being short-staffed, our hours are being eroded. I know where I am working at the moment last year our director of nursing got given the message that she needed to free up 74 more hours to cut the budget so us carers lost those hours which means that we've got less hours to actually put in with our residents. We've got to do things faster. It is coming down to that we're being put under a lot of stress, that the carers are actually feeling the strain, we are injuring ourselves, residents are getting injured. Put it this way, we've got quite a lot of two-people transfers and two-people rolls and turns. We've come down to this: that quite a lot of carers are trying to do it by themselves even though they shouldn't.

Before Christmas one of our carers took it upon herself to do a two-person turn because we had been short-staffed, they didn't cover people who had called in sick because they didn't want to pay out for agency staff or to get somebody on overtime. She rolled this two-person person by herself and dropped him off the bed and that's

all because our employer didn't want to actually cover the cost of calling somebody in.

We are actually having to try feeding people who have got dysphagia or swallowing difficulties. We should be taking a lot more time with them but carers - we're being given not much time to be able to do everything that we have to do and feed these people. We should be taking 15 to 20 minutes to feed them. A lot of carers are getting in there and are trying to feed them in about five minutes flat because we don't have enough people to do it. We don't have the time and everything else to actually do it safely. We do need to have the hours guaranteed and we do need to have levels of staff per resident ratio put in.

It is a difficult industry. I'd hate to see what is happening with our residents. I do care for the residents and for some reason I do still keep on working in the industry because I'd like to see it bettered and to see the residents get the proper treatment. But at this stage I've actually started looking around for another job. I looked at doing a mature-age apprenticeship as an electrician and they're actually offering me $19.99 to actually go and do a mature-age electrician course over what I'm getting now - our pay has just gone up to $19.09 an hour for the top level of carer. I would have been thinking the human life would have been worth more than what an electrician would have been put on.

MR KELLY (UV): Aaron, you have been involved in the last enterprise bargaining campaign at Hall and Prior. What was that like?

MR DEPIAZZO (UV): It was like to and fro. There was a lot of threats going between one party. The employers, the DONs, one of our DONs even told us that if we didn't like it, "There's the door, (____ off)", and that was the language that she used. We got told that we could go back onto the award wage, that they wanted to bargain one condition away for another, very protracted, very long and just not the way of resolving things or getting ahead, especially for the carers. We only got - depending on which level we were at - somewhere between 8 per cent for some of the carers to 15 per cent for the lower-paid carers over about three years.

MR WOODS: Thank you. Thank you for that. One broader question, and that is the outcomes from the enterprise bargaining. Your base rate is 17 and a half or so dollars an hour.

MR KELLY (UV): I think the modern award is as low as 16, but I haven't got the figures in front of me.

MR WOODS: Most of your people who don't have EBAs would be sitting on 17 something?

MR KELLY (UV): I haven't got the figures in front of me but I thought it was 16 plus.

MR WOODS: That's all right. For those who you have been getting EBAs where we're talking 19, would 21 be sort of top level?

MR KELLY (UV): Absolutely, yes. I assume you already have the EBAs - - -

MR WOODS: We have some profiles and we've seen that in WA there's slightly different trends to some of the other states, in part reflecting the conditions here in the general labour force.

MR KELLY (UV): I'd happily provide those to the commission if you want it.

MR WOODS: That's fine. I think we understand.

MR KELLY (UV): But even with those outcomes, you know, the average house price in Western Australia, we're struggling.

MR WOODS: Cathy, you've been in the industry for a while, particularly if you remember back in CAM and SAM days and the other funding models that there used to be.

MS JORGENSEN (UV): Yes, I've been through a few.

MR WOODS: In terms of ongoing professional development and training, what's your experience?

MS JORGENSEN (UV): They repeat the same five formats. It's the manual handling, fire, hand-washing, food safety, and that's it. We get that repeating every year.

MR WOODS: What about extending your professional capacity so modules in, say, oral health or some of those issues?

MS JORGENSEN (UV): We have had things on stoma bags, on catheters, PEG feeds, but that was just about three years ago. That was the last time we had something like that.

MR WOODS: So there's not an annual program of upskilling and - - -

MS JORGENSEN (UV): No, only those basics that you have to follow every year.

MR WOODS: Are there other opportunities for you to extend your scopes of

practice and professional capacities?

MS JORGENSEN (UV): Years ago they did the level 3. I did the level 3 in the 90s but now that's not recognised. They have offered it to a few of the girls since. We've got a few advanced carers now.

MR WOODS: Have they done cert IVs?

MS JORGENSEN (UV): Cert IV and cert V the advanced carers are. They're the ones that do the pills.

MR WOODS: Yes. So they do the medication management.

MS JORGENSEN (UV): Yes, but they were going to null and void them with the EBA, just recently.

MR KELLY (UV): Her employer wanted to abolish the advanced carer positions which we - - -

MS JORGENSEN (UV): After they told us how much it cost them to - each individual girl cost them a couple of grand to train up, and then they were just going to abolish it.

MR FITZGERALD: What qualification do you need to be an advanced carer?

MS JORGENSEN (UV): You have to have skills with pills and minor dressings.

MR WOODS: Medications. It is a cert IV?

MS JORGENSEN (UV): Yes. Then further on from I think they still have to do something else as well.

MR WOODS: That takes some of the pressure off the RNs because they're doing some of those functions?

MS JORGENSEN (UV): Yes.

MR KELLY (UV): In the negotiations we've done with a number of employers, our members are very willing to take on additional training and take on additional competencies. They expect, however, obviously to get paid for it. Up until now it's been, "Let's upskill people. Let's give them career opportunities." That's great, but unless you back it up with additional wages, you're losing good people once you train them.

MR FITZGERALD: So what's the difference between a worker that has a cert III and a personal care worker that has a cert IV? What's the sort of pay differential?

MS JORGENSEN (UV): It hasn't been anything up until recently with this EBA they were offering. The advanced carers are on $2 more than the rest of us. That's it. The level 4 and level 3 was the same, other than the advanced.

MR DEPIAZZO (UV): Our level 3 and 4 carers out at Hall and Prior are basically on the same, unless you get offered to do a med com shift. Then that's only on the provision that you're being passed to do a med com shift.

MR WOODS: So where you're taking responsibility for opening the Webster-pak or whatever and ensuring that the resident takes their tablets under supervision.

MR DEPIAZZO (UV): Yes.

MR WOODS: Very good. In terms of the expectations of the RNs, are you finding that there is a change in what they are expecting you to be able to do, or has that been fairly standard for a number of years.

MS JORGENSEN (UV): Yes, we do more than what our job description is, and have always. The RNs will do the care plans and they will do the writing up, but they come to us to ask us how that resident is developing, what's wrong. They come to us to always ask the question. They just do the pills and the dressings.

MR WOODS: Unless there's catheter changing and other - - -

MS JORGENSEN (UV): We empty - we just do the bag. You know what I'm talking about - - -

MR WOODS: Absolutely.

MS JORGENSEN (UV): - - - without going any further.

MR WOODS: Yes, I understand that totally. Aaron, in your case what opportunities have there been for professional development and career progression?

MR DEPIAZZO (UV): There really isn't that much unless you look at going and doing your enrolled nursing or your registered nursing afterwards which the majority of carers that do the enrolled nursing or the registered nursing get the hell out of aged care afterwards. They don't stay. Over at Tuohy Nursing Home we are having a problem with retention of registered nurses. The registered nurses, they're actually going to - from what I got told they're going to up the pay for registered nurses at Tuohy Nursing Home to be able to retain them, but the carers aren't being offered the

same sort of thing.

We, as carers, are often on the front line. We are the ones that are going to get abused by residents that have limited mental capacity, that have schizophrenia and psychosis. The registered nurses will often stand back and just watch. Some will not come anywhere near the patients, except to give them their pills, and that's it. Everything else has to be done by the carer and we're being asked to put ourselves into physical danger.

MR FITZGERALD: Under our proposals the cost of care or the price of care would be established, based on the recommendations of a regulator to the government. At the end of the day the government will set what that price is; whether it's community care or whether it's for residential care. So what's the instrument, do you think, by which you can actually ensure that wages increase in line with the increase in the scheduled prices. Over and above that the individual organisations can charge for additional services, accommodation is separate to that, so there's a whole lot of other factors. But in relation to the scheduled prices or the regulated prices, what are you recommending as an instrument by which across the nation, or just in WA for the moment - - -

MR KELLY (UV): I believe the government needs to make a decision about what the minimum rates of pay should be, and for the employers to have access to the additional funding they should have to demonstrate they've got registered industrial instruments that reflect those minimum rates of pay. Now, that wouldn't stop employers who want to charge more or do whatever else, negotiate higher rates of pay based on that. But requiring service providers to have registered industrial instruments - I mean that's the IR system we've got.

MR FITZGERALD: Sure.

MR KELLY (UV): That's how you - you know, there's compliance and all that sort of stuff, the system is already in place. But they should have to demonstrate that they have registered industrial instruments which meet these minimum pay requirements. At the moment the employers get the money and then we are left to bargain, and we get what we can. Our experience is that it just doesn't work. It's like pulling teeth. I was at a function the other day talking to my counterpart who works for the MUA. They were trying to bargain for 30 per cent in the ports in Western Australia. It's a completely different world to our members. He was actually talking to Cathy.

MS JORGENSEN (UV): I told him how much I earned, he was horrified.

MR KELLY (UV): Other workers in the system just find - it's almost embarrassing how lowly paid aged care workers are, and to say that they have to bargain in the

same way as someone in the mining industry or someone in the ports or whatever, it's chalk and cheese. So the government really as the funder needs to make a decision. The minimum rate of pay for a carer or an enrolled nurse or a cleaner in aged care is whatever it is, and the government is then accountable to the employers and the workforce as to what that outcome is. Then there can be bargaining on top of that but to just say that the employers are going to get more money, and to use the expression it will trickle down to better wages, is just a fantasy. The experience in WA doesn't - - -

MR FITZGERALD: Yet in the WA instance we've heard this morning from a number of providers and their peak bodies that have raised with us the obvious fact that there's very substantial workforce shortage issues here. That is true across Australia.

MR KELLY (UV): That's right.

MR FITZGERALD: That's exacerbated in WA and parts of Queensland. So in a normal environment you would see that the employer or the provider would want to attract staff. One of the ways they attract staff is to pay slightly higher wages than their competitor. But is that not happening at all here?

MR KELLY (UV): No.

MR FITZGERALD: Notwithstanding these enormous constraints you're not seeing much movement at all?

MR KELLY (UV): Cathy and Aaron should be living the high life here in Western Australia, because they're in short demand. They should be doing very well, but normal bargaining doesn't take place in a sector like this where the government is the ultimate funder.

MR FITZGERALD: Sure.

MR KELLY (UV): The employer can't just say, "Well, I'm going to jack my prices up and I'm going to fund better wages through it." They can't do that. So from that end the bargaining fails and from the other end - I mean Cathy and her crew took a four-hour stoppage. Now, that's a very dramatic thing to do in aged care. These are the people that they literally bend over backwards to care for and they're going to walk out. Now, if it was an industry where we could all walk out the door on a Monday morning and tell you, "See you later when we get $25 an hour," things might be different. But it just doesn't work. That's what the MUA are going to do this weekend, I think. If Cathy and her crew were able to do that well then the outcomes might be different. The normal bargaining rules don't apply.

MR FITZGERALD: In terms of your union, you also represent a whole range of carer workers in the disability sector and a number of other sectors. So one of the issues that arises here is the flow-on effects across that care worker group. Most of those are in provision areas where the dominant funder is the government as well. So I presume these issues go across a large number of human services areas that your union covers?

MR KELLY (UV): That's absolutely right. We deal with aged care and disabilities home care; residential aged care and home care and disabilities. The problems are the same. We have spent the last three years negotiating EBAs with the top five disabilities providers in WA and raised them up off the award. But in the disability sector they dream of aged care wages, that's how poorly they are paid. So I know that the Productivity Commission has put out a report in respect of the disability services sector, a national insurance scheme so that these sort of services are adequately funded. It seems very attractive, certainly to the staff, and I know to the people they care for. The normal bargaining rules do not apply because you just can't walk out on an aged care home or a disability provider, for that matter, the same way that other workers can. The community has to face up to it, they can't take advantage of these workers any longer.

MR FITZGERALD: You provide coverage for those who are in the community aged care sector. What are the differences between - - -

MR KELLY (UV): In home care?

MR FITZGERALD: - - - resi and home and community care?

MR KELLY (UV): Well, they are the lowest of the low. I mean the conditions in home care are appalling. You have home care workers who basically drive from client to client. Most of them are employed as casuals. Often they're only paid for when they are with the client. So some of them see a client for an hour, go to another client, they don't get paid in between. They might see another client a bit later on, they get paid again. So they are in - they are the poorest of the poor in the care area. That's an area of great need. But the comments that we make about bargaining, the rules of bargaining not applying, apply equally to home care.

That's why it's imperative that the government - if they are going to give these providers access to additional funds - you know, you now have major corporations in Australia getting into aged care. They are going to make a tidy profit out of the recommendations you make. We think the commission has a responsibility to make sure that some of that money ends up in the home care workers' pockets, because what's the point otherwise? The buildings will look fine, the balance sheets will look fine but people like Aaron and Cathy they will be telling the next generation, "Don't bother, get a trade. Don't be so stupid, don't go into aged care." That's

self-defeating.

MR FITZGERALD: Can I just go beyond that? The issue of workload - we're running out of time but, just on this workload issue, as you know, we've had lots of representations around the way in which this issue should be dealt with. Some have been fairly prescriptive ratios, you know, staff to client ratios. Some have been of a different nature. Given the variability of the client needs in aged care, increasingly so between very frail, medically frail, longer-term dementia, transition care, all those sorts of things - whilst superficially - and we fully understand why some of the unions are advocating workload ratios. In truth, it doesn't seem to necessarily be the right instrument. I understand why people are putting it forward but is there a better model than rigid ratios to deal with the workload issues, because the more we look into this the more prescriptive ratios look attractive but inappropriate; but you may have a very different view about that.

MR KELLY (UV): At the moment the employers run it as lean and mean as they can. The problem with it being purely outcome-based is often the people who need to complain when the outcomes aren't what they should be are the ones who are least able to complain. So providing some sort of minimum staffing levels - I mean call it rigid if you like, but at the end of the day if you end up having too many staff the worst thing that happens is the residents actually have someone to talk to as well as someone just to feed them. On the downside if you don't have enough staff the implications are quite drastic.

So you can say rigid but if you're going to err on the side of caution, I suppose, the worst thing that can happen if you have minimum staffing levels is that sometimes you get a few more staff than you need. The tragedy of that is what? If you don't have minimum staffing levels and you allow the employer to run it as lean as they can - and you've heard the outcomes, it can be quite dramatic. So I suppose that's how we view it. I understand these days you try and go away from being prescriptive and the old outcome-based stuff. Unless you're going to have a regulator in every ward or every room, outcome-based funding can be quite problematic.

MR WOODS: Thank you. We have run out of time. We do appreciate you coming in and giving us your direct experiences and it is also useful to have you here to bounce off some of these broader issues as well. So thank you very much.

MR KELLY (UV): Thank you very much for the opportunity.

MR WOODS: Can I ask Angela Smith to come forward, please. Thank you very much. For the record could you please state your name and whether you are representing any organisation.

MS SMITH: Thank you. My name is Angela Smith. I don't represent any particular organisation. I speak as a member of the community, as a carer of somebody with mixed dementia. I have, I believe, probably better than the average understanding of the aged care history and I also have a good understanding of the science behind a lot of what is also going on. As you would have read in my submission I'm very concerned that there seems to have been a heavy bias of submissions from people who purport to be representative of peak bodies and purport to speak for the majority of older people or people in care when, in reality, they only speak for a fraction of the people who are older and in need of care or miss receiving care in the community.

For example, I think Carers WA said they have a membership of 15,000 but of course there's over 200,000 obviously in the community providing care. So if they're not even asking us for our views then they obviously can't present our view to places like the Productivity Commission. It was not until after I read newspaper articles about your draft report and I went back to see what submissions had been presented by groups who purport to represent people like myself, that I realised that not only were they not speaking for me or us but they hadn't even asked their own members, of which I am a member of Carers WA, Alzheimer's WA, National Seniors and the Council on the Ageing.

I'm very concerned that there seems to have been a huge emphasis on the economics, and I think that's been put by other speakers. I don't believe this is an issue that should be dealt with by somebody who calls themselves the Productivity Commission because to me what we're talking about is a human rights issue. Older people who are healthy and happy are not the issue that comes within this ambit; it's people who are disabled. They don't choose to be disabled, that's the lot they have been delivered. According to my understanding of the United Nations charter on disabled people it's in breach of the charter to discriminate against disabled people and I believe what's being proposed is actually discriminatory against disabled older people.

As I mentioned in my submission I have experience particularly with the history of aged care in relation to the pensions income and assets test. When that was first introduced there was a huge amount of public debate of whether or not the family home should or should not be exempt from the pensions income and assets test. The government eventually conceded that the home would be exempt because they knew that they would never get any legislation passed if it was taken into consideration. I was speaking to my federal member about it being mooted, I think it

was last year, and he gave me the reassurance that a Liberal government would never support any proposal that would include the family home as being an asset. So if this proposal is not even going to get bipartisan support, then it's dead in the water before it even gets put before the government.

The reason that the family home was excluded under the pensions assets test and the reason that I believe it needs to be excluded again is because the majority of disabled older people are women and the only asset the overwhelming majority of them have is the family home that they inherited when their partner departed the mortal coil. A lot of them, whether or not they should or they shouldn't, feel it is the only asset that they have that they may be able to leave to their children. Because of economic circumstances that have happened in the few years where their superannuation has been robbed - they've been robbed of their superannuation as far as I'm concerned and as far as other people are concerned - they've had to take out reverse mortgages on their family homes already and so there's not the asset there for aged care facilities to look to the family home for financial backing.

One of the issues that was raised all those years ago with the pensions income and assets test - and you need to think about today's 60 and 70-year-olds who are not disabled but are likely to become disabled - is that they all tend to have accountants, financial advisers and the like, and those very, very clever people work out ways of avoiding systems that are put in place. For example, with the family home, what they did the last time and what they will undoubtedly do this time is they will persuade people to assign the family home to the children or to a family trust and so the asset is not there for anybody to access anyway. So I guess what you need to be considering is where you're going to get the money from for these reforms if there are no family homes accessible to access. Are you going to order the sale of the home or that it be seized and that the proceeds - in which case - - -

MR WOODS: You know we're not doing that.

MS SMITH: Yes, that's right, but what you are basically saying, by saying that a disabled person must be prepared to forgo part in the family home that that disabled person is being asked to do something that a fit and healthy person wouldn't be asked to do. So the fit and healthy person can hand over their home to their children or will their home to their children but a disabled person can't. For those who can't or won't set up something like a family trust - there is a lot of fear and there's a lot of distrust among older people of - I mean, let's face it, we don't trust politicians because we know how quickly they can change their minds and we also know that government policy can be changed, and so even though you can give us all the assurances in the world that you're not going to kick out younger children or carers, well, sorry, but we tend not to believe you because that is a policy that can be changed.

There is a fear factor out there about, and one of the suggestions that you make

is that in-home carers should be assessed for their capacity to care. We all know that's going to involve doctors, and quite frankly we don't trust doctors. The ACAT teams, we've heard criticism already, that they - some of them, obviously not all of them - have allowed themselves to be worn down by persistent family members who want their aged relatives put into a home. So a person who might very easily only need a little bit of home and community care finds themselves being conned by the kids into going into a rest facility, only to discover they're being assessed. The Aged Care Assessment Team says, "This person doesn't need high care." The family is saying, "Yes, they do." Eventually, as I said, the aged care teams are, in cases, being worn down and are providing reports suggesting that people are in need of high care when they are not.

So when that sort of information - and the aged care grapevine is very, very effective, as you can imagine. If there's one thing that older people can do, it's talk to each other and warn them about the sorts of things that are going on. So when we find out that somebody has been stuck in the locked ward of a nursing home when they shouldn't be there, then everybody else then becomes very, very wary of doctors and the ACAT assessment tricksters, as they call them, in the process.

I've looked at the research that you purport to have looked into as far as the demographics and how - I really am concerned that there's a huge amount of scaremongering going on about how there is going to be this huge, big tsunami of elderly people in a few years time. Well, I remember exactly those same scaremongerings going on in the late 70s, early 80s, about what was going to happen shortly after the turn of the century, and of course it didn't happen. So it comes back. As I have said in my submission I think there's a lot of people who are pushing for this particular agenda, have a vested interest in that particular agenda. They want access to older people's houses because that's where there is a lot of money. There are alternative ways of providing this aged care and I think you need to be looking at an alternative way of funding aged care.

The huge bureaucratic monsters that exist - we have very nice people, lots of not-for-profit people who are competing with each other for funding for Home and Community Care and they are providing duplicated services. They are all having to train their own people in their own little groups and they're all having to provide their own administration, they've got to provide their own this and their own that. From a productivity point of view I think that the entire industry is just a gross waste of resources. When we hear that in some instances more than 60 per cent of the funding goes in administration to Home and Community Services and then when I ring up somebody say, "Do you think I could have a little bit of help with something?" They say, "Sorry, you don't qualify, and we haven't got enough volunteers to do the work. You'll just have to manage yourself."

As far as I'm aware I'm just bloody lucky that I have the use and the strength

and some financial resources behind me, because I can do what a lot of older people can't do - and they're being forced into the facilities. I mean the whole purpose of the Home and Community Care program when it was introduced was to help keep people in the community in their homes and save the huge cost of providing them with in-home aged care. Instead, the money that should be going to help people stay in their homes isn't there, and so they're being effectively forced into aged care facilities when it's just not necessary.

MR FITZGERALD: Thank you. Can I just make a comment? We understand the issue about homes and houses, and of course you're right, there has been campaign after campaign to stop it happening, and we have the system we have. We have a highly rationed system. We have a system with three tiers. We've got mega-expensive facilities being built at one end and a capital strike at the other. So we may have won the war about not including the house but that's the system we now have, a highly rationed system.

Now, those that won't look at using the house do have to deal with the reality that that has had a consequential effect, and the consequential effect is what we've got. So you can say other sources, but what are they? At the same time we've got the disability report, which would include - which we'll need to increase $6 billion a year. We've got a massive mental health budget that needs to be substantially increased. We have a health budget that even on your calculations will go up massively and we've got an ageing population. Whether it's a tsunami or not is immaterial. So if you've got all those happening in the human service area but we're not prepared to look at the wealth of individuals - fundamental underpinning of equity is to look at the wealth of individuals - where are you going to get the money from, because if you don't all that happens is we get further rationing, more people miss out, more - longer waiting lists. Now, that's okay, but that's a high price to protect the house.

MS SMITH: I don't believe - I am not convinced. Having read the research material I am not convinced that there is going to be a huge increase in costs. A lot of the people who are arguing that there is going to be a huge increase in costs have a vested interest in that argument.

MR FITZGERALD: Well, can I ask this question: do you believe that by 2040 or 2050 the population that will need aged care services will have substantially increased?

MS SMITH: It will have increased.

MR FITZGERALD: Do you agree - our predictions are that they will increase from one million people today to 3.6 million people in 2050 requiring aged care?

MS SMITH: No, I don't. I'm not convinced about that because as I've explained in my submission I think there's a lot of reasons why that won't be the case. A lot of today's 45-year-olds who will be 85 in 2050 are already - you know, their planning for their futures is significantly different to 85-year-olds today. They've got a completely different financial base and they've got a completely different health base. They may have an issue when they're 105, but the suggestion that today's 45-year-olds are going to be as sick when they're 85 as today's 85-year-olds, I think is - - -

MR FITZGERALD: But underpinning that - my last comment is therefore you don't agree with any of the work been done by Alzheimer's Association about the projections of dementia?

MS SMITH: No, I don't, and I have argued that. There are 100 causes of dementia, some of them treatable, some of them curable, some of them reversible. 99.99 per cent of the time we hear nothing about 99 per cent of the causes of dementia. All of the emphasis is placed on Alzheimer's and I - having been involved and having read a lot of the research and spoken to a lot of the people involved - I am not convinced that there is not a vested interest that is pushing that barrow that is - - -

MR FITZGERALD: So my last comment is from a public policy point of view your advice to the government is discount all of that available evidence and design a system that will deliver a much lower level of services than what we're projecting. In fact, that's what you say. You're saying - and your belief is that our system is far too generous in terms of its projections, that the number of services will have to be much less than what we're projecting and therefore the costs will be much more manageable. Is that the - - -

MS SMITH: I'm saying that it's - not generous, I'm saying it's far too pessimistic about the future based on a biased input. If you were to talk to some of the people who have been struggling to get their voices heard over and above the industry who are controlling not just where the funding goes and the voices are being heard, but where the research is being directed - you don't have to be a rocket scientist to know that if you could reduce the onset of dementias - - -

MR FITZGERALD: Sure, we agree.

MS SMITH: Absolutely. By five years or - - -

MR FITZGERALD: We've been very clear that if you could do something significant in the area of dementia that would make a huge difference.

MS SMITH: Yes.

MR FITZGERALD: Having said that, prudent public policy says let's just assume that that's not going to occur at this stage. If it does, that's excellent, fantastic, we'd all want that, but you wouldn't base public policy on that.

MS SMITH: If the pessimists are correct the alternative is not necessarily to be looking at the family home.

MR FITZGERALD: No, I hear that.

MS SMITH: My experience, and the experience of those in positions like myself who I have spoken to, is that the money that is being wasted in duplication and empire building - if we could improve the productivity of the aged care industry and its affiliates then we would have no trouble finding the extra billion dollars, the extra moneys that would be needed in a worst-case scenario situation.

MR FITZGERALD: Thank you.

MR WOODS: Okay, thank you very much.

MR FITZGERALD: Thanks very much.

MR WOODS: Can I ask Clive Rogers to come forward, please? Thank you. Could you please state your name and whether you are representing any organisation.

MR ROGERS: My name is Clive Rogers. I'm not representing any organisation. I'm a private dentist.

MR WOODS: Thank you. You have provided us with a submission. Do you want to take us through that or make some key points?

MR ROGERS: Yes, I can take you briefly through that. I was actually coming from the standpoint also that we're not really talking about older Australians, we're talking about people with disabilities. We've encouraged the society - for people to live with disabilities. Then we should be providing services and making that easier for them, and supporting them so that they have what would be considered a nice life, I think that would be fair. I've only been here for a short period of time and I agree that our care workers are not paid very well at all. We have a large infrastructure once again building beautiful buildings to house people in institutionalised care that appear lovely but as I constantly say to people, "It's not about the building, it's about the people - it's about the carers." I visit over 40 facilities here in Perth and it's definitely about the people, it's not about the facility.

I agree with a comment that was made before in that there are people other than the large corporations who have been trying to have their voices heard for a significant period of time - about 20 years now. In my particular area of dentistry - just to let you know, for 16 years now I have been a domiciliary dentist, which is quite unique, wandering around to nursing homes, private homes and hospitals dealing with people who are elderly or have disabilities. I'm a qualified dentist and a qualified teacher, I'm a qualified trainer and for five years previous of this I was a university lecturer for dental students in this area, which is special needs dentistry. I, like those care workers - most of my friends say, "Why don't you get into the big bucks? Go and work for the average person out in the community. Do some cosmetics" - this is what I choose to do because I actually believe in our community. I believe in working for our veterans and our elderly people; it's important. However, I'm quite disappointed in the management. There's quite a few people who have been saying things that are important and they haven't been listened to for quite a period of time.

I am seeing constant neglect every single day in nursing homes in oral health care. It's interesting to see that one of the submissions made - and don't quote me - I think it was 2005 saying by 2010 there would be a dental work room in every care facility. It didn't happen. I go to the ones that have just been built this year; didn't happen. I'll walk in and there will be a first class hair salon, but for me to do my work, there's nothing. It's not about that. When I go in I'm doing the major repairing

work. It's the day-to-day care that stops people from declining into ill health, regardless of who they are. Not everyone in this room will have perfect oral health but we'll be keeping the balance. As soon as you develop a disability, each one of us, that prevents your daily care, if someone else doesn't take that over for you within a very short period of time - six months to a year - your mouth will turn into a disaster. It will be causing you infection, pain, making eating difficult - changing yourself, the whole thing.

Now, I am, in my submission, saying, "Yes, it's great. I think it's important that we need to be training dentists in this area. We need to have dentists, dentists, dentists," but that's not the key here, it's really carers. It's people taking over. Also it's in our mindset too. There's a few people like myself advancing in years; we've virtually got to start realising that this is going to happen to us. In our current climate when you go into a care facility now, if you have a disability that prevents you from brushing and/or selecting your own diet and you are unfortunate enough to have a medication that changes your saliva, in two years you will be a dental disaster. When my submission goes on I put just a few photos of what I have seen in the last 12 months. I could have put hundreds of outright broken down infected teeth. That will be you.

As I mentioned, off the record pretty well every single nurse manager says to me they want all of their teeth taken out before they come to a care facility. They won't put that on paper. They are the nurse managers that say to me off the record, "We've got accreditation coming," and they say, "I know, Clive, we shouldn't be passing but I've been told by the boss we've got a team coming in and we're going to tick all the boxes. I know that they don't look in the mouths and we're going to pass, but what can we do," and I'm going, "You can stop lying. You can tell them the job is not being done. You can tell them that the carers are not trained well enough to do this job," because it is actually a difficult job cleaning the mouth of someone who has a disability and potentially dementia, not that I'm singling that out, but it makes someone less pliant.

MR WOODS: Adds to the complications.

MR ROGERS: It does. It adds to the difficulty. I must say the current training program that's been done by South Australia, unfortunately that is a compromise built on a compromise. I personally knew the late Jane Chalmers whose research that was all founded on and her idea was very much that the dentist is involved at the top and the training of the carers required to be quite intensive. However, that got watered down to the dental examinations being done by the RN and the doctor, who really doesn't know what a mouth looks like. I know that there is a lot of people's salaries and careers riding on that research, though if you look into the data it's failed because they can't pick up early disease. They can pick up a train wreck. We don't need to see disease when it's in train wreck stage; we need to see it when it's starting.

So it's all well and nice, so they bring in a training program to train someone to do oral care for not just one person, a group of very complex mouths on a day-to-day basis and it's a one-day training of all the aspects. As a dual qualified educator, that's not best practice, that's complete, utter nonsense. I have run this class for people who are cert IV trainers in TAFE who write training programs and competencies and they just look and it say, "It's just a joke. It's just to make people feel good." The big problem however that has happened is if you take a RN, who is already busy - these ladies in the care facility they're busy, underpaid - and say, "You've got now a new job. We're going to be getting you to do the oral assessments and we're going to train you also how to clean the mouths, and you're then going to become a trainer of the staff even though you've got no qualifications, education," it's complete nonsense.

This person now actually can fully see - because they're very clever ladies and men, really - that there is a problem. In fact that makes people withdraw. I've actually seen a decline. Before, people would stumble in and try and do daily care. Now they realise that they don't actually have a hope in hell. I've been proposing more intensive training. There are competencies out there but people don't want to pay for it, people don't want to spend the time. For example, there's a large facility here in Perth that employs over 2000 people. For manual handling they have a special 15-person team whose job is - they have 15 people below them, all qualified in manual handling who disseminate this knowledge through that 2000 people. For people who have swallowing problems they have a similar 15 or 16-unit team with a sub-team of 15. Now, do you know how many they have in their oral health team - which is the gateway for all of your food, your breathing, everything? They have no team. Well, no, they do, they have a few RNs who have gone off to a one-day course that isn't possible to train them in anything, and that's it.

So from that point of view that's where I'm coming from and, really, a chap called Pat Shanahan, a dentist here in Perth, he was telling me this 20 years ago. I didn't believe him that people wouldn't listen. He said, "Just stop trying, Clive." So that's a little bit of what I did.

Yesterday I went and saw four people. They were all 80 plus, private hospital, one of Australia's leading private hospitals. Their shares went up 40 per cent last years, I believe. Not one dental treatment in the whole place. I did two surgical extractions last week on my knees next to the bed. They worked out really well and the chap is out of pain. Two nursing homes, a denture that hasn't been out of the mouth for, it appears, over a week. Every single one of them had four abscesses to eight. My colleagues in the eastern states, who I am in constant contact said, "I see exactly the same picture."

I have other dentists who would like to become involved, however, they go, "Clive, after seeing the nonsense and the hoops you have to jump through just to get

into a facility and help, we're just going to stay back until they get a little bit more organised," because people make my life hell. I had one classic case which actually will probably become Australian or national news eventually of a lady who I got called to see because she had two teeth that were choking her, it was life threatening. I got consent from the two daughters who are not official guardians and I went and saw her. This lady has advanced dementia. When she was in the community she lived in one of our most premier suburbs. She went and saw two of Perth's top dentists and her mouth was very well maintained. When I got to see her in the care facility she had 19 abscesses. Two of the teeth had drifted off to the point where they were choking risks and I used strategies and techniques which I built over years and I gave her a local anaesthetic and I removed these and one other which was potentially a problem and got consent and my comment was, "This lady has had extreme oral agitation."

My way of testing for pain on people who have dementia is that I usually touch an area of the gum which is not inflamed and has no apparent pathology and very gently press that area and you get no facial expression change. Then I gently move to the area where I am thinking there might be and you know what you're going to get, you get grimacing and - I don't do it once and I'll move back and at stage - I'm not trying to traumatise these people but I'm wanting to gauge how sensitive these areas are. In this lady's mouth I was actually struggling to find a spot to actually do the non-test, the standard. All of her 10 teeth at the bottom were decayed down to the gum and had formed eruptions so many times you could see from the amount of pus draining in that mouth and in the top.

Now, that lady should never have got to that. She had been signed off actually by some government dentists that had come and seen her. She should have been provided access to care, to a specialist medical and dental, a long time ago. People said, "When was the first abscess? Maybe the second - the fourth." But this was 19. Yes, I sorted out two. I then ended up with a conundrum. There are oral surgeons in this town and anaesthetists, the same people that when people fly in around the world we separate conjoined twists, who are prepared - normally they're booked up months ahead. When I phone people like this, they'll break their list. They'll say, "Thursday, we'll slip them, we'll work them up." If the doctors are on site - I've had cases like this where I send a report to the doctor and I get a phone call. I know the report has hit the desk two minutes ago, they've rung me, "My God what have I done? What can we do?" I said, "What I need from you is" - what I call the perfect baton pass - "I need all of this lady's medical details for the specialist doctor and the specialist dentist and they'll sort this out."

MR WOODS: Can I just advise you of the time.

MR ROGERS: Yes, the time. This lady's doctor, daughter and care facility prevented her to have access for that treatment and when I reported this to the Office

of the Public Advocate, they said - they didn't even investigate the neglect. They said, "Just leave things as they are." No. As the surgeons would say, "What's the problem here?" There's a lot.

MR WOODS: Thank you very much for coming and giving your evidence and thank you for your submission.

MR FITZGERALD: Can I just make a comment. You're the third oral health specialist we have had present and so it has been very valuable insight both in Sydney and here. It is an area that we hadn't fully appreciated, there's no question about it. Can I just ask this one question. We can talk about improving the training of the various staff and all those sorts of things but is there something beyond that that is necessary at either a state level that is required? So we take on board your issue, we take on board the need for training. We take on the board the fact that the standards are in fact not picking this area up. But over and above that is there something more substantial that is required in the state of WA that would make a significant difference? All of those are important but is there something over and above that we are missing?

MR ROGERS: No. WA is not really all that different from the other states. However, what we're missing is a lot of - from my own profession you would have all heard, "Teeth for life," we're encouraging to have teeth for life. There is a certain time here where you actually need to sell your racing bike, you are not going to be riding it; there's as point here with the way we've structured the care - because this is about daily care - where you've got to cut and run, have all of them pulled out, unfortunately, and go to dentures and realise that's how it's going to be. Looking at me, I have some disabilities that I picked up from a car accident and it was like ageing 10 years and there are lots more unfortunate people than myself who lose - we've actually got to start accepting that that may be a loss that we have.

A commonality - and this has actually been said - and this is Australia-wide and my other colleagues say it - I've gone in and said, "Your dad needs to have his teeth out," and the daughter will, "He'll never look the same," and I said, "Well, they're all rotten anyway." "Why did he lose his feet?" "He had major infections in there and the doctor was worried about them so they amputated his legs." I said, "So you allow them to amputate his feet, but you're not going to let me" - "You can always throw a blanket over his feet." I'm going, "What? Are you serious?" That has been said to me more than once. I think we have to get a little bit of reality on this. But training of carers - - -

MR FITZGERALD: That's the call.

MR ROGERS: Also, for instance, advertising on - we don't educate people. Most people in this room should realise that your teeth brushing does not stop tooth decay.

It's for gum disease. It's your diet. Your diet stops the tooth decay. The brushing does nothing. If you watch the Oral B ad - this disinformation is disseminated throughout society.

MR FITZGERALD: Thank you very much.

MR WOODS: Thank you.

MR FITZGERALD: Thanks for your diagrams. We have a collection at the moment of bad mouths.

MR ROGERS: Thank you.

MR WOODS: Can I ask Tony Fowke to come forward, please. Thank you very much. For the record could you please state your name and whether you are representing any organisation.

MR FOWKE: Yes, I'm Tony Fowke. I'm an advocate for mental health carers and today I don't actually represent organisations but I'm a member of a local one, a federal one and an international one, so that is the background.

MR WOODS: Thank you.

MR FOWKE: For about 30 years I have been an advocate for carers of those experiencing mental illness and particularly families and others close to them - often called carers but I think that gets a bit confused when we talk about carers in this situation. I'm talking about people closely connected with families and people like that. So as I said before, I make this submission today as an individual with that background but perhaps more significantly as a senior citizen which may be obvious. My teeth, I hope, are all right. I'm a bit worried now.

I make this submission in the context of an integrated person-centred approach where things are dealt with and a whole range of services working together to achieve the best possible outcome for the person involved so the person is always the centre of what is happening. That outcome to be determined in accordance with the express wishes of the individual or their family where they're not able to make that kind of decision themselves. There are people living in the community with a mental illness who are receiving support in various different ways but for some of them the time will come when they need extra support because of the ageing progress.

I say "some of them" because for various reasons the average person with a mental illness has a shorter life expectancy than the general community. So that is another issue by itself. This is because they don't receive the full care and attention that they need during their lifetime. So it is a person-centred approach, it is an approach that is just dealing with a specific issue. I suggest that extra care cannot be provided in what is currently called aged care facilities, the extra care that people suffering from those disabilities experience, because I don't think they are equipped to do that. There needs to be a separate, seamless approach to the continuation of appropriate care from a community setting, whether it be at home, in supported accommodation or in a hospital to a facility that is able to provide that care in an appropriate way. I should make it clear I'm not here talking about dementia but other mental illnesses which can often be episodic in nature.

Depression in older people is common and occurs for different reasons. These could be such things as the onset of a physical illness or personal loss. Sadness can be common and is a normal part of life but depression is not a normal part of ageing.

It is well established that there are older people suffering from depression and anxiety that remain undiagnosed and untreated. This means that their quality of life in their later years is not what it should be and there is a perception that this is just part of growing older. There needs to be a specifically targeted awareness raising campaign in the aged service sector to increase awareness about depression and anxiety amongst other people, coupled with mandatory mental health training.

Depression and anxiety, as well as other mental illness, are treatable. Just because people are old does mean that they should be deprived of treatment which could improve their quality of life. This, I think, would be something that their families or others who are closely connected would expect to be in place. This is not a particularly new issue and I go back to the Human Rights inquiry back in 1992 which was conducted under the direction of Brian Burdekin and it talked about depression then and I just read what it says because it sets it out again:

> According to expert opinion depression among the elderly - but it may be twice as common as dementia. About 50 percent of elderly people have at least one symptom of depression. Estimates vary, but one Australian study found major depression in 10.2 percent of those over 65. (Even on a conservative estimate, this would mean over 100,000 older Australians suffer this painful condition.) One measure of depression is the suicide rate, which is higher among people over 65 than in any other age group.

It may have changed a bit since 1992 but certainly for men over 65 it's in the higher range for people committing suicide.

> Depression frequently accompanies other health problems. It often occurs alongside dementia, and the symptoms of the two conditions are sometimes confused. It is associated with chronic physical illness, which is itself more prevalent as people get older. Depressive symptoms are also a common side effect of prescription medications, including hypertension drugs - and the elderly take far more medications than the young. Ironically, depression is one of the most curable mental illnesses. However, the evidence indicated that among the elderly, it is often - unnecessarily - left completely untreated. All too often it is not even diagnosed.

So my submission is that there should be specific facilities and training for people who go into care to make sure that there isn't this additional burden that they have to bear over and above the normal ageing process. Thank you.

MR WOODS: If I can pick up a couple of your points. I'm not sure if you've had the opportunity to look through our draft report on aged care but one of the reforms that we're proposing is that the current packaged and boundary nature of care at the

moment - whether you fit into this form of care or that form of are - should be totally restructured and that the needs of the individual should be assessed and that care should be directed to address those needs and - you mentioned episodic, which is indeed true - to address episodic needs but also to focus in restoration, rehabilitation. If you have had a chance to look at our draft report, do you have any views on that as to whether that goes some of the way to addressing these issues?

MR FOWKE: It certainly does because if it's the whole situation examined around the person then you should look at every possibility and that possibility should be treated. But, unfortunately, I guess it's the lack of staff and trained people, it doesn't happen. I mean, it happens before the person gets to the aged care facility. They may not be fully diagnosed with everything that is wrong with them. So when they go into an aged care facility that full examination has to take place which may well disclose things other than a mental illness that they have been suffering for some time.

MR WOODS: Is your experience with people who are ageing and who also may have a mental illness and related needs based on those who are in the community or those who are in residential facilities or both?

MR FOWKE: Both.

MR WOODS: Do you notice any difference in the treatment that is available and provided to people who are receiving community based care compared to residential care?

MR FOWKE: Well, I'm not an expert in that area but my gut feeling is that they don't have a lot of people going into the facilities or into the community setting who are able to determine that issue because specialists in the psychiatric area are in short supply and it's very difficult to get one anyway so it's just part of the existing problem.

MR WOODS: Would your proposition to us be that in the first instance focus on a more complete assessment of the needs of the person and particularly, as you say, depression can often be either overlooked or confused with other behavioural issues and the follow through a form of treatment. Is that where you want to put the primary emphasis, both at the assessment and then at the consequent treatment?

MR FOWKE: A more complete examination and assessment upon admission but it should be a constant review because the depression can occur as a result of the circumstance the person is placed in. The facility itself may make them depressed.

MR WOODS: Yes.

MR FITZGERALD: One of the things we are encouraging is the development of aged care health teams which would operate on a local or regional basis and there are some examples of that even here in Perth. It seems to me that one of the things that we need to do is make sure that, if we are going to go down that path, that team have sufficient health professionals, including those that deal with mental health conditions, in particular depression, as part of that team so that when they enter or go into a residential facility this is one of the things that is picked up. A lot of the emphasis is training the staff in the residential services. But increasingly it seems to me there is a range of specialist supports that need to come in from time to time to address some of these more complex issues.

MR FOWKE: Yes, and it shouldn't just be the medical model either, it should be the psychological side. I mean, what is causing this problem? You can mask it or get the symptoms under control with medication but that doesn't actually solve the problem itself.

MR FITZGERALD: Thank you.

MR WOODS: Thank you very much.

MR FOWKE: Thank you.

MR WOODS: We will take a short break and we will resume at 3.20. Thank you.

MR WOODS: Thank you. Can I ask Silver Chain to come forward, please. Can I ask each of you to identify yourselves, the organisation you represent and the position that you hold.

DR LEWIN (SC): Gill Lewin, research director at Silver Chain.

MS BAIN (SC): Carol Bain, general manager country services, Silver Chain.

MS FAHEY (SC): Avril Fahey, regional manager home support services, Silver Chain.

MS CUMMINS (SC): Sheilah Cummins, general manager home support services, Silver Chain.

MR WOODS: Thank you. Thank you for coming and can I say thank you for all of the contributions that you have made to date to this inquiry, not only in written form but also coming to workshops and being available and having our staff ring you up and say, "What do you mean by this? How does this work? What do you do there?" So we are very grateful, it has been an excellent contribution and we have benefited from that. You have provided us with submissions but I assume that at this stage you would like to tell us things, talk to us.

DR LEWIN (SC): I will start, if I may, and thanks for the opportunity. I just wanted to pick up on a couple of issues that we have written about in our submissions, firstly research and then I'll go on to restorative home care. As pointed out in the report, there is a very limited evidence base within aged care and I believe that this partly attributable to a much reduced level of funding going into aged care research when we compare it with disease-specific research. I and Silver Chain and also the AAG have particular concerns because you may be aware that the NHMRC have disbanded the review panel which is for geriatrics and gerontology and nursing which means that aged care research can now be reviewed by any of the panels rather than having its own panel and we are concerned that it will, therefore, be reviewed by people who don't have the multidisciplinary skills that are really necessary to understand aged care and the research in the area.

One of the other things that the report pointed out was how important independent evaluation of aged care services is which I totally endorse. But I have some concerns to really express the importance and value that I believe that practice based researchers have and that there is a whole body of information about the value of evaluations which are conducted by a combination team of internal and external. One of the things about having practice based researchers which I think is incredibly important is, of course, we're interested in the long-term in translation of evidence into practice.

Over my years at Silver Chain I've learned of the absolute importance of involving everybody within the organisation in the process of gathering the evidence and working out a model if they're then going to translate it and take it on. So that what I am essentially suggesting is that we need more practice based researchers but we also need the multidisciplinary networks of academics and others that they can work with and therefore have the opportunity to develop and gain skills so that there is more of a career base for researchers that are practice based as well as academic. So that was really what I wanted to say about research.

In terms of restorative home care, as you're aware it's my particular area of research for some years, and the report noted that there was limited evidence to support restorative home care. Now, whilst there is sufficient evidence as perceived by the UK for them to actually be investing GBP50 million over the years 2010 to 2015 in order to incorporate these sorts of models throughout their social care system. The concern that I have with what was proposed within the report was not that it wasn't acknowledged that restorative home care services can have benefits, because it definitely was, but it would seem that they are envisaged as specialist services rather than, as in the UK, as a basic building block.

The model that I have been promoting for a number of years is one in which when people experience difficulties, instead of us going straight in there and just doing for them what they're having difficulty with, we spend the time understanding the difficulties and assisting them to overcome. So that's right up-front and that is the model that the UK re-ablement services are taking. So that when somebody is first referred for home care services the re-ablement service is like an extended assessment period, it's goal directed, time limited, with the intention of helping the individual get over their difficulties if they can - and a very significant proportion can with assistance, using different strategies. But if they require ongoing assistance it's the re-ablement that does the care planning and it's at that point that the individual is then referred on to providers.

As I understand the model that was proposed in the draft report, restorative home care would sit as a specialist service only available to the second tier and perhaps - - -

MR WOODS: I'll clarify that for you. You finish your bit and I will come back it.

DR LEWIN (SC): My concerns about it being a specialist service is, first of all, who to target because, as you are aware, there is no evidence at the present time to indicate that we can identify those who will benefit most up-front. Our own trial here was a randomised control trial where virtually everybody had the opportunity to participate and it was shown to be effective on that basis, so as a population based strategy. When we did a specific study to try and get the staff to identify whether

they thought they could target, they felt they couldn't. They said they were continually surprised by who did well on the program.

Whilst I am totally supportive of individuals having choice - I think consumer choice is very important - I don't think that we are always well equipped to make choices, especially when we're vulnerable, having immediate difficulties and that for an individual to make a choice, I want to go on a program that might assist me to not need an ongoing service I think is a very big ask at that time that the person is experiencing those difficulties which is the advantage I see of the re-ablement approach where during the time that they receive the re-ablement approach they're actually provided with the hands-on assistance that they need as well as the restorative strategies.

The model that is currently working in WA with the regional assessment services, which is how I thought the model proposed in the paper would work, was that the regional assessment service or the gateway would do an assessment then refer off to restorative home care. Much of what is in the restorative home care requires obviously detailed assessment to understand the difficulties where they original from and I believe that there would be a lot of duplication if that were the process. One of the difficulties that Silver Chain has had, as you will be aware, is in having a full complement of allied health staff to actually staff the restorative home care programs and as a specialist service it read to me that we were going with a model that would require a specialist team such as allied health whereas we're currently moving down the track of developing - we're funded by Health Workforce Australia to actually develop the service so it can be delivered by care coordinators who have received special training to be able to do that but with the allied health providing the consultancy and specialist service in support.

The other concern was that if it is a specialist service, if it is allied health based then there would be considerable delays in that service being available to people, given the shortage that we know for community based allied health and that if we're working within a model where we have single allied health practitioners working by themselves that would be a very expensive model and not cost effective as the interdisciplinary approach we believe is. Those are my points.

MR WOODS: All right. Perhaps if we can address that before we then move on to other issues. There has been some confusion in interpreting our building-block approach and we will make sure that we overcome that in the final but it was certainly meant as a layered - I mean, diagrammatically that is how it was produced but the intention was that when a person was assessed for their needs that the needs would be drawn from a range of basic support that they may need, a range of personal care that they may need and a range of specialised services. But the bundle of needs, the entitlement, whatever that looks like - and we would like to explore that further with you - would draw on all of those things so that some people may only

need basic support with a bit of personal care, others may have continence issues or other issues that cut in immediately.

We also saw great value in having some of that care or support services delivered in a targeted, goal-directed, time-limited basis so that, as you say, there might be a 12-week period of, "What can we do for this person to help them regain or retain the level of independence that they either have or had previously," and then reassess what their needs are after that period. So we were very persuaded by a lot of what you had been telling us but we didn't go the full extent of saying, "Let's make that the primary front end to all other things." Our thinking at that stage was that there may be some services that do have a short period of, "What can we do to provide restorative or rehabilitation care, but that there are other services from the front-end assessment you could more reasonably, confidently say they're going to need for six months or 12 months and let's start them on that as well and reassess as time dictates."

So we are happy to be tested on that and to explore further. We are very familiar with your proposals and are very supportive of getting people back to a level of independence as soon as we can but we just didn't take ourselves to that step of saying, "But that is for most people the front end." But we're happy to continue that discussion and engagement. But certainly it wasn't seen as a layer, that you had to go through the first layer to get to the second layer to get to the third layer. It was drawing services from all of those. Diagrammatically we represented it that way and maybe that's the problem but, as you know, trying to put things into diagrams is pretty complex.

MR FITZGERALD: The reason question for us is: having done this needs analysis, whichever tool you use, you then have to be able to convert that into an entitlement to services, put simply. One of the things we're struggling with is what does that actually look like? The simplistic models it's two hours of domestic cleaning, it's three hours of gardening and all that. But that doesn't seem very appropriate. So what is the way in which you describe the entitlement? That is the challenge going forward. So you have the issue about how do you do the needs analysis, we call that a building-block approach. Then you've actually got the entitlement. Is it bands, is it specific services? How do you describe this entitlement that Michael in his old age takes to Silver Chain? What does it look like?

That is quite challenging. So at the moment we have asked all the participants really to say, "Guide us on this. What should it look like."

MR WOODS: And, "Which bits for how long and what's their objective. What are you trying to achieve from that delivery of services? How do you know that you've got there and what do you then do next?"

DR LEWIN (SC): I would say that first of all the needs analysis ought to be actually an intervention process, as I have said. So the needs analysis sits at the end of an opportunity to improve and at that point I don't see why we're necessarily going beyond the package concept where we have different levels of funding allocated to the level of support that somebody needs which is most probably going to be based on dependency, such as the work we did in the WA community care classification project. That would be my personal view and at that point it would be identified whether people needed specialist services and that would be part of the case mix.

MR WOODS: But some of it would be again - well, hopefully all of it is goal directed but each of these services intended to have a particular outcome but some would be more time limited and to assess progress against them and others would be of a longer-term duration. Do you need that 12-week extended assessment and initial work-up of understanding the situation for everybody, which is the sense I get from your literature, or in some cases is the support that is required fairly self-evident at the front end and can operate for a period and be reassessed? What's the flexibility around your proposal?

DR LEWIN (SC): With my recall, it was about two-thirds of individuals who would go through restorative intervention. Now, the others were people with progressive neurological disorders that were fairly advanced. There were people with palliative care who needed home support and there were people with advanced dementia. They were our only exclusions. I would still argue that that should be the only - - -

MR FITZGERALD: See, this is the challenge we've got because many of the HACC providers which will be substantially affected by what we're proposing, both in terms of having greater opportunities to expand their services, but some of them who feel noticeably threatened are saying, "Well, the person only wants X service, they can come to our door, we know what we're going to give them, it's very simple," that we're overcomplicating it, we're adding assessment layers. Of course there's assessment layers already in HACC, there's multiple ones in different states - I know WA is doing some things at the moment - so we're being torn at that end to be very careful about overassessing people for what people say are basic things. On the other hand, you're proposing to us that the majority of people would go through a more extensive/restorative or re-enablement process, so those tensions are quite difficult to come to grips with at the moment.

DR LEWIN (SC): You see, I would be quite radical; people who required only domestic assistance, home maintenance, transport, my first question is: does this community want to make this available just on the basis ultimately of age? That's, let's face it, what happens within HACC. We know that from the New South Wales data, the Victorian data. 60 per cent of people have no functional need as measured. Now, if that is the case, why do we do it through a formal service provider? Why

don't we give those people the means by tokens or whatever to go out and purchase that on a private basis? I would see that as a way of actually encouraging autonomy, independence, whatever. That personally would be the way, I think. When somebody has a level of dependency that they begin to have ADL difficulties, I think there are very few older people who would not prefer to shower themselves than be showered by someone else and that they would choose, if there wasn't family pressure or any other pressure, to see whether that was possible with an intervention.

MR FITZGERALD: Without trying to simplify your position, your threshold in a sense of entry into the formal aged care system, if I can just use that expression, is in fact based on dependency, not support. In other words, you go beyond the threshold as somewhere where you need services but you really are becoming more dependent on a third party to be able to live well or comfortably in your own home environment.

DR LEWIN (SC): Yes.

MR FITZGERALD: So your entry point is a different threshold than what we've got in HACC at the moment which is significantly different to that.

DR LEWIN (SC): Yes.

MR FITZGERALD: Yes, okay, good.

MS FAHEY (SC): I want to talk a little bit more about restorative care, having worked within the program. I think restorative care as an entry point from my experience and the Silver Chain experience is that we actually promote well ageing. I think that's the challenge that we have, certainly in HACC, that people believe that because they're getting old, they actually need someone to come and do the tasks for them and I think that is where we start to have difficulty because there is that expectation of, "I actually need someone else." In my experience working within the HIP program is a lot of clients will come to us saying, "I need help with this, I need someone to do it for me," but through the comprehensive assessment which is virtually an intervention at that point of assessment, the majority of clients actually start to change their perception because I think there is a real common misconception in the community that being old means, "I need to have help and I must have help at home to stay there, being independent."

For me, the reason why other providers haven't picked up restorative care is that they're not quite sure what they should be doing. There's no incentive to pick up restorative care. They're block funded. There's a challenge with finding an allied health workforce which is the current model that we're working with. However, I think, as Gill mentioned, we are working towards getting a coordinator-led model which means that we can do the very broad and deep assessment that is the basis of

restorative care. The 12-week period that we've talked about really is an opportunity for a client or the aged person living in the community to develop some competency around the new skills that they're developing, the new way of looking after themselves.

MR WOODS: So is this the three hours a week for 12 weeks type thing or what are we talking about?

MS FAHEY (SC):   It could be anything. We often have clients who are referred by their GP and the client says, "The doctor says I need someone to come and shower me and do my cleaning."

MR WOODS: The doctor said, yes.

MS FAHEY (SC):   Yes. What it is is that the client may have slowly deteriorating mobility, so they actually need someone to supervise them initially while they're working through a strength/balance program which they could be doing under the direction of a therapy assistance or a carer. They may not have any equipment in the home that would enable them to transfer safely across a hob or, you know, standing in the shower, they might need a chair. Restorative care can address those types of issues.

I think one of the things about restorative care that is perhaps different to the standard HACC is that we're not just looking at "doing for", we're trying to engage the person and I think in our current model, we also address the other psychosocial factors that enable people to be purposeful in the community. So we're not just sending a cleaner in to vacuum, we're actually sending people in to promote wellbeing, to promote engagement in the community and I think that is why, for me, restorative care really needs to be up-front. It needs to be before people come in. It's before they become dependent on services, because we know that the HACC model makes people more dependent. From our study, HIP actually makes people remain independent for one to two years after they have been through the program, and I think that for me is why it works. People don't become dependent up-front on a service because it's been set up for them.

MR FITZGERALD: Who funds HIP?

MS FAHEY (SC):   HACC.

MR FITZGERALD: So it is a HACC service?

MS FAHEY (SC):   Yes.

MR FITZGERALD: Is HIP a HACC service that is offered in other states or is

this a specific WA HACC service?

MS FAHEY (SC): We use the allied health funding to fund HIP, so we use the block funding and we use that to fund it. So it is possible that other providers could pick it up, whether it be - - -

MR FITZGERALD: So if I looked at HACC funding, what are you funded under?

MS FAHEY (SC): Allied health.

MR FITZGERALD: Allied health.

MS FAHEY (SC): Yes.

MR FITZGERALD: And then you create the program for HIP.

MS FAHEY (SC): Yes.

MR FITZGERALD: But it's actually allied health funding from HACC.

MS FAHEY (SC): Allied Health funding, personal care funding, home help funding and we package that up ourselves.

MR FITZGERALD: Yes, thanks for that.

MS FAHEY (SC): So it is possible that other organisations can do it. We've certainly made the how-to manual available but I think because it's not mandated, because there's no incentive, other organisations find it a challenge to implement. It's actually counterintuitive. We're funded to deliver this volume but if we make people more independent, we're going to have trouble delivering our volume, so let's just keep the clients that we've got.

MR WOODS: We understand people are driven by incentives.

DR LEWIN (SC): There is currently a trial in New South Wales. They're funding four pilot programs, and in Victoria - - -

MR FITZGERALD: Under what name?

DR LEWIN (SC): I think it's called Enablement.

MR FITZGERALD: We have had some submissions or presentations at a public hearing that have talked about enablement and restorative programs. That's why I was interested as to where you're getting your money from and what that category is.

MS FAHEY (SC): So we're fighting against our own volume because we're using our volume to separate our clients.

MR WOODS: You're actually delivering what the people need.

MS FAHEY: Well, I think that's right. A lot of people come in thinking that they need a cleaner to come in and see them once a fortnight for two hours and they actually are discharged with no need for services. 70 per cent of the clients that come through don't need ongoing services and don't need them for up to two years.

MS BAIN (SC): Can I just add something to that. When you're looking at regional and rural areas and restorative models, what Gill and the research team at Silver Chain are looking at now with having a non-allied health coordinator that's able to deliver restorative models is very important because we've not been successful in Silver Chain in implementing the same model in rural because we actually can't get the allied health staff. So where before Vaughan talked about community and actually having difficulties with personal carers, there are difficulties in all programs in rural and remote in all types of staff, but specifically allied health staff, and that will bear some consequence when you do come to look at your assessment model and how you're going to do that as well. I think it does need further thought especially in rural areas. Regional areas it's not so bad but especially rural Western Australia with small populations there does need to be some thought to how that's actually implemented.

MR WOODS: So who are these care coordinators? Are they sort of coming out of an EN-type model or - - -

MS FAHEY: We've been working on a training package. We've had a project with Health Workforce Australia in developing some training and so we're targeting cert IV HACC care coordinators and what we're doing is putting them through a training program, which is, I suppose, a little bit about allied health assistance but certainly a lot around an assessment. Certainly not a "fill in the box, tell me" assessment, it's certainly around a "show me" assessment; a real functional based program.

MR WOODS: So the cert IV level, yes.

MS FAHEY: And above. It's going to be an advanced - - -

MR WOODS: Cert IV plus.

MS FAHEY: - - - practitioner at a cert IV level.

MS BAIN (SC): I guess, looking at the assessment framework we would like to see those types of roles embedded within the assessment teams so that the front end as Gill described would have that restorative approach to the assessment, which at this stage it's very early days in WA for the assessment framework but, you know, that's not the case at this stage so it's perhaps a weak link.

MR FITZGERALD: Even in the WA one you have an assessment, a quick assessment, then you have more detailed assessment, don't you?

MS BAIN (SC): Not so sure about quick but - - -

MS FAHEY: Yes, the regional assessment service is the one that has to determine whether a person will come to HIP. So they have - - -

MR FITZGERALD: Sure. Yes, I know. So in a sense in our model the gateway is that first point and then, based on some criteria, they then refer or provide an entitlement to Michael to go to this service called Enablement, or whatever name we give it. That's right.

MS FAHEY: I would suggest that probably that's a duplication of assessment in some way. I think the best way for it to work is, "Yes, you're HACC eligible," or, "Yes, first time presentation for services you go to Enablement first," because I think what's happening is, with the original - - -

MR WOODS: That's the bit we're struggling with.

MR FITZGERALD: No, I don't think - yes, that's going to be a problem.

MS FAHEY: With the regional assessment service at the moment we're basically duplicating the assessment and the value of a restorative assessment over an assessment for eligibility is we start intervening from the moment we walk into the house, and I think the value for us is that we're not separating out the assessment and the intervention.

MR WOODS: Could some of that be fast-tracked where it was patently obvious what some of those needs are?

MS FAHEY: Yes. "You've had a fall, you've had a - - -"

MR WOODS: You don't make everyone struggle through three months of getting them back on - that's why we just need to understand - some of it you walk in the door and, "Yes, we get the sense of where you're at and let's help you regain your independence." In other cases, "Ah, yes, there's an issue here and let's start bringing in some additional - - -"

MS FAHEY: The way the program works is that the assessor - we call them a care manager - can set up services from that very point of time and the services could be personal care, they could be domestic assistance, but they have a restorative slant. So we certainly allow a lot more time for the care aid so that when they're doing the care that they're not doing it for them, they're allowing the client to work within their, I suppose, limits of their condition or whatever, and I think that's - they don't have to struggle through 12 weeks of assessment, they get the service the very next day if that's what's required.

MR WOODS: My concern, though, is that then there's some capture by the organisation that's walked in the door if it's not the independent gateway. So that we need the person to understand, "Now, are you most likely to benefit from a restorative program, and here is your choice of three providers. Are you in need of particular services," because that's fairly evident after a proper professional assessment, "and here are half a dozen providers. You take your entitlement to this and this." How do you do that? How do you manage that?

DR LEWIN (SC): Well, I would say why wouldn't this be like the UK and be part of the gateway? So it remains independent. We say 12 weeks but in actual fact the average length of stay is only seven and it's based on people achieving their goals. To me, separating assessment and service provision makes a heck of a lot of sense except from when you've got a program like this which is integrated, but I still think that you could have the gateways and that they would be different from the people who were providing the ongoing care.

MR WOODS: We're fast running out of time. In fact we have, but nonetheless there is so many things that we could pursue with you, what two or three things do you particularly want to bring to our attention in the bit of time that we've got left? Open invitation for you. Comments on the rest of our report? You've been through it fairly thoroughly. Are there any particular other bits of the report where you express some concerns or curious about things that might have been raised in the transcript?

MS BAIN (SC): I'm definitely curious about something and I've got to ask Robert something and I'm sure there will be other - - -

MR FITZGERALD: You're going to talk about the multi-disciplinary health care.

MS BAIN (SC): I've gone through that report inch by inch and I have not read that.

MR FITZGERALD: Here in Perth you actually have a multi-disciplinary aged care health thing, which actually has ACAT sitting within it, which is interesting. The problem we've got is - and there's actually other models. We talk about in-reach.

Well, what is in-reach? In-reach can be a doctor but that's not what we're talking about. This is about residential but it has application in the community and you already do a part of it. You will have seen the submissions and you will have seen in the public hearings that there's a whole lot of issues that affect older Australians, especially where they enter residential care. We heard this afternoon about mental health conditions; we've heard about oral health; we've heard about this. We've heard about the difficulty of getting GPs to enter a service; we've heard about GPs even understanding conditions of aged care.

So some people have put forward the notion, and this is more broadly, about team-based health service, which we did in the Health Workforce. All we're talking about here is a multi-disciplinary health team which is focused on aged care, based at a local regional level which would be able to actually provide services into residential services. There's no reason why that can't be extended - and in a sense you do part of that, you do that with your allied health workers and what have you. So it's really that concept. Whether it's called "in-reach" or whether it's called a "health team", what is very clear is that team based health services have a very significant role to play going forward, which we highlighted in the Health Workforce report. So it's about that notion.

The caution we've always put on these things, including in-reach, is that they just need to be fully evaluated to make sure they're delivering - because they're highly expensive. These are very professionally geared services. The notion that the only response is keep training up the staff endlessly, there is limitation to that. You actually do need to bring in people with knowledge, but the individual practitioner going in there, it just seems to me to have no sustainability at all. So that's what that's about. That's the notion. You actually have one in Perth based not far from here. Whether they do much in-reach is another issue but we actually met with them in the lead up to the draft. I don't know what it's name is called.

MS BAIN (SC): I was going to say, who are they? It would be interesting, the link - as Gill, when we were talking - about the link with that and Medicare Locals and hospital and health networks because that might be an opportunity for the aged care sector to be involved in that because that's another part of what's going on.

MR FITZGERALD: Well, look, there's no question at all we want a much greater interface with the health system, and everybody says that, but trying to operationalise that is quite tricky. Now, we're not quite sure about the local hospital networks, we're not quite sure about the Medicare local networks, it's not there. They may or may not be the most appropriate way to do this, but what is very clear is trying to get individual practitioners from a range of different professions is going to be exceptionally difficult. A team based approach has merit, but it needs to be fully evaluated, it's as simple as that, and it is likely that it would be funded through the health system rather than the aged care system but again that's open for discussion.

It's not a novel concept. We do that in chronic illnesses, chronic disease management, but this is becoming an interesting notion.

MR WOODS: Thank you for your excellent question.

MR FITZGERALD: If the other commissioner doesn't quite understand it, don't worry.

MR WOODS: Thank you for your time and we'll explore those issues with you further.

DR LEWIN (SC): Thank you.

MR WOODS: Could you please for the record state your name and the organisation.

MR BELCHER: My name is Wayne Belcher and I am representing myself.

MR WOODS: And Grey Matters.

MR BELCHER: Yes, that's the trading name.

MR WOODS: Thank you. You've prepared and presented to us a detailed written submission but no doubt you've got some points you particularly want to highlight.

MR BELCHER: Yes, I do just have a page and a half of notes which I'll give a copy to you and the commission. My comments are in keeping with the day. They're intended to be provocative, if perhaps somewhat in cheek. They're aimed at causing us to keep thinking about caring better for older Australians.

Nothing so conflicts the Australian dream as the prospect of ending life in a warehouse of older bodies called a nursing home. For profit and not for profit alike, residential aged care providers have for several decades provided fairly efficient, cost-effective and reasonably high-quality solutions for managing care and health needs for the most vulnerable of all population, that is, the mind and will-deteriorated compliant elderly and younger people with disabilities.

Of approximately 180,000 people in today's nursing homes in Australia, about 40 per cent are low-level care recipients. A very recent study out of Cornell University in the US in their autumn of 2010, so six months ago, concluded that some 12 per cent of residents in American nursing homes could reasonably go back into the mainstream of society as recipients of a range of community care services, provided certain measures were in place. These people were mostly assessed as low need for residential aged care.

The provision of care and services could be made in the living environment of their own choosing, which most call home, and we know that most people say there's nowhere else quite like it. Unless we now really begin to think about getting more options for long-term care on the table, our nursing homes will likely be a non-negotiable last resort for too many elderly in future generations of Australia. The sandwich generation people are already looking forward to their own future care needs and just saying, "No, there has to be a better way." After all, who really wants to go into residential aged care? The medical community through the AMA is already getting on board. Our political and regulatory stakeholders are listening or soon will be. Entrepreneurs are trying to come up with plausible and marketable alternatives for a place or a methodology to have better care delivered. Where there's

a will, there's a way.

The first action is one of cutting the low-need from the must-have groups in the vulnerable residential care population. A realistic assessment standard that has health and aged care portability is a need. The Cornell University study began with social workers selection for those in nursing homes who they believed could be transitioned out. The research has established that 57 per cent of these would successfully live independently or could reasonably live at home with appropriate provision and support measures. ICD coding with comparable subsidy payment rates are essential to facilitate that.

The critical factor that remains for care recipients is the access to and provision of medical and nursing care when the chronic care needs are complex. Other important factors are the availability of family and social support combined with feasible and appropriate housing and accommodation options. Some institutional variables such as oxygen supply, intravenous medication therapies, pharmaceutical delivery, equipment supplies, security monitoring, food preparation are already in place in a range of community services or can be. These services just need to be authorised for in-home delivery and use. Increasing the range of high-care community package services can partly accomplish this.

Another method of reduction of demand in the sense of an inevitability about admission to residential aged care is a change in the way nursing home length of stay is envisioned. At present, the sign on the nursing home door is like Dante's, "All hope abandon, ye who enter here." Someone needs to be in place to advocate strongly for the return home for every individual and trained to know what could make it work and why. For some smaller than the current number of clients, there might really be no realistic alternative; that's smaller than current. The answer is not just great discharge planning, it's great discharge planning with the imprimatur and associated realistic resources to effect, deliver, manage and monitor the service provided elsewhere than a nursing home. Perhaps this is an advocacy in practice model for the Productivity Commission's proposed prospective gateway and gatekeeper.

There was only one determining factor in the Cornell study that predicated against return of clients to the community from a residential aged care facility. That was poverty; that is, pension only, no underlying assets for care recipients. Housing remains a driver for the asset and income poor as a baseline need for care. Nursing homes are expensive. The complementary costs for provider and care recipient alike for the capital and recurrent costs of care in nursing homes is escalating beyond the reach of many, provider and client alike. But better, more cost-effective high-quality care alternatives, I'd really like to see that.

Some 80 per cent of today's Australian residential care recipients are receiving

some measure of government pension. Perhaps the loss and resulting opportunity costs of the family home is too unrealistic a price for the complex high-care residential care recipient to pay. You have the larger submission. I'm happy to take questions.

MR WOODS: Thank you for the work that you've put into that. It's lovely to see contributions to the public debate. I'm sure you're also looking for a paid model for your other consultancy work, but it was helpful. A couple of things: (1) when you look through our proposals for breaking open the sort of packages of care and also breaking open the question of accommodation from that of care, with a greater focus on home care and restorative care, rehabilitation, does that go some way to your point about portability and care needs and if it doesn't go far enough, where else would you take it?

MR BELCHER: No, I think we need to have a consistent assessment of need across both residential and community care and only those that we really determine as being the most highest people in need of residential care being sponsored in such a way, and I'll leave the definition of that up to others.

MR WOODS: Yes. We don't want to set up the operating model, the detail.

MR BELCHER: But along with the assessment, I think we need to be consistent too in whatever subsidy is paid for care, based on a consistent assessment; it's paid, whether it's residential or community care.

MR WOODS: Yes.

MR BELCHER: That's not what we have at the moment.

MR WOODS: It's not what we have at the moment but hopefully, if you go back through our report, you will identify that we're saying that the assessment for care is a separate question to where people want to live to have that care delivered. In some cases, and as you yourself agree, there will be some for whom a residential care environment of the current form of nursing homes is the most appropriate place, but our argument is that that's not the case for a large majority of people, that in fact they can be cared for adequately and properly in their home, if that is where they want to live, and their home can be a range of things, which brings me to the second point that you raised that I'd like to touch on, and that's the form of accommodation support and we would hope from the reforms that we are offering that providers of accommodation and care would offer a greater range of accommodation options so that you could have social housing, you could have congregate living, you could have supported assistance in apartments and the like and the care delivered in those environments. Does that then again go some way to meeting where you see care should progress to over the years?

MR BELCHER: Absolutely. I don't think we'll begin to see some of the options that are going to come out in housing if we can break the accommodation issues apart from care. There is not going to be a paucity of demand for housing for seniors in social housing or affordable housing requirements for the next 20 years. Tens of thousands of places are needed. So providers of whatever cut of cloth, whether for-profit, not-for-profit, there is plenty of business to be had. The issue is how, in social housing, how we as an Australian community fund it, but the demand is ever present and growing.

MR WOODS: The final that I want to raise is where you refer to subacute and transitional care. Again, we see that the owners and operators of the current model of residential aged care facilities should in fact look at the facility and the care that they deliver in that facility in a much broader context, that for some people it might be an eight-week stay because of some rehabilitative program, it might be a transition care 12-week program coming out of some other acute intervention or it might be subacute, it might be respite for an extended period, it might be long-term dementia, it might be palliative and end-of-life care for the vary frail aged who can no longer be adequately and properly supported in the environment. But, again, does that fit into your model of where life should be in the future?

MR BELCHER: It does but it complicates for me the issue of separating accommodation from care in terms of subsidies. Not entirely but if - - -

MR WOODS: The care would be subsidised separately from the cost of the accommodation.

MR BELCHER: But for me I have some concerns about that being entirely the case. Let me explain. If we are able to take into what is currently accepted residential care place, a high-care place, a person from a hospital who is attracting funding for a hospital at, say, $1200 a day or in a private hospital for a medical occasion of treatment $700 a day, which includes an amount of subsidy for capital for providing that purpose, and we have residential clients who are receiving - and I don't know what it's likely to be - let's say it's $300 a day or whatever, but they're required to either meet a daily cost themselves or have paid a significant premium, whatever way that is worked out. But 80 per cent of them are pensioners of some form or another. Aren't we making the system too difficult?

So for really sincerely high-care clients, would we not be better off just to have a simple daily contribution to the cost of capital, whether by the funder, the key government stakeholder on that occasion of service or by the person who has the means to pay without getting into the other issues of contributions to capital?

MR WOODS: We're certainly offering that as a choice, yes.

MR FITZGERALD: At the moment we're doing something which is different. Taking your point, the person that doesn't have the means to pay the government pays for, both accommodation and care. If the person has means, they can elect to pay a daily fee, a weekly fee, a monthly fee or, if they feel it's in their interest, accommodation bond. It's up to them. So that choice is now for them to be able to make. So we have increased the flexibility enormously on what the current system is. I'm not quite understanding, why is that not in keeping with your - - -

MR BELCHER: I just think we're making it too difficult. To throw a refundable deposit potentially into a scenario where people are very high care, 60 per cent of people could be occupying a hospital bed under ACFI comparable measures of need, are we not making this too difficult for people in need of care rather than - - -

MR WOODS: That is why we're offering the daily charges as an option that everyone can have.

MR BELCHER: I would support that more proactively than a premium.

MR WOODS: We are just trying to keep it neutral.

MR FITZGERALD: One of the things is there are people around who don't believe accommodation bonds should exist at all and there are some that believe that we should let me rip and between there I think what we are trying to do is come to a reasonable position. But most importantly is try to shift it so that the consumer, their carer, their advocate can actually make that choice rather than being prescriptive about it.

MR BELCHER: As I said, I'm not entirely averse, I just have some feeling about this. The strongest feeling I have with it though it that the key stakeholder in this sector, which hereto has been the Commonwealth through its funding, must be an equitable partner. So if it costs $40 a day for people the Commonwealth suggests we are regulatorily required to care for, they pay $40 a day or some other commercial lease arrangement that supports the cost of capital and the risk that the provider takes. I'm not sure I subscribe to banks not being prepared to loan on that basis. I would have thought it's an arguable position.

MR FITZGERALD: It depends on the nature of the facility you build to some degree as well as to whether it's a bankable proposition so I think that's the key to it.

MR BELCHER: Sure.

MR FITZGERALD: Can I come back to your point, we seem to be at one in the notion that we want to enable people to be able to remain within the community as

long as possible. We also seem to be at one with you in terms of saying that the future residential aged care facilities will look very different from what they do today. In fact what we are trying to do is remove the whole notion of the black box, low-care, high-care so that, as Mike has indicated, restorative approaches, rehabilitative approaches, subacute care as well as end-of-life care, palliative care. The one issue that, however, distorts all of that to some degree is dementia and we have heard other people argue about how big this will be. What seems to be the case is even if we can keep many people at home for longer, for people with very severe dementia, for their own safety and the safety of others that group does seem to eventually end up in a residential facility.

So at the moment all the projections going forward are that we can do a whole lot of things to allow people with dementia to stay at home for a very long period of time but there is now a point at which that is not a safe option for people.

MR BELCHER: We think that and it might be issue of funding because what we see at the moment coming out of the EACHD packages is I think it's about 66 per cent of those clients are discharged to care. But are they discharged to care because of a financial imperative where the subsidy and, therefore, the services they get are just not able to keep them at home? What would it take, is the question that we have not been able to answer through great research. So what would it really take to keep a person at home in their community?

MR FITZGERALD: In a safe environment.

MR BELCHER: Yes. It may well be that we end up with 66 per cent still being discharged but we haven't done the really good quantitative research, I feel, on that issue that can lead it to be indicated otherwise.

MR FITZGERALD: Thanks very much for that.

MR WOODS: Thank you for coming. Thank you for your written submission and if you have some extra notes there, pass them on to Alan.

MR BELCHER: Thank you very much.

MR WOODS: The GLBTI Retirement Association, please. Thank you for coming. Could you each, for the record, please state your name, the organisation you represent and the position you hold.

MS COMFORT (GRAI): Yes, thank you. Jude Comfort, the chair of GRAI.

MS LOWE (GRAI): June Lowe, board member, GRAI.

MS SINCLAIR-LANE (GRAI): Debbie Sinclair-Lane, board member, GRAI.

MR WOODS: Excellent. Thank you for your very detailed submission. It was very helpful and certainly went through a number of very useful issues for us. You no doubt have points that you want to draw to our attention today. Please.

MS COMFORT (GRAI): Perhaps I could lead off first. First of all, thank you for the opportunity to be here this afternoon and, yes, we have put quite a bit of time into putting two submissions forward.

MR WOODS: Yes.

MS COMFORT (GRAI): Our biggest concern is that while - and for the record I will be using LGBTI as the acronym to the all-inclusive of diverse sexuality and gender groups as outlined in our submissions. The whole area of terminology can get a little bit confusing.

MR WOODS: But you have provided some very helpful - - -

MS COMFORT (GRAI): Thank you.

MR FITZGERALD: Yes, thank you.

MR WOODS: - - - advice to us on page by page, para by para.

MS COMFORT (GRAI): And we'd be happy to assist you further if required.

MR WOODS: Yes. But no, I mean genuinely, although it's only a very small part of your submission. I mean those sorts of things are important and we are very keen to get them right, so thank you for that.

MS COMFORT (GRAI): So as far as LGBTI issues are concerned, first of all we're very pleased that we at least made it to the table and we made it to the report in several places, because that's a little bit of a first for many government reports. We are usually a very invisible population. However, what we are less pleased about is

that it seems that we've been lumped in with culturally and linguistically diverse groups.

MR WOODS: Yes. No, that's all right, we'll slip that one out.

MS COMFORT (GRAI): I guess that was our major contention. It felt to us, and I think I can speak for my other two colleagues as well, that even putting us in the CALD group meant that you didn't understand the issues at play.

MR WOODS: That might be a separate issue.

MS COMFORT (GRAI): Yes.

MR WOODS: But let's explore that.

MS COMFORT (GRAI): Yes. So I guess that's one of our - that is our major issue, that we don't feel that we're a CALD group at all.

MR WOODS: No, that's all right.

MS COMFORT (GRAI): But we do have special needs. One of the things to really keep in mind, and I guess this sets the scene, is that as a minority group that we have been vilified for so long and that we're not supported by so many legal aspects. This then flows through to how older LGBTI people experience ageing and retirement living or residential aged care. So I'm not quite sure what sort of level of detail you require at this stage, but that's an opening statement, if you wish to quiz us.

MR WOODS: Are there other points that people want to make first? We might as well sort of have your presentation and then can come back - - -

MS COMFORT (GRAI): Yes, because we have some ideas for some solutions.

MR WOODS: Yes. Well, why don't you lay them out and then we'll have a conversation?

MS COMFORT (GRAI): Do you want to mention anything first?

MS LOWE (GRAI): Yes. We're particularly concerned about, as we raised in the submission, the lack of legal protections. We are hoping that further law reform can be undertaken, things like looking at various policies and procedures as well as laws. It's a fairly complicated area. It's hard to know - I mean that's one of the reasons for you enterprise, if you like, is to try and simplify it, which gives us a wonderful opportunity, because it means that we're on the ground floor, in some ways.

Visibility becomes - as Jude said, there's a huge issue because people in the LGBTI community are not - basically not game to be out, generally speaking.

I would put it to you too that - this is from a personal perspective to put a personal front on this, that if I were a fair bit older than this and in a residential aged care home I would probably be assumed to be a straight woman, because I have three adult children and I have got grandchildren, but I also have a female partner of now 20 years. But would I be game enough to out myself in that position? It's very likely that I would not, even though I've - in this position where I'm empowered and I'm healthy and I'm on my own two feet. It's completely different when you're surrounded by people whose good thoughts you are totally dependent on. If you are not safe in that environment you are not safe anywhere.

Basically as a lesbian you make a choice every day whether or not you expose that or not, even as somebody in a fairly strong position, let alone in an aged care home. So I do stress that people in the aged care sector need to be very vigilant and very aware and not necessarily expect that somebody outs themselves because it may not be their habit, but that doesn't mean to say that they're heterosexual. You can't assume which is - what is generally done. The current confusion tends to be around that sexuality is confused with sex. It isn't understood that it's part of a person's whole personality and the whole part of their identity. That's one of the reasons why we stress training and education. We think it's absolutely imperative around this issue. Thank you.

MS SINCLAIR-LANE (GRAI): Hi, I'm personally speaking. I'm an openly gay facility manager of a residential aged care facility here in Perth. I would just like to say from my own personal experience that the residents in aged care are generally invisible, that nowhere in the accreditation model or anything are our needs met. We are lumped under cultural diversity and things but we do have specific needs. We all know that facility managers and providers say, "We don't have any of those here." Well, we are 10 per cent of the population and we do have them in the aged care facility. I would like to see that promoted within the ACATs and the Residential Aged Care Manual; accreditation, have it monitored, have it known, get the language out there and let's be more gay friendly.

MR WOODS: Couple of things. One, with our proposed reforms which would place a lot more emphasis on community-based care, does that go some way to enabling the group to live in a secure and familiar surroundings with the people who they care with and for rather than, "Sorry, there are not enough CACP packages or EACH packages, so off you go to the local residential aged care facility." Is that going to help in some way?

MS LOWE (GRAI): I think it will, but it also highlights the need for funding for LGBTI community organisations to provide direct care services as well as advocacy

services. At the moment there are not LGBTI-specific projects in Australia, which is extraordinary.

MR WOODS: No, at the moment that says that you don't have LGBTI providers who have been successful in getting packages, but that's a separate question to under our reforms where if providers emerged who were able to provide sensitive and appropriate care to the LGBTI community and that that community accepted and chose those services - so under our reform that could happen, because it's the person needing care that gets the entitlement, not the provider that gets the package. So could you envisage that there would be providers who could emerge either from those communities or outside of those communities but who empathise with and understood the needs of the LGBTI community?

MS COMFORT (GRAI): I think that would go part of the way. What I would like to advocate for, and we talk about it here, is the need to upskill - like we probably don't have enough people within our community to offer those services. So we would be out and you would - having to be bringing in other providers. What I would like to see is that there is some funding on a national level to see training packages, culturally appropriate standards set so that we could rely on a greater area to call in those sources. Like at the moment, as June said, we're just an incredibly vulnerable and invisible population. To me it's a bit like maybe where the CALD debate was 20 or 30 years ago. Since then there has been a lot of money thrown in to training and upskilling all sorts of service providers across all sorts of sectors to raise the visibility and raise appropriate care and understanding of the issues. I think that's one thing that we're absolutely seeking.

MR WOODS: But sorry, aren't there two issues there? One is to make sure that there is sufficient training (a) available, and (b) taken up for the mainstream providers and their carers. But isn't there also an opportunity there for providers either from within the LGBTI community or from outside it to focus on and specialise in provision of services to the community?

MS LOWE (GRAI): I think it provides a good opportunity.

MS COMFORT (GRAI): Yes.

MS LOWE (GRAI): I think it will be a very welcome and progressive step.

MS COMFORT (GRAI): Absolutely.

MR WOODS: Okay.

MS COMFORT (GRAI): I was just going to say I worry about our capacity sometimes. I know that it will not be able to be met from entirely within our

community.

MR WOODS: No, we understand that it would take some time to develop. But I just think that there are opportunities in the proposed reforms that may assist. The accreditation process, you mentioned you're a facilities manager, what are your views on the accreditation process, both as it relates to whether the facility is delivering appropriate care to the community within the facility, but even more generally, just while we've got you at the table, on the accreditation process, does it accurately capture what actually happens by way of delivery of care on a day-to-day process and so we would have confidence in the accreditation process? So if somebody said, "I got 44 out of 44, we're doing brilliantly," do I come away from that with confidence that that's the case?

MS SINCLAIR-LANE (GRAI): I think that the language in the outcomes needs to be more inclusive for our culture, which it's not currently. We mentioned before that we're sort of lumped in with the CALD people, so therefore I think it would be very difficult to monitor and assess our needs on a daily basis as to whether they're being met or not.

MR WOODS: Okay. So that's in relation to the LGBTI community, but if I can take you back more generically to the accreditation process in relation to your facility, not just in relation to the LGBTI community, do I have confidence that the accreditation process accurately captures what happens on a day-to-day basis in the facility?

MS SINCLAIR-LANE (GRAI): Yes.

MS LOWE (GRAI): Can I jump in there?

MR WOODS: Yes.

MS LOWE (GRAI): That's interesting because just yesterday, I had a lengthy conversation with a friend who worked for quite a long period of time for the agency which is responsible for running out the assessments and she actually wouldn't agree with that because she found that facilities that ticked all the boxes, that looked really smart and on top of things. She was a little bit subversive. She would go and spend time and she would hang out and get to speak, without her clipboard, to the residents. She found that if she spent enough time, that they would open up. She found, in her view, there were a lot of deeply unhappy people who were in these facilities and didn't like being told what to do all the time. This isn't a GLBTI issue, this is completely - - -

MR WOODS: No, this is on a broader basis.

MS SINCLAIR-LANE (GRAI): I can only speak for the facility I work in.

MR WOODS: We understand that.

MS LOWE (GRAI): She said she went to ones which were highly accredited but she found that the clients were very happy and that there was a shield around the clients and that they were terrified. They were actually intimidated and frightened to say anything. In a way, it's similar to the issue that I was talking about, about the vulnerability. Because you're so vulnerable, would you complain?

MR FITZGERALD: Going back to your legal issue, you've indicated in your submission that both the Aged Care Act and the Home and Community Care Acts don't recognise LGBTI as a special need category. So the question is, you think that is important that you are identified as a special need group, even with those two pieces of legislation. Is that correct?

MS SINCLAIR-LANE (GRAI): Yes.

MR FITZGERALD: The second thing is what difference do you think it would make? They're linked in the sense that I agree that recognition is exceptionally important but by being included in that group, that special needs group, in your mind does that have a flow-on effect or does the lack of recognition have the alternative effect which is invisibility, that you're not there and therefore nobody recognises the issue? It's a very specific issue. Do you really think we should recommend that these acts acknowledge this particular group as a special needs group? Is that the right approach?

MS LOWE (GRAI): We believe so. If you're needing to have special projects put in place and they're not identified as a special need, they just won't - it raises the bar.

MS SINCLAIR-LANE (GRAI): It raises awareness, I think.

MR FITZGERALD: The second thing you raised specifically is the government's Code of Ethics and Guide to Ethical Conduct for Residential Aged Care and if I'm reading the paragraph here correctly, you're saying that excludes discrimination based on sexuality and leaves it at the discretion of the service provider. Is that correct?

MS LOWE (GRAI): That's our understanding.

MS SINCLAIR-LANE (GRAI): Yes, and that was particularly to do with religious - - -

MR FITZGERALD: Yes.

MS SINCLAIR-LANE (GRAI): We recognise that about a third of aged care facilities are owned and operated by religious - - -

MR FITZGERALD: Correct.

MS SINCLAIR-LANE (GRAI): And we're not lumping all religions together. However, that obviously does become a bit of an issue for our particular group.

MR FITZGERALD: So just taking that head on, if you were to in fact recommend that that get changed, what's the consequences of doing that? What's the consequence of not only changing it, but of the fight that you would then be presented with in relation to that issue? In other words, is it worth the effort? Is that really where you want to focus the energy and the effort, or is it in some of these other issues that are more significant? I'm not asking you to prioritise, but just how significant an issue is that relative to some of the other issues that we're talking about?

MS LOWE (GRAI): I think it raises interesting legal conflicts and that's one of the reasons to do it. If religious organisations have exemptions under the Equal Opportunity Act on the one hand and then have a requirement to meet these needs on the other hand, then it will expose something that needs to be changed and put pressure on it to be changed which will have flow-on effects in other areas.

MS SINCLAIR-LANE (GRAI): I think it should also be recognised that I don't think we're a lone voice in this. I know you've also had a very lengthy submission from the LGBT National Health Alliance of which we are a member.

MR WOODS: ACON.

MS SINCLAIR-LANE (GRAI): ACON and others, so our response would be a fairly hard-fought national battle, I would suggest.

MR FITZGERALD: That's all right. I just wanted to understand the consequences. The third one then is linked to assessment. Let's assume the gateway gets up and we have this centralised assessment delivered at the local and regional level. Again, are you saying to us that you believe that the person's sexual preferences or, in this case, the identification as gay, lesbian, transgender or what have you should be a relevant question in the assessment process and what's the unintended consequences of that, if any? So again, if you're saying that you want this recognised in the assessment process - and I want to use an unrelated example of that with the indigenous. Everybody ticks the box, "Are you indigenous or are you not indigenous?" Some people think that's a very bad question, others think it's a very important question for public policy, so there's a debate that goes on there. But

in your case, are you really suggesting - and if you are, that's fine - that the assessment process needs to overtly acknowledge and ask those questions or is it something that the individual would be able to raise as an issue of concern in the assessment process? So just give me some sort of sense around that. I'm not asking you to be prescriptive. We're a long way from that actually happening.

MS COMFORT (GRAI): Could I answer that with partly my other hat on. In my day job, I'm a researcher and lecturer at Curtin University. One of the areas that we have noted here is the lack of research in the whole LGBT area. Now, I would argue very strongly that - we don't collect that information at the moment - by not collecting it, when we come to things like that, we are always at a disadvantage because it's hard for us to string together evidence and it's a little bit like a catch-22, "Show us the evidence," and we'll go, "You ask the question, then we'll be able to show you the evidence." I think that is a very important point. We're talking about a social issue like this that is also a change in face, that we don't collect that data from the start.

Secondly, I would say we can't make it mandatory that somebody answer that question, and I think that's the way we get around that, by saying, "If you would like to have your sexuality acknowledged" - however, what we don't want is the assumption - and it happens to probably all of us on a daily basis - that you are heterosexual. That is just life when you live as a 10 per cent minority. I think by putting those questions on the form, even if the person doesn't answer it, the person administering that might go, "My goodness, not everybody is going to be heterosexual who comes through that door." That's the sort of attitudinal change I guess that we're talking about. A lot of what we're talking about is big social change. We're trying to get people's attitudes changed. It's pretty horrendous when you find - I know this is more than Gallup polls, so we might say how legitimate that is, but we have places where nearly half the population think that homosexuality is immoral. Now, if we have people who are working in aged care facilities with that, that is a belief they can keep to themselves.

MR FITZGERALD: Sure.

MS COMFORT (GRAI): How do we ensure though that that belief pattern does not impact on the care given? I think that's the crux of why we need to at least collect some of this information and make it a safer environment for people who are disadvantaged in the way they have been treated to feel they can talk about it. By making it more visible, whether it's on a form, whether we have a photograph on - you know, we're not always a heterosexual couple, there's a whole - collecting that data is one strategy.

MR WOODS: On collecting the data might there, though, be a bias in the answers that some people would feel (a) uncomfortable about revealing their sexual

preferences but (b) - - -

MS COMFORT (GRAI): They've felt that for 80 years.

MR WOODS: Yes, I understand that, but let me go to the second bit, that they might feel uncomfortable about saying, "No, I don't want to declare," because - - -

MS COMFORT (GRAI): The data is not reliable when you get it.

MR WOODS: Yes.

MS COMFORT (GRAI): Dr Jo Harrison makes that point. She says you've got to know that the data you collect is low. You're not going to get full disclosure.

MR WOODS: That was my assumption.

MS COMFORT (GRAI): So at best point, no, it's not reliable data but it acts as a signal.

MR WOODS: Leaving that question blank for a lot of people in itself would be a very confronting thing to do.

MS COMFORT (GRAI): I think in a broader sense the more we push for this at this aged care level we're pushing for this across all sorts of forms and I think we will see change. Hopefully in the not too distant future we'll go, "What was all the fuss about, asking this question?"

MR FITZGERALD: I understand absolutely where you want to get to and the struggle and the number of different strategies you've got to use to get there. Just one very last, and again it's a very specific issue. You've indicated that there would be some value, in fact you say it's invaluable cornerstone would be an LGBTI ombudsman within the Complaints Investigation Scheme. Given that there are lots of different groups with additional needs or special needs, whichever term you want to use, it's unlikely that that would occur. Again, in this Complaints Investigation Scheme one of the things you would want to be very clear about is that these sorts of issues are actually able to be dealt with both sensitively and appropriately. I suspect that's the real purpose of this, or are you actually wedded to the notion of a dedicated complaint handling person?

MS COMFORT (GRAI): If the person who is handling the complaint was appropriately trained it would be good enough. If it were known that the person that you would be going to would have that sensitivity that would be good enough - similar to the allied program.

MR FITZGERALD: Yes. Thank you.

MR WOODS: Just on terminology so we don't trip ourselves up, you've used throughout this, LGBTI. Quite often GLBTI is used. Do you have a strong preference or is that just the preference that you exhibit for your documentation?

MS COMFORT (GRAI): Well, no, there's a whole raft of very complex research on this. We don't always want to privilege the male members of that - - -

MR WOODS: I understood the point but I just wanted to check also whether by sticking with the terminology we use that's going to - - -

MS LOWE (GRAI): That's not - well, you are beyond reproach.

MS COMFORT (GRAI): Yes.

MR WOODS: Fine, thank you. That's all right.

MS COMFORT (GRAI): I think if you footnote it as we have and say, "Yes, that is to include all of - everybody - - -"

MR WOODS: I did note the footnote there and I thought that's very neat. We can just cut that out and just - - -

MS COMFORT (GRAI): I use it in a lot I write.

MR FITZGERALD: As long as we get you out of CALD we'll be fine. To be totally honest with you I don't understand how that's occurred because in our conversations we've never actually anticipated that you're part of the CALD group. So in the drafting when that first came up I was actually surprised and I thought, "Oh, better go back and rewrite our report," because we actually do acknowledge the very substantial differences.

MS COMFORT (GRAI): We also have members of our community who are also CALD members.

MR WOODS: We understand that intersection.

MR FITZGERALD: It wasn't intended in the way in which you and other groups have read it, so that's our mistake but we accept that.

MS COMFORT (GRAI): Thank you. Could I just do one little plug. I don't know if we gave you this before but GRAI has finished a big research project last year. It was one of the very few things we funded and we've come up with some best

practice guidelines for aged care facilities. We did a statewide survey of all facilities in WA. I think we've got some of the solutions here. So if you're interested in that - - -

MR WOODS: Excellent, thank you.

MS COMFORT (GRAI): What we don't have is the money to implement it and I guess that's another issue all together, but it's worth a plug. I think there are a lot of people committed to this across Australia. We're a small advocacy based group here but we have other allies across Australia - - -

MR WOODS: Yes, and we have a meeting with some.

MS COMFORT (GRAI): - - - and we hope we've got the opportunity to work together on this.

MR FITZGERALD: Thank you very much.

MR WOODS: Excellent. Thank you for your time.

MR WOODS: Can I ask Aegis Aged Care Group to come forward, please. Welcome. Would you please for the record each of you state your name, the organisation you represent and the position you hold.

MR TAYLOR (AACG): Geoff Taylor; I'm a director and co-owner of Aegis Aged Care Group and federal director of the Aged Care Association.

MR CROSS (AACG): My name is Michael Cross. I'm the other owner of Aegis Aged Care Group and I am the chief executive officer.

MR WOODS: Very good. Thank you, and thank you for your written contributions to this inquiry and also for a lot of very useful detailed analysis which was very helpful, and for your further submission to us based on our draft report. Please take us through your presentation.

MR TAYLOR (AACG): I will leave Michael to do most of the talking on this because I do a lot of it at the federal level, but just to say that we think that the draft submission, or draft report that you've come out with is excellent. There's a lot of things that as owners and operators and builders of aged care facilities - we've spent probably 150 million on building facilities in the last 10 years - that we think that if your report was able to be implemented in its entirety we would be very happy because, as far as we're concerned, you've come up with all of the answers to the problems that the industry has been talking about for 20 years. From our point of view we could hit the ground running if your report was implemented by the government tomorrow.

MR CROSS (AACG): Let me first of all just put a very personal note on this and explain when I became involved in aged care for the first time I was in blissful retirement, believe it or not, 10 years ago. I knew nothing about aged care at all. My father was in a palliative care ward at Hollywood Hospital and basically he had stabilised and the Hollywood Hospital hierarchy indicated they wanted the bed for more deserving people. I considered my father as more deserving but anyway they gave us this long list of facilities that they believed would be suitable for caring for my father, and my brother Richard and my sister Margaret and I, like many hundreds of people do all the time, went out looking.

We took this list and said, "This is going to be easy. We will all be able to meet at morning tea time and dad will have a nice place to stay," and it's the expectation. Nothing could be further from the truth. We were absolutely shocked at what we found on this list. We subsequently determined of course that that list was compiled because they were places that had vacancies, and they deserved to have vacancies. We rejected all of them. Subsequently, after a great deal of research, I personally became involved in looking for an unfunded bed for my father

and I paid $225 a day out of my own pocket to put him into an unfunded bed because I was not happy with what I found. So that was my introduction, as sharp as it was, and I then set about saying, "Okay, this isn't good enough." Felt like the guy that stuck his head out the window and said, "I'm going to do something about it."

I did manage to find, as I say, this place for my father. He subsequently had a fall and died in hospital, but it taught me a lot about what was lacking and I set about trying to make a difference. I asked around about who does things well in Western Australia in aged care and Geoff Taylor's name came up after many years of experience that he's had. So I met with Geoff and I can remember one of the first questions that I asked him about aged care, because I was determined to get involved, was the anticipation I had that there was some sort of rating system involved in these places, that there must be good places out there. I had only seen places that were built in the 50s and the 60s and should have been destroyed or pulled down in the 80s and the 90s because they were just not up to today's standards.

I asked Geoff, "Why don't they have a rating system like they do in restaurants and in hotels and indeed in universities and schools? Why do we not have such a system?" I think Geoff thought about it and he didn't really come up with an appropriate answer for me and it's subsequent to then that of course I now understand why. I became involved with Geoff and I was impressed with his facilities. I wish I had seen his facilities when I was looking for my father at that time. I've carried that through all this time and I have set a standard, my standard in building. Geoff mentioned we've spent $150 million building from scratch 12 new facilities and we've bought some old ones with the intention of doing them up. Since I became involved in 2001 we've gone from 440 beds to 2000 beds and that has been predominantly through a determination that both of us have, but me in particular, to not put people through what I went through about my father.

I set about setting a higher standard, and it's a standard that, as you said earlier, is about what's the future of aged care. I think we have been building to date - and we're stopping now - but we have been building what is the expectation; that is single rooms with en suites; that is intimate lounge rooms, dining spaces, and serveries, spa areas, and cafes, so it becomes what we are, and it's not unlike this hotel, the hotel across the road, or the number of hotels along the terrace here. It's about providing hospitality services to those who deserve it, and I know that my father deserved more. Why can't we have a five-star rating system that recognises the benefits and the disadvantages of a particular facility relative to those of others.

We all know that people expect a single room with an en suite. I can say to you it's not viable to do that in today's environment, and when I present to all my orientations, I personally go to all of them. With 2300 staff, there's quite a few of those orientations. At that, I often quip to people, "If you've just arrived in Perth and

you have a decision to make as to where you want to stay, you have a choice: you could stay at a backpackers in Scarborough and pay 10, 15" - I haven't stayed in one for a while - "but $30 a day, or you could stay at a motel on the Great Eastern Highway, you could come here and stay at the Sheraton or the Novotel, really nice places. You have a choice of the rate that you want to pay. Anything from $60, all the way up to $1500 a night." Where is that in aged care? I think what you're endeavouring to do is to do exactly that; is to set some standards. I'm not saying it should be $1500, but it should be something reasonable and something that can inspire Aegis to start building again.

The other corollary that I use is a supertanker corollary: once you stop building, as Aegis has - and being responsible for new builds I can have four or five facilities under construction at one time. At the moment we have two, with one actually finishing in June, after that we have a couple of refurbishments and extensions. It's not going to happen until your report comes into play. We need to get it right and we need to not allow the government to water this thing down, because if it's watered down it will get confusing to everybody and the providers won't be building.

The supertanker analogy is, it's taken us five years to slow down; we've just opened a facility, we started looking to build five years ago, it takes another five to 10 years to start building again, to actually go from the stage of identifying a plot of land to then building on it. As Geoff mentioned we can implement it straightaway; yes, we could, but the impact of that will be five, six years in the future. If in WA we're 3500 beds short today, what are we going to be short in that additional period of time. So I can only implore that we actually enact what you have put forward. As Geoff said, we do support it. We don't just support it as providers. I support that personally because of what I went through with my father those years ago, and I think that most people who're impacted by aged care would support that.

There are a whole lot of questions that we can ask of you, most of which you already know, probably, the answer to because you've written the report. So we have some other minor points, but I just wanted to deliver that very personal message and why Aegis is what it is today and what we want to become tomorrow. We, like many other major providers, are ready to make a difference again, but we need the incentive. No bonds, no building; it can't happen.

MR WOODS: Okay. We're certainly, as you know, trying to neutralise the decision making process for potential residents, so they can choose a daily fee or a bond. We understand the value of bonds to providers and the bankability of them. But we might as well tackle head on, what do you anticipate would be the likely response from potential residents if a daily charge, a weekly rent, together with removing their current incentive to retain a part pension by implementing the idea of the seniors bond. Do you expect that there would be a significant shift away from

bonds? If so, how would you manage through that transition? Or do you think most people would continue to pay bonds anyway? Where are you at in your thinking?

MR CROSS (AACG): My view is that your idea of balancing accommodation charge against bonds is exactly right. Geoff and I both reached for our calculators straightaway. We don't charge huge bonds in Aegis; our average bond is quite considerably less than that of other providers. We actually worked out, in actual fact the bonds that we charge are slightly less than the accommodation charge that I think we're entitled, under your formula, to collect. So we don't have a problem with the fact that the value of the bond to others may fall; it won't fall to us. We're not concerned about that.

The likelihood that people will pay a bond or not will depend upon their own financial advice that they get and their capacity to pay. We require that those that cannot afford to pay get assistance from the government. They do need to get the assistance; if they can't afford to, they should be supported. But that should mean that the government would be paying less to those that can afford it and more to those that can't. It's a neutral-sum game. All we know is, we need to get the compensation necessary to justify building place.

My background is that, previously, a long time ago, I was a banker with the Commonwealth Bank, and I know that banks lend either against a capital value of an asset or the cash flow. Their first preference is the reverse of that; banks today are cash flow lenders. Banks will lend against a certain cash flow. If its certainty comes from the fact that people get old, that's great. If certainty comes from the fact that the Commonwealth is paying, that's great too, so it's a double win. Banks will lend against cash flow or against capital, so it depends on whichever way you want to look at it. It doesn't matter to us whether it's bonds or not.

Whether there is an impact on our quite substantial existing bond pool, because we do have a lot of bonds, but that's because we have nice facilities. I don't believe, even over time, a substantial difference in that would arise, because of the advice that people will get for the points you mentioned, with pensions and things of that nature.

MR WOODS: Okay.

MR TAYLOR (AACG): I'll just add to that, the way that we've always done our bonds is to assess what we think is a fair bond for the buildings and the rooms that we build. It's never been, "What are your assets, and we have to leave you with $38,000 and the rest of it is your bond." So our average bonds, across nearly 1000 bonds, is $223,000. Our bonds range, at the present time, for single rooms from about 220,000 up to 330,000, with our most expensive facility in Nedlands at 400,000.

But our experience is that when we tell people what the bond is, generally they're very accepting of it. If they want to pay a higher bond, it's for their own reason of keeping the pension. Because you brought in the pensioner bond fund, then that won't be an issue. We've looked at how many of those Super Bonds we've got, and we've got 30 out of 1000 or 960. So it doesn't worry us. If people have been getting bigger bonds than the norm, than what's fair, in their opinion, then those people are going to have a problem. I know from my position on the board of ACAA that there's a lot of drama about the - - -

MR WOODS: You'd know a few providers who are fretting on this.

MR TAYLOR (AACG): Yes, about the reducing of the bonds to a reasonable figure. My very big concern is that the government is going to do something silly with this for the sake of those people, that minority of people, for what will be a problem for them for a short period of time.

MR WOODS: So you'd see as our reforms as a pre-emptive strike against something that might be an unfortunate policy decision?

MR TAYLOR (AACG): Yes. What you've put up is fair and it's what we do. For us the issue is an accommodation charge for a single room should be about $60 a day, and we're paid half of that and it's not indexed up, so the person pays that for five, 10 years, whatever time that they're in the facility, and an equivalent bond is around - without a retention - the retention is about 330,000. We don't see that people will baulk at either of those; if that's what they've got to pay, that's fine.

MR FITZGERALD: I know we discussed this with Michael prior to the draft, but one of the issues is: if the government were to remove the licences in the way that we've indicated and both the supply and the accommodation charges are freed up in the way that we've recommended, in the public hearings we've had so far, people have raised concerns about, how will the government ensure equitable distribution of residential aged care facilities in the community. I'm just wondering whether you have a thought about that? One thing about licences is, if people take the licences up, you can actually plan where the facilities go.

Of course as you've pointed out to us in WA and other places they're not even being taken up at the moment. But if we can get the government's contribution for supported residents at the more appropriate level, what do you think will actually happen with stock? Will we end up with a situation where there will be a lot investment of new stock in certain areas and almost nothing in the areas where there's substantial need or do you have a different take on that? If it is going to be a poor distribution of stock what do you think the government should do about it? So just your insights.

MR TAYLOR (AACG): Well, what control is there over where hotels are placed? What we see is that the future without licences will be that we will have to market ourselves properly and have a good standard of accommodation to attract people to keep the occupancy up. So if people build facilities beside each other - and there have been instances where a facility is doing well and another one gets built down the road then they both fail. That's something that people will have to look at when they make the decision to buy a piece of land and build near somebody else. I don't know that you can control everything. As it is now in WA there are four regions. If you take Perth metro and - sorry, four metro regions. If you divide it into four, like a cake, then you can build anywhere in that region. So there is not the control over where you can put it. It's not broken down to suburbs or anything at this stage, so I don't see there would be anything different.

MR CROSS (AACG): One point I want to make on that - - -

MR WOODS: By offering licenses in outer metropolitan or rural regional areas doesn't actually lead, necessarily, to somebody building in those anyway, does it?

MR TAYLOR (AACG): No.

MR WOODS: So there's no advantage in the current arrangement to ensure that facilities are properly distributed.

MR CROSS (AACG): But that's where competition comes in - - -

MR WOODS: Exactly.

MR CROSS (AACG): - - - in terms of the accommodation charge that you can charges. That's why you need this user-pays system. If it's supported by the government for rural and remote, then so be it. It should be supported more strongly.

MR TAYLOR (AACG): The government should provide big incentives - - -

MR CROSS (AACG): Yes.

MR TAYLOR (AACG): - - - to build in the rural and remote areas.

MR CROSS (AACG): Because it's about - what is lacking at the moment is the lack of information. I get extremely frustrated when I'm trying to determine where we should build our facilities, when we were building, that is. The information was just not on offer from the Commonwealth. It was like secret government business. You had to try and track every provider as to whether they were going to build, but it got to the ludicrous situation where you monitor all the ACARs and nobody - you knew who had been allocated beds but so many of them just let them lapse, or they

went six or seven years. You never knew when or if they were ever going to get built. So you ring up and say, "Oh, look, can you tell me what's the concentration of facilities?" It should have been tracked by the government so we know what they are. We had to pore through street directories and phone books to determine exactly. Let's make sure we know where all these facilities are. Then we go out and drive around and look at them.

But all that information should be available through the government as a part of this. There should be greater knowledge, greater disclosure of where these things - because it's going to end up being that it's competition. It's about competition. I'm not going to set up a facility next to another one if I know there's one going to be built. To some extent our associations not being joined together with ACAR and ACSAA - that should have happened. We should be talking to each other, but the government should also be providing information so we can avoid this conflict of facilities being on top of each other.

MR WOODS: The government would be able to tell you where facilities are but it wouldn't be able to tell you where somebody is busily thinking of building a new facility under this arrangement because they wouldn't actually - - -

MR CROSS (AACG): So they tell you where they are. No - the database - - -

MR TAYLOR (AACG): Well, they should tell you.

MR CROSS (AACG): - - - was always about a year or two behind. The database was never accurate. You talk about extra services yet it was never accurate as far as that's concerned. It made it impossible.

MR FITZGERALD: Yesterday in Adelaide we heard from the ACAA, the South Australian branch, who raised concerns that our proposals would lead to a very substantial increase in excess capacity or, put the other way, very large levels or increasing levels of vacancies. So just to try to test that proposition, do you think that is a likely outcome? Again, I know you can only speak for WA but they were very concerned that we would end up with a position where we would worsen the current vacancy rates.

MR WOODS: We questioned why operators would actually get themselves into that situation but - - -

MR CROSS (AACG): Can I answer this?

MR WOODS: Yes.

MR CROSS (AACG): I hope that happens, frankly, for the reason that I talked

about in my opening statement, because the places that are going to have the vacancies are the places that shouldn't be there. They should be pulled down and converted into other residential developments. They're not viable in terms of what they offer to people and they're not acceptable in terms of what they offer. So yes, there will be, because there has to be, a substitution; because not only in Western Australia do we have the wrong - it's sort of like the perfect wave scenario, the perfect storm, sorry.

You have this confluence of situations. One of them is the fact that our stock is wrong. Our stock of buildings is low care dominated. It's sort of 50 and 60 beds, low care. So you've got small en suites and bathrooms which are not suitable for high care. So 55 per cent or so of our beds are not suitable for high care. You can't pull them down because you cannot put enough beds on that to make that viable - because we pulled down the Bassendean Nursing Home. We bought the block next door, added a third to it, we put the same number of beds on an area of one-third larger, and we still had double rooms to that. But single rooms with en suite, you pick up a low-care site, you're going to find - so the infrastructure is wrong.

Those places need to be closed. They're probably in areas that are very valuable anyway, but they need to be replaced by the facilities that suit better the lifestyle needs, and the fair lifestyle needs, of our elderly. So yes, there will be vacancies and there deserves to be vacancies and the providers that have sat and done nothing for the last four decades, well, maybe they should go off and do something else, don't know. If they can't afford or are not prepared to - your report will enable them to be able to go out and rebuild those places.

MR FITZGERALD: Sure. We certainly did raise with them yesterday an issue about where these vacancies were occurring, what was the stock, and you've actually said what it is. You see, from our point of view it appears that it's occurring in the older, less suitable stock rather than the newer more suitable stock. But anyway, that was an issue - - -

MR CROSS (AACG): And you, as the commissioner, should actually go and look at some of that stock, because - - -

MR FITZGERALD: We have.

MR WOODS: We have.

MR CROSS (AACG): Right.

MR WOODS: We understand.

MR CROSS (AACG): So that's what needs to happen. If your commission report doesn't get enacted those places will continue to be there. They will continue to provide good care - don't get me wrong, it's excellent care, they're fantastic people who work in there, but their building doesn't support that.

MR FITZGERALD: Can I raise a question which isn't in your current submission but was in your first one. It was the ACFI. You made a suggestion to us at the time that the ACFI subsidy rates would go from 64 to three; three categories with some additional subsidies. Now, as you will have seen from our report we talked about ACFI but not in the sense of a radical change to the ACFI instrument. I was just wondering whether you have any further views about that. This is in the context of community care also, trying to work out what are the entitlements to community-based services. But just in the residential area, which is your area of activity, is that something that you feel that we really need to look again in the final report or, as most submissions - I must say most submissions have really been about making sure that it's more accommodating for behavioural issues, and a number of the more complex behaviours, and also making sure that the rates are appropriate. So I just - your view, after the draft.

MR TAYLOR (AACG): I'll start and Michael will finish, because it's his favourite subject. It's that we've been involved with Care Awaiting Placement for the state government here for nearly 10 years. Initially it was paid on a set - it's one rate for every resident and the government paid on a take-or-pay basis; but it has changed, with the Commonwealth government getting involved. But it still is one rate paid for everybody, so you take the good with the bad. Some people coming along are very - intensive care and others not so much. But for the staff and the facility it makes a big difference not having to do all of that documentation that's required. They can do their clinical documentation that's required whether you're in hospital or in an aged care facility and they don't have to worry about the funding side of it.

So that if the government - we suggested three rates on the basis of high-care, low-care and intensive care; which aged care system used to be ordinary care and intensive care were the two rates. I remember back in the early 80s - and the intensive care rate was $6 more than the ordinary care rate. I think we should go back to that. You just take the good with the bad. All this thing about - all this 64 categories and people are missing out on funding because they're doing the work but not claiming properly. That is just ridiculous. If the government wants to work out what it costs, just divide the funding by the number of beds and - high-care and low-care and say, "That's your funding across the facility." It's just a nonsense.

MR CROSS (AACG): The most important thing is that you provide the right care to the resident as they need it, certainly, but we went from an RCS system to a worse system, there's no doubt about that. As Geoff said, one of the things I'm most proud of is starting care, awaiting placement, and transition care, before transition care is

what it is today, and the most recent one is the care that we provide to those older adult mental health units that we've got. For these people - and there's people sitting in hospitals that are called bed blockers because they're sitting in hospitals, "But I'm sorry, we've got nowhere else to go. I don't want to be here. I don't want to eat this food. I don't want to be languishing here. I want to be out with someone caring for me." To go from a system where our staff have to spend hours and hours and hours writing these notes and protecting themselves - don't get me wrong, accreditation is absolutely vital and it must keep going, the CIS system is vital, but we've got to reduce the amount of documentation spent on justifying funding. Simplify the system so the staff have time to provide care, and that's so easy when it comes to the state and Commonwealth transition care system. It works well at one level but the staff working in transition care don't want to go back to residential aged care because they don't want to go back to all that sort of paperwork.

MR FITZGERALD: I presume in transition care, it's a flat rate?

MR CROSS (AACG): It's a flat rate.

MR FITZGERALD: For clients with mental health conditions in that particular unit, that's a flat rate, is it?

MR CROSS (AACG): It's a flat rate. It's a higher rate because the staffing levels are higher and the numbers are smaller. But yes, it's a flat rate. It works so well. The number of levels as such is not important, as long as there's not too many. There's just too many being proposed.

MR FITZGERALD: Sure.

MR CROSS (AACG): Also when you came and saw me last time, do we need to have the four? You know, we've got certain needs that need to be met; whether they be to do with the roof over their head, the food that they eat and the care that they received. If we go too far down the track, the laundry services et cetera, keep it simple. The thing is just to keep it simple so everybody doesn't spend a lot of time just tracking all of these different things. If we can please just keep it as simple as possible.

MR FITZGERALD: Can I ask, over the last number of days that we've been doing public hearings, you will be aware that there's been a very strong push by the unions - different, I might say, and well articulated - for a greater prescription around workloads, for a start, both registered nurses, enrolled nurses and of course personal care workers. You will be aware that in the draft, we didn't go down that route and our inclination is to look for alternative ways of dealing with this. I just wonder on your insights about how do we deal with this increasing concern, not only, I might say, by unions, but by a very large group of consumer advocates about the excessive

workloads on staff and what's the right approach to deal with that. Now, it varies between providers, I understand that, but system-wide, this is an issue that is growing in intensity.

MR CROSS (AACG): I don't think you can go down the path of prescribing staffing levels. It would be a very slippery slope. Why can't the accreditation agency? That's why the accreditation agency is there, to ensure that the care is being provided. Reinforce it in whatever way you like, but don't let the unions and other vested interests actually stipulate what those levels are. When a resident comes in, there's a whole spectrum of care needs that they have and they will come in at one level and when they leave us, for whatever reason, they're at a different level, so there's this continuum of care. The staffing changes. We've got 27 different sites, so the continuum of care for our residents, from one day to the next, let alone one year to the next, can change in terms of the amount of care that you need, the number of staff you need to have on. You've got other providers, not Aegis, that have a no-agency policy that can impact on all of that. That sort of thing shouldn't be allowed to happen. Make sure the staffing levels are met such that we can provide the accredited amount of care to a standard required. Let those people determine whether we're providing sufficient care. There is no prescribed amount of staffing required for a particular resident. Their needs could change from one day to the next, let alone the other 90 or a hundred-odd residents you might have in your rooms. So please avoid, as much as you can, going down that path because one person's opinion on what staffing is required is certainly not another.

MR TAYLOR (AACG): From an accounting point of view, what we do is that we say that our wages should equal our ACFI income. So we've said to the unions that their job is to go to the government and get them to increase the care funding because since 1997 when this system came in, the government department in Canberra has spent their time reducing and reducing the care funding that we get. Now, Warren Hogan recommended the 1.75 per cent cap which was to increase the indexation. That happened for four years, missed a year, then five, but that's because all our funding is getting reduced against the rising costs of wages all the time.

So if people were just paying their staff according to the increase in co-pay that we've been getting, then we'd have no staff working for us. So the government is at fault and the union should be pushing the government to increase that care funding. The care funding is probably - well, as I worked it out and said in our first paper, it's about $19 a day short. If you did a proper model on it you'd probably come up with a higher figure than that, and that's for existing. If our funding is more than - obviously if the staff are saying, "We need more staff," then we would provide more staff.

MR WOODS: Do you have an enterprise agreement with United Voice and others?

MR CROSS (AACG): Yes, we do. I finalised both of those last year. As a result of that our average wages did increase but not as much as others have been forced to. We had no problems with them at all. We have a very good relationship with the ANF and also with the new United Voice, and we had a very smooth sail. Other providers, couldn't say so much, but we have a very good relationship with the unions. We increased our wages last year. We're on about 7 or 8 per cent across the board; we made that decision. As Geoff said, it's all about, we say, more ACFI revenue equals more staff equals more care; so everybody is a winner. That's what we say to our facility managers: "If you can allocate what we're entitled to get from the government, then we'll make sure we give you more staff," and that's what we do.

In the heady times just before the global financial crisis - or just after, sorry, we went to a 16 per cent agency threshold because everybody was going to drive trucks north. Now, we've got this new boom happening in Western Australia which you're very aware of. We've managed to keep it to around about four and a half per cent. So we've actually - despite the trend, because we did those two agreements and because we have the approach we do in highly valuing our staff, we find we keep staff. So we're actually now a preferred employer as far as aged care is concerned, for a whole multitude of reasons. That includes the quality of the facilities. You mustn't forget, staff like working in a nice facility. If they're staying effectively at a place like the place across the road or this lovely hotel, they're going to enjoy their work more, they're going to stay with you. As far as the totem pole is concerned, pay is only about number four or five, it's the value you place in the employee.

MR WOODS: We're over time but can I just ask a brief question. With these reforms and by separating out the care from the accommodation, it will allow more care to be delivered to people in a range of accommodations, so their current home, retirement villages, independent living units, supported accommodation - a whole range. Do you see that that may change your business model and that you might broaden out the type of accommodation that you offer, is one question; and then the second is, what has been your experience in planning and zoning issues with local councils in terms of trying to create integrated facilities that might also include, you know, the coffee shop, the pharmacy, the whatever else, as part of the total facility that you offer?

MR TAYLOR (AACG): Just on the first one, we philosophically are against community care because for maybe half the people that are in community care packages it's appropriate, but the other half it's not, and the ACATs endeavour to get people to stay at home and we think in a lot of cases encourage them to stay at home when they shouldn't. Because we build our facilities to a hotel style we think that there's a lot of low care people that significantly gain from the social atmosphere of living in a facility where they all go to the dining room together and meet people of same age and backgrounds and so on. So we think that community care packages, the amount of them is going to keep people away from where they really would get

the best care and the best accommodation, rather than sitting at home - - -

MR WOODS: Well, they would be able to choose in the future because they get a care entitlement and then they choose what accommodation - so that will free some of that up.

MR TAYLOR (AACG): Yes. As long as they're encouraged to look around and see what's there and if facilities are there.

MR WOODS: Absolutely. You'd be marketing your facilities.

MR TAYLOR (AACG): Yes. Well, under your system you would have to market like hotels market.

MR WOODS: Yes, exactly. Local councils - - -

MR CROSS (AACG): My point on that is, the most insidious disease, and fortunately neither of my parents suffered from it, is dementia. Now, we have a very large proportion of our beds where the residents are held in specific dementia beds. If there's one thing about community care I have a problem with and certainly each dementia at home is not only the financial cost, because the cost is quite similar to that of a high care resident in a residential aged care facility, but the social cost on families of each dementia at home is actually going to become a huge, huge problem. I see it just as a little bit of a cop out, a little bit of a way the government is sort of saying, "Nobody is building aged care facilities so we'll just give more places as far as dementia is concerned." Until that is solved, the importance of your report going through is absolutely critical for dementia residents.

On the council aspects, we have a very good relationship - I think probably I've dealt with every council in Perth because we've built pretty well everywhere. As a consequence of doing it prudently, doing it carefully, having good consultants - and we have the same team people - the key to it is have the right people. Find your location, have the right people - planners and the same architect, we have a panel of two or three builders only that we use - and they tend to sail through. I must admit, with a couple of minor exceptions - a few council issues, a few meetings I've been to - we haven't had a major issue - if you do it right and you do it with a certain amount of credence. My perspective, it's not been a major issue as far as councils, if you do it right and you get the right advice.

MR FITZGERALD: Thank you very much.

MR WOODS: We're very grateful not only for your submissions but also the amount of analysis that you've put into them that just gives a very practical edge. It's very helpful.

MR CROSS (AACG): Well, we're ready to do a lot more in aged care, you know, and unless your report goes through almost in its entirety we're not going to be building - my wife would be very, very happy, I'll add, that I don't do any more but that will be the outcome. So please get the message through to government.

MR WOODS: You need to talk to the presidents of some peak councils to make sure they're doing their job.

MR FITZGERALD: Thank you. An excellent report, thank you.

MR WOODS: That concludes our scheduled presentations for the day. Is there anyone present who wishes to make a brief unscheduled presentation? That being the case we will adjourn and resume in Canberra. Thank you.

MR FITZGERALD: Thank you very much, thanks for your patience. It's been a very good day.

AT 5.17 PM THE INQUIRY WAS ADJOURNED UNTIL
TUESDAY, 5 APRIL 2011