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TRANSCRIPT
OF PROCEEDINGS

PRODUCTIVITY COMMISSION

DRAFT REPORT ON CARING FOR OLDER AUSTRALIANS

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

TRANSCRIPT OF PROCEEDINGS

AT BRISBANE ON THURSDAY, 7 APRIL 2011, AT 9.02 AM

Continued from 6/4/11 in Canberra

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MR WOODS: Today is the second day of hearings in Brisbane. At the conclusion of today's hearings we will offer an opportunity for any unscheduled participants to make a brief statement should they so wish. Our first participants for the day are Guide Dogs Queensland. Welcome. Could each of you, for the record, please state your name, the organisation you represent and the position you hold.

MS LAINE (GDQ): Chris Laine, Guide Dogs Queensland, chief executive officer.

MR EBRAHIM: Bashir Ebrahim, manager, rehab services, Guide Dogs Queensland.

MR PROBST (GDQ): Haroon Probst, Guide Dogs Queensland, adaptive technology coordinator.

MR WOODS: Thank you very much. Please make your presentation.

MR EBRAHIM (GDQ): Thank you very much for allowing up the opportunity. Guide Dogs Queensland uses Access Economics data and in that report that's very pertinent to our presentation. It estimates that in 2009 over 575,000 Australians aged over 40 had a vision loss and around 70 per cent of these are aged 70 plus. The report also estimates that approximately 66,500 of those people in that particular group have blindness or vision impairment. The top five causes of blindness and vision impairment in Australia are macular degeneration, glaucoma, cataract, diabetic retinopathy and refractive errors. A quarter of all vision impairments are preventable in Australia.

Risk of vision impairment is significantly increased for people with diabetes, and people who smoke and people who have a family history, hereditary link, to eye disease are at higher risk. Excessive sunlight exposure is also a major risk factor for acquired vision loss. Based on the current incidence rates that are presented, by the time a person is aged 60 to 69 they have a 1 in 20 chance of a level of vision impairment which prevents them from holding a driver's licence. There are currently more than 30,000 blind and vision-impaired Queenslanders and the majority of these are over age 60. We anticipate that the number is going to double, if not treble, by 2025. Guide Dogs Queensland is the only organisation in Queensland that provides a full state-wide service.

We provide specialist services across all the major areas of Queensland. We have seven regional offices and our Brisbane centre provide low vision assessment units on a monthly basis, and we also provide domiciliary in-home training and rehabilitation programs. When we look at the prevalence of vision impairment and blindness, of the 480,000 Australians aged over 40 with a vision impairment in 2004 50,000 were legally blind. If we look at percentage by age group, it indicates that of the 60 to 69 age group 5 per cent have a vision impairment; of the 70 to 79 age group

11 per cent are vision-impaired; of the 80 to 89 age group 29 per cent have a vision impairment; and of the 90-plus age group 41 per cent are vision-impaired.

We then project that by 2024 the number of Australians with a vision impairment or blindness may increase to nearly 800,000. Vision impairment prevents healthy and independent ageing. It is associated with the following risk factors: risk of falls increased is two times; risk of depression increased three times; risk of hip fractures is increased four to eight times; admission to nursing homes three years early; social dependence is increased two times; and social independence is decreased two times. There is also a high rate of suicide amongst the blind and vision-impaired population if you look across the disability-aged sector.

The draft report fails to distinguish between those people who acquire their vision loss over the age of 65 and who are dependent, requiring supported housing, and those who are still leading active lives and maintaining their independence with appropriate specialised services in their own homes. It also fails to acknowledge or even understand that people with appropriate specialist support may not require supported or residential accommodation but will maintain the quality of life and enjoy the many activities they always have done in their local communities. However, the overall ageing of the population means that specialist services for people with blindness and vision impairment will become more necessary and it will become essential for us to ensure that appropriate support is available for the increasing number of people with blindness and vision impairment.

Specialist services offer proven and cost-effective ways to maximise independent living, reduce the demand for costly high care services and improve overall inclusion socially and quality of life for people with blindness and vision impairment. People over 70 currently make up the largest proportion of people with blindness and vision impairment, and that's currently around 70 per cent. Of this cohort, it will continue to grow, and grow significantly with ageing in the Australian population. There is therefore a fundamental need to better integrate the work of specialist disability services with aged care services, to ensure a more efficient and efficacious response to the increasing number of aged people with blindness and vision impairment.

Rehabilitation support available through specialist blindness organisations, like Guide Dogs Queensland, helps to build independent living skills and assists people of all ages to remain living in their own home, in the own communities. Older people with blindness or vision impairment often experience a higher level of risk in their physical health, especially due the impact of falls and fractures. Dual sensory disability - vision impairment combined with, let's say, a hearing impairment - greatly increases the risk of falls due to the loss of compensatory information relating to posture, balance and the environment around you. People aged 65-plus make up 97 per cent of the population with dual sensory impairment. Orientation and

mobility training provided by specialist blindness agencies significantly reduces the risk of falls and accident and injury.

Mental health is a significant and highly preventable issue for many people with blindness and vision impairment, and it is mostly due to the prolonged struggle for inclusion and the high levels of social isolation experienced across the lifespan. International studies have found that people with vision impairment experience a higher risk of depression, between two to five times higher than the general population, and between 25 to 30 per cent of all older people with vision impairment demonstrate some evidence of depressive symptoms and signs.

The draft report focuses primarily on reform to the personal care and residential care systems but has failed to provide any framework for community based services which support people remaining in their own homes and independently participating in their lives and community. Of the greatest concern is the lack of acknowledgment for services provided by specialist service providers. It failed to specify how specialist service providers will work within the framework itself, apart from noting that they will need to be accredited and will be heavily regulated. Guide Dogs Queensland has concerns with the proposed system, where access to service decisions are made based primarily on price without regard to the appropriate accreditation standards and benchmarks created.

Further, the type or quantum of services which will be approved is not discussed, nor the criterion for eligibility for either the service or the individual. Guide Dogs Queensland is concerned with what appears to be cost-shifting of people who are blind or vision-impaired to the aged care system, which has made no provision for the cost of support, has no expertise in blindness and vision impairment, is focused around personal care and residential accommodation rather than episodic services with a goal of independence and participation.

We have a number of recommendations we'd like to present; they are 11 in total, and they are brief. Recommendation (1), that people who are blind or vision-impaired be recognised as having a unique set of needs generally requiring access to specialised episodic services. Recommendation (2), that the report acknowledges and makes provision for specialist services for the blind and vision-impaired with the goal of enabling independence, integration and participation, in addition to those services reflected in the report which are based primarily on personal care and supported accommodation.

Recommendation (3), the aged care sector is currently built around personal care and specialised accommodation and does not accommodate for the needs of people who are blind or vision-impaired. It is recommended that availability of early intervention, blindness and low vision services in the rehabilitation area be specifically integrated as part of the aged care and support building block approach,

tier 3 specialist care, restoration and rehabilitation category, within the aged care system, whilst noting that service for people who are blind or vision-impaired will be episodic, also recognising the opportunity for longer-term cost-savings through the reduction in falls and delay in entering supported accommodation - in other words, ageing in place.

Recommendation (4) , that the ACAT assessments which are currently generic be amended to include a vision screening process. That element will identify vision loss and generate referrals for a specialist assessment and subsequent specialist services. Assessors will need significant training to understand the functional impact and specialist interventions required for vision loss. Recommendation (5), the draft report relies on HACC, home and community care, as the provider of community services. People who are blind or vision-impaired do not currently qualify for HACC funding, so it's recommended that this be rectified and looked into.

Recommendation (6), with the large number of people affected by imposition of an arbitrary age in defining how service would be provided, timelines and benchmarks be identified to ensure assessments, referrals and interventions be completed in a timely manner. Recommendation (7), access to specialist disability services be based on an entitlement in accordance with the national disability strategy and the UN Convention on the Rights of Persons with Disabilities for the equality of service regardless of age. The proposed system will introduce a potential co-payment based solely on an arbitrary decision of age, rather than entitlement.

Recommendation (8), that nobody should be worse off as a result of these changes. In the current report, however, over the age of 65 years a person will be potentially liable for a co-payment, to receive services to maintain their independence, something which is currently provided free of charge. Recommendation (9), that both reports, disability and ageing, be considered together, not in isolation, as 70 per cent of people who are blind or vision-impaired who are currently receiving services from the unfunded NGO disability sector will be transferred to ageing based on an arbitrarily-determined age and for which no financial provision has been made.

Recommendation (10), currently there is little expertise in vision loss and provision of specialist services in the aged care sector. So it's recommended that systems be developed to purchase expertise from NGO specialist service providers. Finally, recommendation (11), aids and devices - currently they are not noted - are to be available in exactly the same way as the disability strategy. It is recommended that the report identify and recognise the spectrum of vision impairment and the range of equipment appropriately available to meet diversity of need. Specifically it's recommended that the report recognise and build capacity for the provision of white canes, support canes, electronic travel devices, guide dogs, braille and alternate formats, magnifiers, and other adaptive equipment to enable individuals to undertake

everyday tasks.

MR WOODS: Do either of your colleagues wish to make a statement?

MS LAINE (GDQ): We all participated in the writing of this statement.

MR WOODS: Okay. Thank you very much. You have obviously given some thought on how you would present today. Probably in the few minutes we have got for discussion, we'll just clarify a few issues, because there seems to be some fundamental misunderstanding of what the draft report is about, which we would like to explore with you. Primarily the aim of the reforms is to move very much to community based independence, restorative rehabilitation; maintenance of people in their own home environments, wherever possible, with all of the appropriate aids and supports, depending on their situations. I'm not sure that you have fully understood what that direction was.

It is entitlement based, that is exactly what we are moving to, rather than at the moment where people have to fit into packages or programs; people get assessed for what their needs are, including blindness or vision impairment, or other needs, and they get an entitlement to services and that's what drives the system in our new reforms. Programs like HACC won't exist. You made reference to programs like HACC, but in fact the services that are currently delivered by a range of programs, whether it's HACC or CACP or other programs, will be within the full menu of services that are driven by the needs and entitlements of people. But we won't be having a HACC program as is, etcetera. So there are a number of areas where I am not sure that you have fully understood what the draft is about.

MS LAINE (GDQ): The concern is that currently blindness services are not provided for within any of the current frameworks.

MR WOODS: We understand that, yes.

MS LAINE (GDQ): Yes, and so it is our recommendation that if we are moving to a more equitable system, or one that is more capable of managing older Australians within the homes, then there needs to be allocation and recognition that current services which are provided to older Australians who are blind or vision-impaired are funded by non-government organisations which don't receive funding from government but rather are funded by the community to provide these services.

If we are going to give the impression to the population of Australia that these individuals are now covered within this new structure, then there has to be some allocation or some recognition that, firstly, the services or the qualifications of expertise will have to be accessed from somewhere, because currently it is not within that realm, or that there would be provision for outsourcing of these services to the

organisations which currently provide those services. The other concern is the outsourced and funded, because if the community believes there is no longer a requirement to fund a non-government organisation that is providing these services then in order for these services to continue to be provided they need to be funded - - -

MR WOODS: It is certainly not our intention to disrupt the current good services that undertaken in this area, and we would envisage that the roles that you play would continue to be the roles that you play. So there's no proposal to disrupt that, and you would continue to serve, as you do, your client base in its current manner. Hopefully, you would have one further venue of referral to you, not only through the GPs, etcetera, also the gateway proposal where appropriate would also continue to direct people, because it is the strong intention to have people remain independent, to get the support. In terms of your funding, are you wholly community-funded or are there a different organisations within the broad blindness and vision impairment group have different - - -

MS LAINE (GDQ): Within Queensland, Guide Dogs Queensland is the only organisation that provides services across the whole of Queensland. Currently less than 3 per cent of our funding is received from government. In other words, the Queensland government provides a fee-for-service funding for long cane training only for Brisbane and the Gold Coast. So there is no Queensland funding outside of Brisbane and the Gold Coast, and Queensland is a very large state. There is a very small amount of funding, Non Schools Organisation funding, that we receive for special ed for children, and that is specifically for kids in schools.

MR WOODS: Supplementary.

MS LAINE (GDQ): Yes, supplementary funding. The rest of our funding, 97 per cent of what we spend, providing free services, which is somewhere around six and a half, seven million, we gain from the community, either through fundraising, through our own income streams or through bequests.

MR FITZGERALD: We've now had representation from groups involved in vision impairment in each of the states and territories for which we're grateful. One of the things that we didn't make clear in our report is the range of services that are currently provided by organisations like your own and many others. You're absolutely right. We need to make sure that the disability report now has come together, and we'll make that much clearer in the final.

So what we would envisage would be that organisations such as yourself dealing with sensory impairment would continue and would continue to provide both services and aids and supports. They would provide that both to people with disabilities that are under the age of 65 and people with disabilities over the age of 65. So we'll make that abundantly clear and we haven't done so clear enough.

There's no question about that and I think we know how to do that.

However, there are two issues, and that is the one that you have raised and Mike has just raised, is funding and the second part of that, and it's related, is the co-contribution. So you're right. We do see that in terms of aged care, that there should be some modest co-contributions. There already are. In the HACC services there are co-contributions. So it's not a system without co-contributions. But what they are is they're totally inconsistent. There's no linkage to ability to pay; there's no consistency in their application; they're often discretionary and determined by individual agencies. We don't think that's a good way forward.

The specific question for you is, if I can take the co-contribution first, is do you think that any of your services and the aids you provide should have an element of co-contribution in that. We understand from some of your sister organisations in other states that, for example, the guide dogs are free to anybody of any means, but the more expensive sometimes equipment for vision-impaired people, particularly computer based or Braille systems, there is a co-contribution. So I was just wondering if you could just explain in Queensland's case your approach to co-contributions.

We are very conscious that a fairly substantial portion of your income comes from donations. So given that, it's of a different nature. So just your way forward on the issue of co-contributions. Do you think there's any role for them either in aids and/or services?

MR WOODS: Do you charge at the moment for any?

MR EBRAHIM (GDQ): Our client service delivery is free of charge, so assessment, training, follow-up, is our philosophy. That is our charter. That's why we raise our funds. We have looked at this. Having worked in the field for more than 20 years, this issue does come up from time to time, however people aren't obliged to pay for those services. At the moment, the board and the chief executive direct that philosophy and I support that. However, the electronic travel aids, the specialist stuff - Haroon is decked out with a few things on his body there; it's actually a GPS system and linked to his mobile phone and so on - we provide those free of charge as well, based on sponsorship, corporate funding and those successful activities that we run on an every day basis and we provide that. There is a selection criteria, eligibility criteria and a range of competencies associated with all those particular things.

When you talk about white canes and support canes and those daily living things, those are in the vicinity of people buying everyday equipment and so clients actually buy their white canes and contribute to that cost of replacement and so on. Some states will provide everything for free. There are some contributions that are

reasonable. Again, that's not a blanket rule, it's a guideline. If someone is financially unable to afford a cane or a particular piece of equipment or to come to the residential centre for training, we may help them with flights, but it's a case-by-case basis. So there is an element to looking at the case by case, but having a structure that allows for the service to get to the majority of people equitably.

MS LAINE (GDQ): We do expect a contribution to meals if they do come in for residential classes and so on. We have an expectation of a contribution towards their meals, again recognising that that which you partially pay for, you have a greater appreciation for. So we are comfortable with a notion of a small co-payment. What we see currently is that in situations where clients require magnifiers or that if they're with the Department of Veterans' Affairs, that can be funded; if they're in aged care, it's not, and yet the rest of us who wear spectacles have a system whereby we can claim for the cost of spectacles and yet a person who is blind cannot claim a similar cost of a magnifier. This is where the differences are and I think that within a new system, these are the things that should be sorted out or rectified.

MR EBRAHIM (GDQ): With your health fund, you get two pairs of spectacles. To someone with low vision, that's a good benefit, but if you can't benefit from the use of those spectacles, an alternative magnifier for the equivalent cost might be a better alternative and more productive.

MR MACRI: Just taking it out broader, I'm just wondering, when you talk about significant numbers of people suffering from depression, increased suicide rates, those sorts of issues, what sort of interface occurs in terms of the broader health services in Queensland for vision-impaired people around mental health services, around - - -

MS LAINE (GDQ): With regard to specific counselling with regard to vision loss, we provide counselling services across the whole of Queensland. It is a speciality within the psychological counselling profession and some of our clients will access counselling for mental health, but within the normal stream, it's a more generalised service that is not specifically related to loss of vision.

MR MACRI: The funding of that or the cost?

MS LAINE (GDQ): We provide that for free and it's - - -

MR MACRI: You provide that as part - - -

MS LAINE (GDQ): Yes. Again, there is a very small amount of funding for service for Brisbane and the Gold Coast, but there is no funding provided from anyone for the rest of Queensland.

MR EBRAHIM (GDQ): That Brisbane and Gold Coast funding that is provided by the government is from 18 to 65, so for 65 plus there is no funding at all.

MR WOODS: Thank you. Unfortunately we have run out of time, but you have raised some very concrete proposals and we are very grateful for those, so we will take those on board. They're consistent in the broad with a range of related organisations who have presented to us. We do urge you to look at the draft in terms of what opportunities it provides and where the interfaces could be made more efficient and effective for the clientele that you deal with. If you do have any further thoughts in the immediate future as to how to overcome any issues on those interfaces, that would be very helpful for us.

MS LAINE (GDQ): Thank you very much for the opportunity to share our concerns with you.

MR WOODS: It's a great pleasure. Thank you very much. We appreciate that.

MR WOODS: Can I ask the Association of Residents of Queensland Retirement Villages to come forward please? Thank you very much for coming and for your written material. Could you each, for the record, please state your name, the organisation you represent and position you hold?

MR ARMSTRONG (ARQRV): Les Armstrong, president of the ARQRV.

MR PHILLIPS (ARQRV): Phil Phillips, vice-president of the ARQRV.

MR WISE (ARQRV): David Wise, solicitor specialising in retirement village law and legal adviser to the ARQRV.

MR WOODS: Excellent. Thank you very much. You have provided us with some written material, but please make a statement.

MR ARMSTRONG (ARQRV): Thank you. The initial response, as you realise, was based on arguments concerning self-regulation and whether or not perhaps the ARVA accreditation scheme could provide an appropriate vehicle in which you can implement that self-regulation. We also had some comments about the type of, the quality and, in fact, the number of participants from which you are seeking input to the report. Today we're going to expand on that a little, because we've concentrated more on the economic issues, rather than the other major concerns which our association has, such as the need for legislative change, and that matter is being addressed continually through the Office of Fair Trading. So our summary today is a number of key points which we are concerned about, mainly with the business models and any economic arisings from that.

The first point is that the typical retirement village business model, it doesn't create any economic incentive for an operator to self-regulate or to create a caring environment for residents. The typical business model, that involves providing services and facilities at cost on the basis that the resident pays a lump sum on exit from the village, and that lump sum is known as the deferred management fee or the exit fee. That leads to the proposition that's so attractive to retirees who are income poor but capital rich, and it allows them to enjoy a standard of living that their income would otherwise not support, on the basis that they pay for that later rather than from their capital.

The difficulty, however, is that village operators only profit when residents leave or die. The greater the turnover of residents, the more profitable the village becomes. That leads to the conclusion that there's no economic incentive and arguably it's an economic disincentive for operators to self-regulate and to ensure that residents are provided with the caring environment in which they are treated with professionalism, dignity, and respect. We obviously have a number of

examples, not for this forum, where we can illustrate perfectly how that happens.

The business model I spoke about, that evolved at a time when retirement villages were predominantly operated by churches or charity groups. They did not have a legal duty to make or maximise profit for their shareholders and those groups were generally required to act in the best interests of their members, which usually included the residents and, in that context, the interests of the residents and the operator were aligned. There's been a quite significant change now, that, however, the retirement villages are the domain of private enterprise, operated by companies with a duty to maximise returns to non-resident participants. So we've got that dichotomy immediately between the old system and the new system, and we need to remember of course that the old system is still in place in a large number of the villages. So there's that fundamental conflict between the duty to maximise profits for shareholders and the need to ensure that residents are provided with an emotionally supportive and caring environment in which they want to stay; not that they're required to stay there, they want to stay there.

Although the physical environments of the village may be well maintained, that is done in order to attract new residents and maximise the profitability, if you like. The profit motive encourages operators to - this is important - reduce the level of compassion, respect, and attention shown to individual residents, reduce that to the minimum level possible without breaching any relevant law. Obviously that doesn't always happen, because we claim, for example, in the last 12 months that there were, in the 4600 complaints that our organisation received from our residents, a small number were justifiable and went to tribunal, but a lot were difficult to prove breaches of the ethos of the industry, rather than the legislation. This is a serious problem in an industry that claims to sell a lifestyle, where on one hand you're trying to maximise your return and hopefully trying to give the residents what they are paying for and the quality of life they came into the village for. That dichotomy is going to be difficult to change.

Dissatisfied residents who've complained to their village managers are often told, "If you don't like it, you can leave." That's good for the operator, and you'll see why later. It's not good for the resident. Dissatisfied residents often cannot leave, because the loss of the capital on exit through the exit fee would leave them unable to afford suitable accommodation elsewhere. We've been moderate, saying "may" or "would leave them"; in fact it does, because very few of the people who exit villages, other than after death, have any capital of any significance at all. Whilst they're waiting to recover their exit entitlement, which can be anything from a few days to many years, they have nowhere to stay. There's no risk to the operator that these dissatisfied residents are going to seek to warn off other prospective residents, because that would be counterproductive to their interest in selling their unit. So you've got a silent objector, if you like, who's sitting there frustrated about not being able to get the money, but unable to wave a flag and warn people about it.

These dissatisfied residents, if they were to bring legal action, often face intimidatory tactics from the operator, including such things as unsolicited attendance by the operator at the resident's unit advising them that their action may result in something as draconian as an eviction notice or what other intimidatory tactics are necessary, and many threats in village-wide circulars criticising the resident's action and advising other residents of the undesirability of this particular complainant being in the village. If this occurs, they collectively - the residents - will be required to meet the operator's legal costs in defending it. I don't intend to expand at this stage on that, but I currently have four cases on my desk where exactly that has happened and where we have received information from a particular operator that he is intending to add to the general service charge this year the $6000 which has been required to outlay to prepare the defence of a case. These dissatisfied residents, also, they can't complain to the media, because that devalues their own units, the units of their friends in the village, and it exacerbates this friction between residents.

On the other hand, the ARQRV does not oppose exit fees per se. We understand they provide an excellent way for capital-rich but income-poor retirees to leverage their capital to improve their lifestyle. That's the key phrase: if they're able to do that and improve their lifestyle and get what they pay for, what they intended, we don't have any argument. We believe that's not the case though. However, the practical effect of exit fees is that once a resident enters a village, that resident loses all economic bargaining power vis-a-vis the village operator. That makes a retirement village resident's contract the most disempowering contract that a consumer can enter into. We know of no other type of contract which doesn't give you the opportunity to negotiate with the contractor at some stage, before, during, or after. That's not possible in the retirement village scenario. That's a big disadvantage.

The only way to overcome this imbalance, in our view, is by robust and effective regulation of the industry, including a mandatory code of conduct for village operators. There are mandatory codes of conduct in lots of other organisations. We certainly have one in the Body Corporate and Community Management scheme area, and I saw recently that the WARCRA, the Western Australian equivalent of our organisation, has had introduced a code of conduct over there. That's something we'll be working on, hopefully, effectively, in the next few months.

The future viability of the industry, in our view, depends entirely on improving market penetration and this in turn depends on improving consumer confidence through more effective regulation, certainly not less regulation, and more effective regulation obviously includes agreement on interpretations on those many sections of the regulations which can be interpreted one way or the other, and that's what causes most of the problem; the inability to find common ground in that area and that's what

I mentioned before, we are processing those claims through another avenue.

The ARQRV believes that there is ample evidence of problems in the industry and inadequacies in current legislation and we'll be able to provide those if necessary. Finally, if any research is required, as there is now, the resident groups must be involved in the commission of that research and the production of the report. We were somewhat disenchanted to see in the RVA response to your report that it's absolutely essential to get quality inputs to organisations like yours and to do so in this instance, you must talk to the government and you must talk to the Retirement Village Association. Inadvertently, they forgot to talk to the 46,000 residents in Queensland, and that's what we're doing on their behalf. So in future, these sorts of things have to include the real key stakeholders. We talk about key stakeholders in this business and it's flippant because it's, "Him, because he's a big operator," and, "This one, because that's a big financier," or, "This particular group because they're an operator-oriented legal firm." The real key stakeholders are the residents.

Finally, looking at that research, it should also include surveying past residents and their families because existing residents are often intimidated, too concerned for whatever reason to criticise the operator and most of the responses you will get from these key stakeholders, as I have called them, are going to be criticisms. That's unfortunate but that's the way the lifestyle is organised and it generates that discontent. Thank you.

MR WOODS: Thank you. Do either of your colleagues wish to make a statement?

MR WISE (ARQRV): No, we were all involved in the preparation of that paper.

MR WOODS: Thank you very much.

MR PHILLIPS (ARQRV): If I may, I'd like to draw attention to some particular facets of the report. If you look on page 331, it says:

> The regulatory framework for retirement living: retirement villages are regulated by specific legislation in each state and territory. The legislation covers most aspects of retirement village ownership, operation and management.

Now, that's a contribution from Minter Ellison. But the legislation doesn't really cover or instruct the operation of the village. That is left to the individual owner and in many cases to the individual manager. This is a mistake to assume that the legislation covers that.

On page 335 there's a reference to the RVA's claim to rigorous self-regulation and independent assessment. Now, that really is spurious. The RVA followed this

because they wanted to avoid the implications of the Queensland Residential Services (Accreditation) Act of 2002. Now, they managed to dodge that by getting the Office of Fair Trading, and that means the government, to issue a regulation ruling that the act did not apply to villages which were accredited under Aged Care Queensland's voluntary accreditation scheme. Now, that was a bit sneaky of the RVA and Aged Care Queensland and foolish of the Queensland government. Why they wanted to do this is not for the benefit of accreditation. That remains what it ever was, a marketing tool, the cost of which some operators at least tried to recover by charging their residents.

Now, on page 336, a contribution from members of the New South Wales Residents Association:

> We will find it difficult to recommend retirement villages so long as there is such lack of protection of residents.

We agree with that. Unless residents go into a village - before they go in and when they go in - everything is transparent to them, there will be disenchantment and the need for organisations like the ARQRV will persist. Also, on page 337, there is a remark which I think the commission has made. In our view, it shows a lack of understanding by the commission to liken the fate of retirement village residents whose village owners go into receivership with the economy at large, which I'm afraid it does. Retirement village residents are not speculators, they are not there because they have made an investment for which they expect earnings. They have simply thought that it is an acceptable place to live for people who, as has been remarked, are capital rich, comparatively speaking, and income poor.

Given that villages are going into receivership because the big corporate players are overreaching themselves financially, government should protect residents from the undeserved consequences. If they do not, elderly people would become increasingly reluctant to into retirement villages and we would have to sympathise with that reluctance, and of course if that happens, governments may find themselves, with reluctance no doubt, having to play a more active role in meeting the accommodation needs of the elderly, and if it wishes to escape that, it must pay more attention to the legislation than what is actually happening.

MR WOODS: Thank you.

MS MACRI: Because we've only got five minutes in terms of time, and I think there's probably a couple of questions around some of this that we'd like to ask you - so thank you very much for your presentation - I guess the first one I'd be interested in - there's two areas, the economic incentive and the turnover. Undoubtedly in the past that turnover - and it was really more around real estate and you're absolutely correct - but my understanding is now that the retirement village industry has moved

on into melding into the broader provision of care and there's a lot of retirement villages now nationally applying for community aged care packages, EACH packages and providing care to the residents rather than that. So what are your comments around that?

MR WISE (ARQRV): There are some villages, not many, that are attempting to do that, but currently the separation between the Aged Care Act and the state based Retirement Villages Act does not accommodate that. For instance, under the Queensland Retirement Villages Act, an operator is entitled to terminate a resident's contract, evict a resident, if they're no longer capable of living independently. That is a fundamental conflict of interest because that puts the operator in a position where they have got to change between terminating this person and earning a profit or helping this person stay on a bit longer. If they have got a legal duty to maximise profits to their shareholders, they've got no choice. They've got to terminate the resident. That's not in the best interests of that resident or of society generally because if that person can be assisted to stay, that would be a better outcome. There's no incentive to provide that support because they only earn a dollar - it costs them to have the residents - they only profit when residents leave or die. So there is no economic incentive. I mean, some of them may do it out of the goodness of their heart but the reality is that we've got big companies now that are basically property developers and it's all about making a dollar. At the end of the day there's no room for compassion and they must make their dollar because that's what they're legally obliged to their shareholders to do. So I don't see how villages offering this ageing in place concept could work. It's not very common in this state.

MS MACRI: There are a number and certainly even in the private sector across Australia now that are offering the HACC, CACP, EACH and EACHD and are approved providers.

MR WISE (ARQRV): I'm not aware of any.

MR ARMSTRONG (ARQRV): That is true, by the way. I'm interested in they're offering that but it's not costing them anything because that's available anyway, the services you mention.

MS MACRI: It is keeping the person in their home.

MR ARMSTRONG (ARQRV): It is keeping the person in their home but what it's not doing is addressing the fact when the person is already in a retirement village. I have to say here that the two key players in this in Queensland are Aged Care Queensland and the RVA and in my opinion Aged Care Queensland are infinitely better at managing this issue than the RVA because they're in the business of non-profit organisations and they're much more responsive to it.

If you allow a resident to believe that by coming into an independent living unit under the state legislation, because co-located in that village or somewhere else close by there's another higher care facility, the operator is morally obliged, I believe, to tell you that the transition from independent, state to higher care, federal is not seamless. It costs enormous amounts of money, there's huge delays in the transfer and it may not even be in the same location. That's the problem you face here. So where it breaks the nexus between federally legislated aged care, it's got nothing to do with this issue here of the retirement village regulation and the retirement village funding.

MS MACRI: One of our recommendations - I'm really conscious of time - is around a more nationally consistent approach to contracts into retirement villages, which obviously is eminently sensible. David, how would you see that proceeding or taking place?

MR WISE (ARQRV): I would certainly support some sort of national standard of contract but the contract would have to be heavily regulated and standardised just to give residents basic rights and, as you say, the right to extend their stay as long as possible using existing services. At present contracts don't offer that right or ability. The contracts are drafted to minimise the obligations of the scheme operator to the extent permitted by law and currently the law doesn't require the scheme operators to allow the resident to stay as long as they possibly can and so their contracts don't allow the resident to stay as long as they possibly can. There may be isolated instances where that happens but it's not currently a legal obligation. In terms of a national contract, yes, I think that is desirable but it would almost have to be enshrined in legislation almost perhaps as a regulation or a mandatory code of conduct or something that set out some very fundamental rights of the residents and made them inviolable.

MS MACRI: That capacity to remain in their own home is fundamental to everybody.

MR WISE (ARQRV): Yes, that's right.

MR FITZGERALD: Just one issue that has come up, and it was in the paper the other day in reference to this inquiry, was about a number of the villages responsible for the onselling of the unit and the article was making the point that sometimes there has been very lengthy delays in the sale of those units and the bearer of that responsibility is in fact the resident, the owner of the unit, and there's a disincentive - they were implying that there is a disincentive for the provider to actually make a rapid sale because they were getting ongoing fees. So I just need to understand the motivation of the provider. You're saying that the profit for a normal village operator, a full profit operator, comes on the sale, the turnover of the units.

MR WISE (ARQRV): Yes.

MR FITZGERALD: So is there a disincentive in any way for them to slow down the sale of a - - -

MR WISE (ARQRV): No, we wouldn't say that.

MR FITZGERALD: Is that because they can't sell the - - -

MR WISE (ARQRV): To the extent the article insinuated it, that wouldn't be our point. They make their money by achieving the sale. So they've got to achieve the sale but the problem is in a village, it might be a developing village and they might have new units coming on line and they've got buyers walking in the gate, they're going to push the buyers to the new units coming on line, not yours, because there's more profit for them in that because they don't have to pay an outgoing resident. Similarly, even if there's no new units coming on line, there might be four or five, six, seven, eight, nine, ten units for sale and there's no way of knowing whether your - they don't do a FIFO queue or anything like that, it's whichever one the buyers want.

So yours might just happen to get overlooked and overlooked and not purchased and the economic risk of that unit not selling is borne almost entirely by the outgoing resident, who is usually the one least capable of bearing that risk. There's no requirement for any kind of down payment on their exit entitlement. In fact there's no guarantee of an exit entitlement at all and that's the problem with village receiverships because if a village gets what we call the "stink of death" about it, and there is an example of one in Queensland that has achieved that where the units are simply not capable of being sold, the outgoing residents get nothing. You have no proprietary right in a retirement village unit; you basically have a contractual right to an exit entitlement and that contractual right is dependent on the unit selling. So if the unit never sells because the village goes bankrupt or just gets a very bad reputation, the outgoing residents leave with nothing.

MR FITZGERALD: Just your example on page 3 - and I don't want to extend this further - you've cited an 81-year-old woman who had a unit for 380,000 but the deferred management fee on exit was more than $200,000. In your proposals going forward, whether it be uniform legislation or a code of conduct, do you believe that the deferred management fees need to be regulated in some way, or is it simply the disclosure? So that if somebody enters into what effectively looks like a bad deal they bear that consequence, or are you saying there's actually something wrong with the DMFs are working?

MR WISE (ARQRV): No; it just needs better disclosure. In that particular instance the exit fee was disclosed as a percentage but a percentage of a future

unknown amount and so turned out to be a percentage of almost 60 per cent of the future sale price, which was unknown. There happened to be a boom, the unit increased dramatically in value, the exit fee ballooned, the resident got fairly financially devastated by that.

The disclosure of the exit fee up-front needs to be a dollar figure. We don't want to put a cap on exit fees because that would restrict competition but to make the competition real the maximum exit fee has to be disclosed as a dollar figure. At the moment a prospective resident will look at two villages and they've got two complicated formulas to compare, and so it's very difficult to meaningfully compare them and so that's limiting competition. Whereas if there were two dollar figures - so when the up-front cost is disclosed there also has to be disclosure of the maximum exit fee - there's easy comparison, so competition is facilitated.

MS MACRI: I would think capital gain comes into that as well. I mean, there seems to be some issues around capital gain and how that is shared.

MR WISE (ARQRV): Yes.

MR WOODS: So are you finding that your advocacy, and that of related organisations elsewhere, is in fact helping turn the industry round so that you are getting better disclosure, you are getting more consistent regulation? Not yet?

MR WISE (ARQRV): No.

MR ARMSTRONG (ARQRV): Not really.

MR WISE (ARQRV): We're often feeling like it's completely futile because, well, the industry has a very effective lobby group and the government listens to it.

MR WOODS: Presumably the industry is dependent on people willing to actually enter the villages and if the advocacy says to people, "Well, be cautious until you have transparency, until you know what you're buying into," then surely there must be some leverage there?

MR ARMSTRONG (ARQRV): Well, that is correct but one thing we'd have to be very careful of - in fact we've just decided not to attend a retirement village expo down at the Broncos next month because our presentation and the documentation we were going to hand out was accurate and it was precise but it was one side. It was basically these are the things you should look at before you come into a retirement village and we've given you 15 absolutely essential questions to ask or re-ask and I suppose it was saying, "Here are the good things about retirement village living," from our point of view and, "Here are the bad things."

We had 26 pages of bad things and half a page of "for" word so we decided not to do that because what we don't want to be doing is be seen to be destroying the viability. We need that viability as much as the operators do for our residents who are in there and the government needs that as well because if the residents and the operators don't fund the villages, it's got to come out of the public purse, and we know that won't happen. So people shouldn't think we're anti the industry and we're anti the operators. We have a particularly good rapport with Aged Care Queensland, an excellent rapport. We're the only state that has that rapport of course, because Aged Care Queensland aren't anywhere else in Australia. I can't say the same thing about the RBA, because they're coming from a different background.

MR WOODS: Thank you. We have run out of time, but we do appreciate the work that you've put into this and your presentations today and your reference to specific parts of our report which we will go back to and re-examine.

MR FITZGERALD: Thanks very much.

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

MR UNDERWOOD (JUA): James Underwood, James Underwood and Associates.

MR WOODS: Thank you for your contributions to date to this inquiry and you've provided us with further information and some helpful calculations and some examples of issues, but please make your presentation.

MR UNDERWOOD (JUA): Thank you very much. It's really only a one-issue item and it's one which came up in previous discussions and actually it's an affordability and enhancement of options item, very similar to what Les just brought up in that previous talk. He was saying how the availability of deferred management fees or exit fees meant that people could access a retirement village product, a quality of product of accommodation that they couldn't otherwise access and that was from the days when we first started building retirement villages 30 years ago and we first went to this DMF model, people would be selling their modest houses for 150,000 and they would be going to buy a retirement village unit which was going to cost them 160,000 and of course that was basically unable to be done. Part of the cost of the village was tied up with the joint services in there.

You would have a proposed community hall and you would have some park areas and hopefully areas for care delivery or whatever. To put those together was actually going to cost more than what you were likely to get for your modest house in Coorparoo or Camp Hill. So we put in place this deferred management fee arrangement where there was an additional amount that was going to be paid at time of leaving the village, which then allowed people to actually pay below what they would receive on average for their typical house and still be left with a small amount positive on the transaction because, as they were in the main pensioners, they had no capacity to move into a debt situation or move into a retirement village. That is something that we are doing currently in residential care in Australia. Currently we have what is called a retention, a $3690 retention. That goes towards the cost of the accommodation and it is an amount which is withdrawn from the bond at the conclusion of the tenancy or it ceases after a period of five years.

MR WOODS: Or caps at five years.

MR UNDERWOOD (JUA): $3690 is not a lot. In fact it more or less came in back when bonds were in the vicinity of 20,000 and 40,000. It was quite a large amount and it just hasn't grown as time has progressed over the 21 years of the operation of those particular retention arrangements since 1991. But if we were instead to take that $3690 as an additional fee, a component to the daily fee, it would

be about $10 a day. If we were then going to use that $10 a day and offer it to people as a lump sum, if we were to use a 3 per cent return, that's 3 per cent the people would otherwise get on the basis of a CPI-type figure, and I'm taking an estimation of a CPI return there of 3 per cent, they would need to put up around about $123,000 of extra lump sum. $123,000 at 3 per cent is $3690 a year.

You couldn't really add that to a bond if the bond were already at a level not too far below their assets after realisation of the sale price of the house because they wouldn't have the extra asset. So what we do is we have, since 1990 or 91 when these retentions came in, it's an item that comes out of the bond to assist meeting the capital costs of the operator and it's more readily affordable for the resident. We've moved beyond that in recent years.

A large part of the additional cost that people pay in an extra services home is towards the accommodation cost. There is of course an amount that people can pay towards additional services, and additional food outcomes. But a substantial part of it is always going to be the accommodation cost. Most extra services homes in this country offer the opportunity for the extra services amount to be withdrawn from the lump sum at time of departure, which is normally at time of death.

What that means is that people can therefore access a quality of accommodation that they couldn't otherwise access if they were going to pay a bond equivalent to the gross amount of that accommodation component of the extra services amount. I thought about this and I thought if we have the situation where we have in the future an option of lump sums or periodic payments but no retentions - and the draft report has specifically recommended the deletion of retentions - if we pull the retentions out of this process and we don't make retentions an available item, then it seems to me that we would be unable to have people access the higher accommodation quality outcomes that they currently do, because the amount that they could afford through putting the money into the pensioners' fund, receive a 3 per cent return on that, in my example they draw it down in seven years, people would be unwilling to go into a situation where at the end of seven years, they were no longer able to have the money to afford whatever they had moved into.

If they paid bond only, it wouldn't be big enough. It's not big enough now. We have to have the bond and the extra amount, that retention bit and that extra services amount bit to be able to afford the quality of accommodation that people wish to access. So I've asked for consideration to be given to continuing to have a retention capability for people to allow them to access a quality of accommodation that they might otherwise not.

I haven't noted in there that many services will put in place what is called a peace of mind guarantee and that is where, whilst normally the amount that is being withdrawn from the bond would not be such that it would exhaust the bond balance

in less than 10 years, some residents may live with us for more than 10 years. It may be some residents will be with us for 15 years; not very many. People are entering very frail and aged into our services today. The peace of mind guarantee is what I encourage clients to do and most do and that is they say if residents are successful enough to live with us for so long that they exhausted their entire balance, the extra fee would be wiped. If we thought it appropriate, we could possibly more clearly identify that that would be a positive thing to see in these things.

There are a lot of flexibilities that we can do and I was very interested when I was listening to Les - I've had the fortune to listen to Les before at retirement village activities - there's one group down in Canberra that have an exit fee of 3 per cent a year forever, and that's called Goodwin Aged Care. Now, that's interesting because in that case obviously they are not going to have an economic imperative to move somebody on for 33 and a third years, which is beyond the normal length of stay of a person in a retirement village. There are a lot of good things that we see out there that may also be in some way applicable here.

MR FITZGERALD: What's your comment about the Goodwin village model?

MR UNDERWOOD (JUA): I think it's an excellent idea. I think it means that they are completely indifferent as to whether a person remains within the village for one year, eight years or 33 years. In the example I've given here, the example I've provided in my written copy, I've looked at being able to go for 15 years and, really, for people entering - I'm expecting predominantly high care - high care in residential aged care today it's an extraordinarily low number that would enter as - 75 per cent of all people who enter are aged 80-plus at point of entry, almost 50 per cent now are aged 85-plus. It's not realistic and they're also very frail when they enter so a 15-year situation should be very fair to most people.

MR FITZGERALD: Can I just clarify your proposal before ask questions. Your proposal is to allow retentions for a period of 15 years, did you just say?

MR UNDERWOOD (JUA): To allow retentions generally.

MR FITZGERALD: Yes, but what's the 15 years that you've just quoted?

MR UNDERWOOD (JUA): The example that I put in the last page there deals with where if that retention were allowed, then the bond balance would be exhausted at just over 15 years.

MR FITZGERALD: Just to be absolutely clear, you're saying that retentions should be allowable for any period of time and it's not capped; in other words, there's no restriction.

MR WOODS: Except there's peace of mind.

MR FITZGERALD: In aged care people are not likely to last 30 years.

MR UNDERWOOD (JUA): Correct. My contention that the availability of retentions would allow our residents greater access to quality of accommodation above what they could otherwise afford and that those retentions should of course not be capped, they should be simply a matter for negotiation, regulation if appropriate but certainly negotiation normally between the resident and the provider, as they are know.

MR FITZGERALD: Thank you.

MR WOODS: But you did draw attention to this peace of mind caveat that some have that says, "Look, here's the bottom line on all of this."

MR UNDERWOOD (JUA): It's a commonsense thing. There is obviously no sense in having a retention that would totally exhaust somebody's bond within two and a half years if many residents are with us for a good deal more than two and half years.

MR WOODS: We're very grateful because not only your recent submission but in others you've actually done some hard yards in doing the calculation so we understand where you're coming from on those. But do you see - and having listened to the previous participants - the concern about the deferred management fee which could be seen as an annualised retention in some form that, particularly for retirement villages where people anticipate that they will then need to move to an aged care facility as well as part of their total life journey, that this is raising concerns by them and do you see the industry is responding? After all, the industry is dependent on people actually taking up the retirement village offerings. So where in your understanding of the industry as a whole do you see things are moving?

MR UNDERWOOD (JUA): The biggest growth group of successful applicants for home is retirement village operators in the private for-profit sector. They are clearly moving towards that but there are a lot of retirement villages and there's not enough of them doing it yet. But they're clearly moving towards that as a good market item and as a way to more successfully market their services. We're seeing organisations in this state and others that are working under the Retirement Villages Act and actively seeking only people on CACPs, EACHs, EACHDs and veterans packages and in this town Seasons, Tall Trees and groups like that - there are different views on how those products are being offered but by gee it's an interesting item. They are actively saying, "That is the type of person we want in here."

My proposal is, of course, is only for high care - low care as appropriate too -

but people exit low and high care almost exclusively through a celestial transfer. They don't transfer anywhere else.

MR WOODS: They don't need the capital retention.

MR UNDERWOOD (JUA): Yes. They and their family are able to make the decision that they are able to utilise whatever level of the assets they think is appropriate to get the accommodation that is appropriate, to then on the basis that there is no further accommodation option required that is their final accommodation option.

MR WOODS: Just one brief further one from me in that situation. You do keep focusing on bonds and retentions. The proposal that we have that a mandatory offering must be a periodic fee, whether it's a daily rental or a weekly rental. Do you see two things: one that that obviates the need to try and fine tune what a bond might look like an in fact you could have a combination of part-rent or part-bond and the other is what are your views on what the take-up of the rental option might be where (a) it's a mandatory offering and (b) it's disclosed to potential residents?

MR UNDERWOOD (JUA): Mike, I think it's really going to be based on the interest rate that we use. Let's say we worked out that the accommodation cost for home (a) was $65 a day. At the moment we're getting in round figures $30 a day, let's say it $65 a day. Let's say home A has worked that out and they have put some science to it and $65 a day is it. That is $23,700 a year. If a 3 per cent interest rate were applied on that - and we've talked about the idea of the pension fund having a CPI-type return and CPI is normally around 3 per cent mark. If a 3 per cent return was put on that, it would be a $790,000 bond. So $65 a day, 23,000 a year, 3 per cent, $790,000. Most of our people won't have $790,000 therefore the bond would not be utilised by those people.

If, on the other hand, the 8.92 per cent - which is currently the MPIR - was used on that same $65 a day, it would 266,000 bond. Would people choose a $266,000 bond? Yes. Why would they chose it? Because they're effectively making a 9 per cent return. They can place on that $266,000 which is taken from their assets, if a 9 per cent return - it's only a very small bond or a comparatively small bond. Where we set that percentage is going to be critical to the level of take-up of these bonds in the future. The transition arrangements for providers who currently have an enormous proportion of their capital paid for by bonds, the transition arrangement, if it was set at a rate where people who were replacing those, payed out the bonds to replace them, were such that most people didn't want to pay a bond, the providers are going to have to find an awful lot of money.

MR FITZGERALD: Sure.

MR UNDERWOOD (JUA): If it's left at a point where they are indifferent, it's my experience that people like to get their affairs in order. We have had periodic payments in place since 1997. They haven't been as strongly advertised or advocated by providers as perhaps they should have been, that is for sure. The take-up has been very poor, 4 or 5 per cent.

MR WOODS: There has also been a strong incentive to not take up the bond on the age pension side which we've tried to neutralise.

MR UNDERWOOD (JUA): There has been that. But that only happened in 2005. Between 1997 and 2005, when bonds were still an asset for the purposes of the assets test, we still had an enormous take-up, we still had very few people take up the periodic payments, just getting their affairs in order, getting it done, getting it fixed up. If there was an indifference because the interest rate was set at that rate, I would expect that a good level of bond take-up would remain.

MR WOODS: I'm conscious of the time, but is there any last points?

MS MACRI: No.

MR FITZGERALD: Only just to understand what you think is happening with these current vacancy rates and this 14,000 residential care places vacant at the moment. Where do you think those 14,000 places are? Are they in the older, poorer quality stock; and, if that's the case, is that a concern, because some of that stock needs to be replaced? You may or may not have a view as to where this is occurring, but our gut sense and discussions with some providers is that this vacancy rate is there, and there's reasons why there is a bit of a capital strike taking place in relation to ordinary high care, and we're trying to address that. But there is also a view that these vacancy rates are actually in relation to stock that over time should be replaced anyway. Is that your view?

MR UNDERWOOD (JUA): The capital strike? Do you mean people not willing to - - -

MR FITZGERALD: Yes, they're taking up the places, but they're not actually building the high care facilities.

MR WOODS: Or the supported resident facilities.

MR FITZGERALD: Or the supported residents facilities, yes.

MR UNDERWOOD (JUA): You know, we have been building four and a half thousand new places a year for years. This view that there is a strike - I know I put the fees in there, but I'll say, in 2005 we built 5700; in 2006, 4700; in 2007, 4000; in

2007, 5100; in 2009, 3700. I have got the 2010 figures, and that's four and a half thousand. This view that we're not building places - we are building them. We are building them at the normal level. What has happened, in my opinion, is that the government has been trying to hand up too many places. So they have been wanting to give us 6000, 7000, 8000 or 9000 beds, and the industry has correctly said, "You've got it too high. We don't need those beds."

At four and a half thousand a year, our occupancy rates are going down. Our occupancy rates have been going down for seven years. We're three-and-a-half per cent lower than we were back in 04. I think I put the figures in to you in my first submission. Okay, what is stopping it? Firstly, home care. EACHs have spectacular waiting lists, and EACHs have gone from zero to 8000 places, and there were another four and a half thousand EACHs given out in December. We only build four and a half thousand residential care places in the entire country in a year, and they have given us four and a half thousand high care at home places, another two and a half thousand low care at home, CACP places, plus of course the veterans' packages continue well. That is soaking up one area of it.

The next one is, these products I've spoken of with Seasons, Tall Trees, other operators that are working very hard to provide congruent living environment where many people, but certainly not the majority, have got CACPs, EACHs, EACHDs, but they're living within those and not moving to the residential care. Lastly, we are living longer. Bernard Salt did a nice one of these in The Australian just a month ago, he said how every 30 years we have lived an extra six years longer. So you go back 30 years, you go back 30 years, and we lasted six years longer.

Now, what that means is that every year we're living an extra 20 per cent longer as a group, and that's actually pushing back the morbidity period. So that period when we lose our independence and we get frail has been being pushed back all the way through. So every year where we think there'd be this group of people there, they're going to be next year's lot, and the next year, and the next year. If we take out 20 per cent every year of our group, because they're being pushed into the future, then that's 20 per cent that the government is putting within our 70-plus figures who are not there.

MR WOODS: We have well and truly run out of time. Thank you for your ongoing helpful calculations, and I'm sure you'll throw us one or two more in the next week or two. Thank you very much.

MR WOODS: Could I ask Older People Speak Out to come forward, please. Thank you for the document you have provided to us. Could you please, for the record, state your name and the organisation you represent and position you hold.

MS LILLEY (OPSO): My name is Maida Lilley, I'm vice president of Older People Speak Out. Actually I was registered to come as an observer for Queensland Retired Teachers, of which I'm immediate past president and their adviser on seniors matters, but I am also vice-president of Older People Speak Out. I filled out some extra forms this morning, but we have had people who are ill and unable to come. So please bear with, because I have only just received the commission actually to come to the commission.

MR WOODS: Yes.

MS LILLEY (OPSO): We see currently that one of the biggest problems with aged care is that it's provider rather than consumer driven, and in very few other industries is the consumer so constantly ignored. The various financial solutions so far put forward to the commission are concerning examples. Solutions need to be based on what is best for the consumer when that consumer is 70 years plus and what they want and need, and who better would know that. OPSO is entirely made up of all seniors, volunteers, who come from a variety of backgrounds and organisations. So our recommendations are based on views of such seniors.

We are the age group to which these services are directed. We believe that the present range of proposed solutions are industry based. This paper intends to put forward consumer based recommendations for your consideration, in the belief that such services must be consumer-driven. OPSO believes that so far nothing more clearly shows the failure to understand this age group and the proposal than that the very frail aged should sell or reverse-mortgage their home in order to pay for nursing home care. These are the generations who suffered the Great Depression of the 20s and 30s, World War II, and, from the female point of view, who received 75 per cent of the male wage in the workforce and were required to resign as soon as they married, and so we all lived on one wage and managed that way. We went without, but it was what everybody else was doing.

One thing we did determine to do was invest in a home which would give us safety and security in our old age, and we expected to leave that home to the children so that they would not have to do without, the way most of us had done without in our younger days. It was what everybody did in those days, so we didn't feel oppressed at all, it was the way of the world. There is also a possibility that some older people would prefer to consider euthanasia or even suicide rather than give up the family home to go into care. To take this away from them is emotionally destructive and it opens the gates to possible elder abuse within less caring families,

and that is becoming more apparent as the years go on.

As the gentleman before me said, we are living longer, healthier lives, and so we're out there in our 70s and 80s and beyond. There are better options. We recommend that an agency be established to oversee the renting of the client's home when they go into care. In discussion with major banks and credit unions that have served us over a lifetime, they are often open to such reasonable solutions which will provide income towards nursing home care, and income for this purpose of course would need to be exempt by Centrelink for those on a pension. This has the advantage of keeping the family home and also gives the additional benefit of adding stock to the very tight private rental market.

OPSO approves the proposal to provide better support to informal carers and the measures suggested to improve their quality of life. So many of them don't even register as carers for what they're entitled to because they're looking after someone in the family. It's noted that there is an expectation of an increase in volunteers working in the aged care industry and while many of us do, it should not be assumed that they will all automatically volunteer and they shouldn't be expected to do the work of paid professionals.

If they do volunteer, they probably need training in such things as feeding of elderly people and of having resource management and adequately funded management so that they can do it effectively. It's also noted that recognition has been given to problems emerging in the formal aged care system. Many private facilities have been using cheaper workers from overseas countries with poor English. It's upsetting to the elderly in high care, mainly because they can't make themselves understood and they cannot understand some of the workers, no matter how caring they are.

In fairness to these workers, they should be offered access to appropriate language development courses and training in working specifically with older people with high care needs. There's also a growing need to raise awareness of career possibilities with appropriate career paths for young people leaving schools and colleges to consider working in the aged care industry. On the whole, they do not consider this.

I have a friend who ran a hospital as a director of nursing for many years and then became the CEO of that same very, very well-known hospital in that city. She used to put the new student nurses very carefully on their first assignment into aged care. Mostly they pulled long faces and didn't appreciate being placed there, but after they had worked with the older people and talked with them and found that they had a lot to offer because of their experience of life, they all decided they were glad they had been there.

The other thing that's a real worry is that cities like the Gold Coast, which is one of the largest concentrations of old people in Australia, only have one or two gerontologists and they really are under stress. I've been on committees with a couple of them and the gerontologists themselves are terribly worried that very few graduates are going into the specialty of gerontology because it's not, as they put it, sexy. They go into orthopaedics instead.

Much talk is given across the whole proposal to the simplification of gateways. This is hugely important and while there are excellent schemes - and Centrelink fits into those - there are many services and products that are available, but the community is still under-informed. There is often brochures when you go to the doctor or they're at the chemist while you're waiting for your script and people only pick them up when they're in desperate need. They don't think they need them yet and they really don't know what they're entitled to and what is there.

The value of retaining individuals in their home - and Sue mentioned this, which I was very glad to hear - it cannot be ignored when the cost of care is spiralling beyond the government's and the private sector's capacity to meet the real needs of people as they age. Bringing aged care delivery service back down to the community grass roots level enables both a better informed and inclusive community for our ageing population, as well as allowing services to be better tailored to meet the individuals' needs.

We find a lot of the services are being given to huge almost multinationals, rather than the local people who have been providing HACC services and so on over the years, so that they're pushed out of their local community ones and the big groups take over. Really they used to be run by churches that most of us attended as children. It was the automatic thing to do, to go to church on a Sunday and send our kids to Sunday school, but those churches now have businesses, rather than caring institutions. It's happened in my old community. They've sold an aged care home to developers because it has views of the river.

If an individual is supported to remain in their own home, then services should be delivered in a timely manner by people who are part of the community where the individual resides. I've been on committees at the general hospital here for the prevention of falls and very senior people from the Royal Brisbane and Women's and Children's Hospital say, "Over 65s are entitled to", and I'm the only person in the room saying, "They may be entitled, but do they get the service and do they get it when they need it," and they all stop in their tracks and say, "Jeez, she makes sense," so it's very important that it is a timely manner and when they need it where they live.

Providing individuals with the funding to purchase their own services needs to be well thought out. It's been very well looked into in America. Many states pay the

person to get the care they need. It happens in Europe too, in Austria and Holland. In Holland when they decided to do that, so many people came out of the woodwork that needed help that had never bothered before to do it officially, that they had double the number to do and they were pleased to do it because they felt it was needed.

We've had people come out and talk to us about that and I think consumer-directed care is probably a very good thing. Many of the people, particularly in their late 70s, have acquired assets through many years of hard work following the depression and World War II. Their homes are a very strong role in how they perceive their life to be successful. If you've got your own home and you've paid it off over a lifetime, it's part of your identity.

Having to dispose of it prior to your actual death can lead to higher mortality rates and certainly higher rates of morbidity. People get very depressed about it and often gerontologists tell us this, that when they do come into care, that they are depressed as well as having complex chronic conditions. Any arrangement that the government makes in making people turn their assets into care funding should be considered very carefully and alternate option to disposing of their home when they are in need of high care should be considered and explored thoroughly.

These people have contributed to our society through the payment of taxes and often are still contributing to their communities and families and they should be entitled to some government support as they age. Age-friendly housing and retirement villages, we've heard some very good presentations about that this morning and they are very few and far between, as the gentlemen from the retirement village has said, where care is coming in and more and more we're supporting people who do this.

One thing we're lucky to have in Queensland is a home maintenance and modification scheme called Home Assist Secure. People like me, I don't think, could live without that support. They are just wonderful. It needs to be available to everybody in every state to enable people to stay in their own homes as long as possible. Sometimes they move into care really before they need to, rather than because of actual health issues, if they can't help with maintenance and modification of their homes.

While governments pride themselves on consulting with people about proposed change, they really should be targeting any such consultation to those who are going to need their services now or in the near future. Investment by the private sector should be encouraged by appropriate legislative changes nationally so there's consistency in the type of accommodation available and costs attached to it. There's a lot of misunderstanding in the community about various levels of retirement and aged care living. Some of this is due to the different terminology that is used where

retirement villages, low care and high care, for a little while were all grouped together as aged care. The people themselves think of hostels as different from a retirement village and certainly as nursing homes as different again. The majority of people do not understand what is actually available.

There could be some incentives to retirees to develop a care plan before they need it, so they can take preventative measures for good health and, by self-management of their health needs, possibly lower their future high-care needs. Mental aged care facilities are rare and can take some of a person's pension that they can't have a decent style of living. This lack leads people to occupy unsuitable and often really quite unaffordable private rental accommodation in the general community. This ties up housing for the community and again contributes to further and faster health degeneration of some older people. That's all I have at the moment, but I'm happy to answer questions.

MR WOODS: Thank you. That was a very comprehensive submission that has been prepared. But also, I gathered, as you made various anecdotal contributions, that you have a wide range of industry - - -

MS LILLEY (OPSO): I had to make it sound like me, when I was told yesterday that I had to do it.

MR WOODS: Not only that, you clearly have a wide range of experience in a number of aspects of this, so those additional embellishments were actually quite helpful to us. Several of the issues you raise we are conscious of and one of the proposals in our reforms is that people have as an option, in all cases when they're entering residential aged care facilities, to choose a daily or weekly rental, rather than to have to pay a bond. Hopefully this will address, in part, your concern. Because that way, should they wish to retain their current home, or rent it out and use that rental stream, or whatever arrangement they wish, or if they wish to sell their home but invest it in a pensioner bond and use the drawdown from that. There are lots of options that we're trying to put into the system. Hopefully we've targetted some of those concerns.

I was interested in your own experience about people actually accessing services that - again, currently services are packaged into groups - HACC, CACP, or REACH - and there are only limited numbers of them. Whereas what we're proposing is in fact that the services be targeted to the person's individual needs not that the person has to fit into one of these packages, and that it be an entitlement not a, "Can you find one where somebody has a vacancy in that package?" So from your own experience, is that going to give people more comfort and security, that once they get the entitlement that's where the empowerment is, and do you think that will change?

MS LILLEY (OPSO): Actually, we had an experience on our retired teachers executive recently where one of our ladies well in her 80s had a couple of falls. She only has a few steps at the back, but she's in her own home and she's been widowed. Her doctor put her in to have an assessment and she was furious that they'd spent the money and the time, because she didn't need it and they told her she couldn't have it for three years anyway. She came to me to complain: "You do all this senior stuff, Maida, what do I do?" I said, "Be very thankful that you're on the books, because in three years you may well need it," and she went away quite satisfied. But it is a worry when people come out of hospital and can't even get a quarter of an hour a day so they can do some rehab at home, have their stockings removed, and put back on and have a shower. To automatically assume that they're entitled, and people at hospitals and at high level in the Health Department really think eligibility is all you need. It takes consumers to say, "It doesn't happen."

So that was one incident, and she really probably does need the care, but she's of a generation where we were, "Pull up our socks and get on with it." We went to school through the war, we had no fathers that we even recognised when they came back, we were born before or during the depression when everybody was careful about everything. We just got used to that in life. I get really concerned when I hear commentators saying, just to take quick figures out of the air, "They bought their home for $100,000 and its worth 500 now. That's unearned income." We're of the age where we started off at 8.9 per cent and went up to 17 to 18. So we paid over 30 years the equivalent amount and maintained it all the way along; when most of us weren't allowed to work as soon as we married anyway; and if you went back to work you were put on temporary work with no entitlements at all. The younger generations don't believe that you managed on one income and had babies straightaway. We're in the pre-pill generation for goodness sake.

So there are two generations older than baby boomers and that's what worried us so much. Government work comes down to, "The baby boomers are about to retire." The first of them are retiring this year, if they wait till 65. I've got three baby boomers at the bottom end, blow what they're doing. I'm still out there and active in the community and I'm the generation above the baby boomers and a lot of my friends are the next generation up. I live near quite a few units occupied by World War II widows; they're active into their 90s. They even come in the fashion parade looking very elegant and the walking stick is an affectation, whereas I need mine. What worries most of us as we're ageing and we're told constantly we're in an ageing society is that baby boomers take up - even Council on the Ageing and groups like that have, "What do baby boomers expect in retirement?" Five years ago, that's their yearly contribution.

MR WOODS: Yes. Certainly our focus is on the current 80 and 90-year-olds, because that's the generation - - -

MS LILLEY (OPSO): I think it necessary to say that in the 85s, twice as many of those living are women.

MR WOODS: Absolutely, we're very conscious of that.

MS LILLEY (OPSO): They're the ones who had the deprived, if you'd like to call it. We didn't think so then, we accepted it, it was what happened. That didn't work, required to resign on marriage, got 75 per cent of the male rate, all this sort of thing. "Why didn't you save up?" Well, hey, a different world. But I have read the report and tried to go through it again when this came onto my lap, and a lot of what's in it is very commendable. Thank you very much for the trouble that's been put into it.

MS MACRI: It is entitlement based, it is around choice, it is around people having greater empowerment in terms of how and where they receive care in the future. The point that you made about carers and volunteers is very important, and the education, the support, and the training of carers and volunteers. Again, we've gone some way in the report to acknowledge that. We certainly, in our consultations, have been told that we could go a bit further and we're having a look at that.

MS LILLEY (OPSO): That would be excellent, Sue, because Older People Speak Out, through working with retired nurses like the lady I mentioned - very well known in the nursing area in Queensland - set up feeding of people in hospitals at the Prince Charles Hospital. They were all retired nurses and they got it done very well. I know the person in charge of gerontology at one of our other huge hospitals: "It's coming; we're getting this sort of thing; isn't it wonderful." No, the administration stepped in and said people might sue, so volunteers are being refused to do things that are necessary, and when they can be of use, they're not necessarily being used for the things that would make a difference.

MR WOODS: I have to say, thank you for making the effort and coming. Your insights have actually been very helpful.

MS LILLEY (OPSO): And I actually went to the Rendezvous first.

MR WOODS: Sorry about that. This room, I can assure you, is a lot better.

MS LILLEY (OPSO): Thank you so much.

MR WOODS: Thank you, that was very, very helpful. We'll take a short break for morning tea. Please join us for tea and coffee at the back and we will resume at 11 o'clock.

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

MR ASHCROFT (ACQ): My name is Barry Ashcroft, deputy CEO of Aged Care Queensland.

MR CHAPMAN (ACQ): Darryl Chapman, director and treasurer of Aged Care Queensland, and CEO of Warwick Benevolent Society.

MS TAYLOR (ACQ): Geri Taylor, Aged Care Queensland, policy and projects consultant.

MR WOODS: Thank you very much and thank you for the many contributions that you've been making directly or indirectly to this inquiry. We've had discussions, we've had visits, we've met a number of your members as well, directly, so we've been very grateful for this contribution. I also note that there's an additional bit of paper that has just landed; apologies for not having read it.

MR ASHCROFT (ACQ): No problem. At least there's something to refer to.

MR WOODS: But, please, make a statement for us.

MR ASHCROFT (ACQ): Thank you. Thanks for holding this second public hearing. We do acknowledge that the first one did conflict with an important occasion for Aged Care Queensland and we really appreciate the second opportunity. We've also enjoyed Paul Lindwall's presentations at our recent conference and prior to that at our AGM, all of the multiple opportunities that we've had to submit and the comprehensive that you've taken to develop the draft report and the details analysis that lies behind that. Nick asked me to pass on his apologies; he's been sidelined, unfortunately, with another important matter and couldn't make it here today, so I'm standing in for him.

We're fully aware of the fiscal restraints under which government operates and we also accept the community-focused, user-pays, elements and market based approach of the draft report. However, if there's going to be a state that tests some of the reforms, it'll be Queensland. We've submitted our views directly to the commission in the past and have contributed to other national submissions from ACAA and ACSA. Today we'll be talking about, specifically, some new perspectives on the Australian Seniors Gateway regional, rural and remote issues, and aged-friendly housing and retirement villages.

As I said, the Seniors Gateway concept will complicated in rural and remote Queensland for a variety of reasons: we have the largest extent of rurality in

Australia; it's populated by smaller services that operate on very small margins and predominantly on a not-for-profit basis; choice tends to be limited because population size doesn't support a larger number of viable services, and you've made mention of this in your report; provider viability hinges on access to skilled managers, staff, and the socioeconomic circumstances of their clients and, at the back of that, much lower real estate values; we also find as a result of that a higher proportion of supported clients. I would say too that all of those issues are amplified in indigenous communities in Queensland.

As far as the gateway concept as proposed operates, we fully support the idea that there should be a one-stop shop for good information. That somebody can ring up, be directed to good support, and we also know that 80 per cent of those inquiries may well relate to fairly basic information. When it comes to assessment, we do have some concerns; they have been highlighted in the draft report. But if we look at the performance of ACAT in Queensland, there's historically been a disconnect between the ACFI funding model and the ACAT rankings coming into each service. We do believe that the assessment under the gateway process must critically reflect the applicant's care needs and a new suite of simplified assessment tools would certainly be welcomed. We also believe that the gateway should be funded appropriately. ACATs haven't in the past and that's where we think some of the issues have arisen.

In terms of care coordination, once an individual enters the system, we fully believe that within a reformed system, that care coordination should be effected by the provider and not necessarily the gateway agency. We would make the point that monitoring of outcomes currently exists under the aged care standards and accreditation agency and would need to be continued on that basis. Some of the pre-existing challenges that I mentioned just a moment ago is that aged and community care delivery is already compromised in rural and remote areas. We've recently been through with the aged care standards agency on some figures that would purport to indicate compliance, but in fact the measure is the length of accreditation period.

What we've, in the last 48 hours, found is that in rural and remote Queensland, we have the highest proportion of less than three years awarded to aged care services and I might also add that in the metro areas, we have the highest rating of compliance. So this is nothing to do with the agency per se. This supports the idea that there's at least some disadvantage there, along the lines of access to good management, access to good staff, being able to pay appropriate rates, particularly when there's a government service in town and they're taking most of the qualified staff away.

MR MACRI: Could I just ask you then, would some of that, because I think it's interesting being rural and remote and you come back to the indigenous issues, and I

guess did you have a look at any of that being in relation to perhaps the appropriateness or otherwise of the standards to some of those facilities, as opposed to - - -

MR ASHCROFT (ACQ): Particularly to indigenous services.

MR WOODS: So it's not a matter of whether facilities meet the standards, but whether the standards are appropriate for the circumstance.

MR ASHCROFT (ACQ): There are a small number, about half a dozen, indigenous facilities in Queensland. My comments were mainly about the mainstream services in those locations and we believe that there is some disadvantage there and I'll go on to suggest that maybe we need to make special consideration of that as they move to actually change their service models. Resourcing and capacity is an issue here that we believe more thought needs to be given to the implications surrounding the assessment effort and the referral capacity so whilst we may have a remotely-operated gateway agency streaming residents to the most appropriate care, it doesn't necessarily mean that the market will be able to meet those requirements, particularly in these rural and remote areas.

What we've found too amongst our membership - and we haven't looked at other states - but 70 per cent of most residential places in Queensland are high care. As we've heard from other speakers today, low care is migrating to retirement villages, and personally I can't think of a village that doesn't actually have CACPs operating in it, even though they may not market that fact that the individual is accessing those CACPs into their own unit. There are others that are promoting the idea that they want to be part of a continuum of care for older Australians. So in those villages, we find that there is an increased level of the delivery of community care and we believe that the range of accommodation and care options for referral may need to be expanded beyond just the traditional aged care model.

Before the gateway agency is launched, if this recommendation is taken up by government, we would suggest that rigorous testing and evaluation will need to be undertaken before there is a phased rollout and this would include extensive consumer testing. As a previous speaker said, if you want to know how effective aged care is, ask an aged care recipient and they'll tell you, and so if we want to really get the gateway agency right, we need to make sure that consumers are fully involved in the testing of that.

I'd make the comment too in Queensland, because of our rurality, there is an example of a successful model of a similar one-stop shop approach. It's called Smart Service Queensland, it was formerly Access Queensland, and it provides a single switchboard to all government services. It has been rated as being highly accessible and underscores that effectiveness. Once again, 80 per cent of the inquires they

receive are for basic information and they can acquit those inquiries fairly quickly. So in terms of our recommendations, as I close on my part of the presentation, we recommend that the commission do take account of specific challenges experienced by rural and remote communities, including risks to service viability, locational disadvantage and the digital divide that is apparent between metro and R3. We term rural, remote and regional sites as R3 communities.

We encourage the commission to ensure that assessment resourcing is appropriate for geographical spread, assessment accuracy, related directly to resident needs, and alignment with the ACFI funding model. We believe that care coordination should be performed by the approved provider once the resident has entered the care system and we recognise that monitoring of care outcomes already exists and to some extent could be reinforced.

We caution that we shouldn't assume that the market should be able to meet demand in all rural and remote locations. We also encourage the expansion of the range of accommodation and care options into the retirement village space. We fully believe that retirement villages are part of the care continuum for older Australians. As far as the rollout of a gateway process, we recommend studying, modelling, testing and evaluating implications surrounding the assessment effort and referral capacity and that we should undertake extensive consumer testing. We also encourage review of successful one-stop shop models, including Smart Service Queensland. Thank you.

MR WOODS: I notice there are three parts to your presentation this morning. Each of them sort of build a Queensland focus on the broader generic submissions, for which we're grateful. That's exactly what we're looking for. The second one is again dealing with issues of regional, rural and remote. I hadn't come across R3, but I understand. The third one is retirement villages and age-friendly housing. I think that third one we can probably do as a separate conversation, but the second one on rural and remote because it integrates so much with what you've just dealt with. Perhaps if we move onto that and then discuss those two as a package.

MR ASHCROFT (ACQ): Absolutely.

MR CHAPMAN (ACQ): Thank you for the opportunity to speak today. I guess from a rural and remote perspective, the basis of the entire Productivity Commission report is based on, for me, consumer choice. From an R3 perspective, the further you go from the metropolitan or larger population areas, there is less choice. One of the significant items where there is less choice is within appropriate and affordable housing or accommodation for older people, where they find they cannot remain in the home that has been their home for many years, there isn't a retirement village alternative and low care services then tend to become a default housing option, so that we talk about 70 per cent of residential aged care people being high care. In

rural areas, it's more likely that the facility was founded on a low care basis and it's still predominantly low care and we're still seeing a lot of applications for admission from low care people.

MR WOODS: They've lost their partner and they might have been on the farm and coming to the village or township and that's where they come to - - -

MR CHAPMAN (ACQ): They feel unsafe in their own home. They feel safer in a facility environment. We do have an additional provision of CACPs-type services, EACH-type services and HACC-type services, but it's not a one size fits all in a rural community. Some communities don't have those services, others have those services and don't have residential care services, so we need to take into consideration the effect that has in R3 communities.

MR WOODS: That whole issue of congregate living, I'd like to explore as to how to free that up in rural communities.

MR CHAPMAN (ACQ): A lot of the alternate accommodation, if it's not a residential care facility, it may well be local-authority-provided pensioner-type housing, often not suitable. There hasn't been a lot of investment in it from local authorities in that area over recent years and the housing stock that they do have is now of such poor quality, it doesn't necessarily suit those people with mobility issues and chronic issues.

MR WOODS: The same with cabins in long-term-stay caravan parks and the like.

MR CHAPMAN (ACQ): Quite possibly. I just will mention though, when I talk about that and those areas and I know Barry mentioned accreditation and the difference between metro and some regional areas with regard to accreditation and its success and otherwise - that's not that rural or remote or regional communities accept less as far as the quality of that care goes, just some issues with regard to how that's assessed. Workforce as well is a big issue in our three communities. We often lose our younger people to metropolitan areas, whether it be as early as boarding school, from year 5 to year 8, and a lot of times they don't actually return to those rural communities.

So whilst they're benefiting from the education that's offered in the larger centres, we're not seeing the benefit of that improved education back in the rural communities, and, try as we might, there are impediments to actually offering incentives for people to come back into rural areas. We also find that some of the major employers in the rural areas are public sector and they are able to offer a much better salary package than you can for aged care operators, whether it be for residential care or community care.

MS MACRI: Would you also find though that quite often a residential aged care facility or organisation is also a major employer in many rural areas.

MR CHAPMAN (ACQ): In many rural areas, yes - - -

MS MACRI: So the continued viability of that is very important for the welfare of the whole town.

MR CHAPMAN (ACQ): It is, and that's one of the reasons why most rural facilities get very good community support by way of volunteer support, donations, fundraising and so forth. Also in those areas over recent years, particularly in Queensland with the resources boom, facilities that once were the major employer and were able to attract good quality staff and retain those staff on average wages are competing against a lot of mining giants that can afford to pay a lot more and are more attractive. There is a little underlying issue there that sometimes you can get a package deal where a husband and wife team come to the town and you are able to attract the wife to work in the aged care facility. We have had the reverse in some areas, where the wife comes in to do the mining work and we have the husband working in the aged care facility.

MR FITZGERALD: Can you just keep your voice up a little bit, so people can hear.

MR CHAPMAN (ACQ): Yes, sorry. So from a client's perspective, for seniors in rural communities, in my experience over 13 years specifically in aged care, one of the most single driving forces is to remain in their local community in old age. If there isn't a retirement village, if there isn't an aged care facility or appropriate housing for them, it's really difficult for them to leave that community. Even if their family has previously moved away, they still have an attachment to that community. They are very much of an age where they still like face-to-face contact with providers. There are some that have well and truly adapted to the digital age, but there are a significant proportion that find it very difficult. From personal experience, we put a digital answering machine in after hours, we get a lot of hang-ups. So it does have an effect on that population.

There needs to be some element of local service planning for local stakeholders, and we reference there that it may include Medicare Locals, the development of integrated health and aged care models will need to be undertaken in parallel with workforce planning. Some form of restructuring packages will need to be offered to enable planning processes and organisational redevelopment. Local cost structures need to be recognised and funded. Viability supplements will need to be addressed in specific location difficulties.

Multi-purpose services with a health and aged care focus could be explored to

provide a viable, flexible and client-focused service. I have had experience in multi-purpose services within Queensland, primarily based in the public health sector. As a community with significant community interaction, they have chosen to forgo some services in those communities to improve services specifically to the aged and alter their accommodation and communities' expectations. They have been very effective.

MR WOODS: Just on that one, before we get into some of the broader issues. The model in Queensland sounds a bit of a hybrid between the Department of Health top-down approach, if I can simplistically describe the New South Wales approach, compared to the community facility build-up and add health services, if I can simplistically describe the Tasmanian variety. Where do you sit and where would you like to evolve to, in terms of multi-purpose services?

MR CHAPMAN (ACQ): The multi-purpose services I have experience with have all previously been stand-alone public hospitals, which have had quite a range of services, where they did surgery on site, in communities of 1100 to 1200 population base, did the full range of maternity services, and general admissions and discharges within for sort of minor and acute episodes, I suppose I could refer to them as; that had very little by the way of community based services, may have had a visiting school nurse, seldom a visiting nurse to do anything to do with geriatric care.

Through time and public consultation, the community itself chose that they would have a model where they would forgo maternity services and they would forgo surgery, because they couldn't maintain the skill level of the nursing and medical staff for those services, and they developed a range of community based services. They are doing more HACC type services, a lot more services in the home, CACP, and now they're moving on to do EACH services, and they have restructured their facilities so that, rather than having four and six bed wards for aged care people who had no alternate accommodation, they have renovated those facilities into appropriate seniors housing for both low care and high care people and they have adjusted the services around that, and that has been well supported by the community.

MR WOODS: So what more, if anything, needs to be done in that space? Or are you satisfied that it is evolving and working of its own accord and that we should just sit back and applaud - which we are entirely happy to do? I mean, we don't want to interfere in things that are working well or are heading in the right direction.

MR CHAPMAN (ACQ): I think I'd make the point that there's only one non-government operator of multi-purposes services in Queensland and it's in one location. What we would be encouraging is the development of those models in other communities, and so some funding to help those communities develop new models, a continuum of care.

MR FITZGERALD: It is true that different models and different services have different cultures, depending on whether they have started from a public health base and added on community services or they have started from a community and they have added on health, or they're run by the health system or they're run by NGOs. So there are a multitude of models around. But there does seem to be - and it's pleasing to see this - that this is a desirable way to move forward in small or regional remote community, but that seems to be universal. It's the nature of a model that is evolving and - Mike's point is right - we certainly will encourage these. We have to look at the funding of them, but the actual nature of the model may be more open to - - -

MR CHAPMAN (ACQ): Yes. They have to have the flexibility though to meet the needs of that specific community.

MR FITZGERALD: Yes.

MR CHAPMAN (ACQ): In one community the facility they ended up with has a three-bay accident and emergency department, whereas 50 minutes down the road that facility has a single-bay accident and emergency department because it's not on a major highway, where the other one is.

MR WOODS: I was going to say is one on a highway and one not.

MR CHAPMAN (ACQ): Yes, so if you had have taken that accident and emergency capacity away from that community, there wouldn't have been acceptance of the model.

MR FITZGERALD: The issue of funding will be an issue though, and I presume we need to look at this more fully, that some of it should be funded directly through the state and Commonwealth health system, and some of it should be funded directly through the aged care system. But one issue has arisen, about which you may or may not have a view, and that is that people have said to us that the aged care component of it should in fact meet the aged care standards, and many of them don't, they simply have to meet the health accreditation. I don't know if you have a view about that. You don't have to have a view about it.

MR CHAPMAN (ACQ): It's an interesting question. I think that would probably just need to have more consideration. From my perspective, I would think, as I said earlier, whether you're in a metropolitan area or a regional area, there is an expectation that when a person goes into or receives any type of aged care service it's of a certain minimal standard.

MS MACRI: I think the difference around that is that one is saying if you come through the aged care standards and accreditation agency model it's a much less

medical model than the ACHS EQuiP program, and certainly the New South Wales model is a health-down model, so that it is not under the Aged Care Standards and Accreditation Agency accreditation, so that there's deemed to be a more medical model in terms of that care and living environment, as opposed to a multipurpose centre, which comes from the community, aged care up and operates in that. I guess that's the difference.

MR FITZGERALD: It's worth having a think about.

MR CHAPMAN (ACQ): Yes. With the multi-purpose services I'm familiar with, one has a much different aged care component to it than the other one. As I say, they're 50 minutes apart. Their community background is a little bit different and I think that the standard that's been achieved in the one that doesn't have the triple-bay A and E department is actually more Aged Care Standards and Accreditation Agency compliant facility than the other one. A lot of it then comes back to the workforce issue, again that it really depends on how they identify and attract the staff to fit that model as well, and how they can retain those staff, and what skills are needed, not just from a service-provision perspective but the managing of those facilities to ensure that the outcome is there for the community. That's one of the other risks of coming from the health model, is that the big brother in Charlotte Street has a lot of input into the outcome.

MS MACRI: What about general practitioners, Allied Health. In that whole workforce, it seems to me again, in some of these smaller, rural communities, that's an absolute issue in relation to - and where do nurse practitioners in Queensland fit in currently to that model of care?

MR CHAPMAN (ACQ): I can't answer that question. They don't but they should.

MS TAYLOR (ACQ): There's an issue, that if there's a part-time medical superintendent that is funded by Queensland Health, then that limits the number of general practitioners who have access right to what was the local hospital. Those sorts of things have to be discussed and debated and resolved with Queensland Health and the new model, multipurpose health service model.

MR ASHCROFT (ACQ): I think the last point that I would make about whether or not these multipurpose services fall under the Aged Care Standards and Accreditation Agency: whilst ever government funding is received for aged care, it will automatically result in the Aged Care Standards and Accreditation Agency being involved, but it will depend on the funding mix and there has to be a funding mix, as we agree.

MR FITZGERALD: Can I move to the gateway, and I'm sure Michael's going to it. We fully appreciate the issues you've raised about the circumstances, both in

Queensland, WA, and Northern Territory; they're different. Nevertheless, one thing I think we're pretty resolved about is that at some point a person, in order to access entitlements to aged care services, needs to go through this gateway. If I can use an analogy, but I don't want them to be as mixed up as the same: all older Australians who wish to access benefits go through Centrelink. By several means and several gateways, they get through and they come through that system. They stay connected to that system. So we're very conscious about trying to provide supports to enable people to access the gateway and we're very conscious that the gateway has to deliver services locally. Clearly, assessments, some can be over the phone but many will have to be face to face and in the home.

This notion of a remote gateway isn't what we're proposing; we're actually proposing regional gateways that operate locally where necessary. It doesn't mean there'll be a shopfront in every town, that's not practical and we don't have Centrelinks in every town. We certainly have information in every town through a whole range of services. The question here is - I just want to be clear about it - at the moment it is actually difficult to get through the aged care system if you're in a community where there's multiple service providers and what have you, and in smaller communities it's less difficult because there aren't many; there is only one person in town.

But given that at some stage you do have to get through the gateway to get an entitlement to a service or a referral to a service if that's what is appropriate, what are the supports that need to be in place for that to happen that we should be particularly conscious of? What we don't want it multiple gateways, because it won't work. But we are conscious that people need to be supported, particularly indigenous communities, very frail people will need to be supported through it, and of course at the other end we do need to be able to deliver assessments locally. So what is your advice particularly about that?

MR CHAPMAN (ACQ): I guess the example I'd give is that with the Department of Veterans' Affairs there's always a veterans' affairs welfare officer and they visit rural communities on a fairly regular basis. I don't know whether that's probably the best example, but it is an example that tends, when you talk to the veterans, that they actually have face-to-face contact, they understand what their entitlements are and what their rights are, and they're given quite a range of options as to where to move to and how they can progress through, and they often are within our aged care system and they're getting levels of support that I guess all of our aged care people should have an entitlement to.

MR FITZGERALD: The second thing is, if I can just pick it up, the care-coordination element. Again, I just think we need to clarify that: the care coordination that sits within the gateway is a default function; that if people are able to manage their own circumstances, fine; if they get referred to a provider, all

providers provide some basic level of care coordination. But for some they actually want care coordination delivered independently of the provider. This is different from detailed case management, which is in fact going to be subject to entitlement. So if the person that's ageing requires detailed and complex case management, that's actually a service that will be provided by a provider, a non-government or another agency; not by the gateway. I think there's been some confusion, so we'll just have to be clearer about that in the final report.

MR CHAPMAN (ACQ): Yes, thanks.

MR FITZGERALD: But can I just relate it to this issue about, in the rural and remote communities, that the consumer directed care model may not be all that appropriate: that's true if there's only one provider, but the notion is sound, because it is possible over time -and we're talking now about a generational change - that alternative providers might emerge in those communities. The fact that they don't today is an issue and you're absolutely right, when Mike gets his entitlements, he's only going to be able to go to one provider. We understand that. That provider might or might not need block funding, to do with the viability issues. But the notion of consumer directed care shouldn't be excluded for regional communities. Do you agree or not?

MR CHAPMAN (ACQ): I agree with that. I think one of the issues though that could help resolve that and actually provide more options is to support even the existing organisation to be more flexible, and a lot of those rural organisations were founded on the basis of good will and are not-for-profit providers that in some respects haven't necessarily moved with the times. They still have the good will but need some additional professional support to broaden their horizons.

MR WOODS: Within your organisation collectively do you find there's a buddying or mentoring process that some of the larger, more professional bodies, not taking over the small regional and rural communities, because they need their own local identity, but is there any matching or support, or is everyone so fiercely independent that doesn't happen?

MR CHAPMAN (ACQ): That's a good question. Depending on the issues, we're terribly supportive, united in caring at Aged Care Queensland. But depending on the issues, it may be that there is competition. Talking about even in a rural community where there might be two, three, or four providers, you may all sit around the table and decide that what our community needs is additional EACH packages or additional residential care. In the system that we have at the moment, we may make representation to the department to have allocations made for that. Once those allocations are made, the gloves are off; everyone is in there competing.

From a mentoring perspective, Aged Care Queensland has been looking at our

younger professional development mentoring program, where people moving within their organisations up to more senior management positions are offered the opportunity to go to other facilities and work under the mentorship of experienced aged care people. We also have some very well experienced managers in Aged Care Queensland that are able to go out and mentor people depending on specific issues. So I think there is, more often than not, good mentoring and it really depends on how remote you are as to how you access those services.

MR WOODS: Just one briefly from me. You talk about the need for assessment tools to focus on the needs of the individual and you draw attention to the disparity between ACAT assessments at the moment and ACFI. Well, in fact under the gateway what is currently the ACFI but albeit in a modified form will be what is undertaken, so there won't be that split that you have at the moment. It will also though be a needs assessment that identifies whether people can continue to receive care in the community as well as in residential care. So hopefully those reforms will take away the particular issue that you are identifying there.

MR CHAPMAN (ACQ): We will welcome those - - -

MR WOODS: There will be the one assessment. If the gateway chooses to use current ACATs, amongst others, there'd be a retraining process, there'd be a simple single toolbox, that would escalate up according to complexity of need and things really.

MR CHAPMAN (ACQ): As long as there is a failsafe mechanism for the providers to revisit those assessments within a reasonable space of time - - -

MR WOODS: Yes, absolutely.

MR CHAPMAN (ACQ): - - - because I guess the experience is that with so much disparity now there needs to be a failsafe mechanism to ensure the accuracy of it.

MR WOODS: There will need to be confidence-building, but there will also be the role of the provider - and it would be particularly in residential where the resident is living with them on a daily basis, so it's the staff who are there very quickly to identify any material change of circumstance - so the provider would be initiating those where they were best placed to do that. It does raise the question of how broad a band the entitlements should be; you know, what is the flexibility within those, without having to then trigger a new and different level of service. We have asked that question of your federal colleagues, and it would be interesting to get your input into that process. So if you go back through ACSA and ACAA on what does an entitlement look like, that would be helpful to us. Robert?

MR FITZGERALD: I was just going to reinforce that. The system is activated in

a number of ways. The original assessment can be re-examined by the consumer asking for it, by the carer, by the case manager. So the system is meant to be interactive. But the point that Michael raises is that we are still struggling with, particularly in relation to community care, what is the nature of the actual entitlement, how is it described, is it prescriptive, is it a broad band, what is it. So we're just trying to work that through.

That's less of an issue once you enter into the actual residential facilities, for which there will be ongoing reassessment. The question there is, when do you need to come back to the gateway, and we have just got to work that through, because what we don't want is every movement, every change, coming back to the gateway, because then the gateway actually does become a lock-up rather than an enabler. So we are conscious of those sorts of issues.

MR WOODS: Sue?

MS MACRI: On page 2 where you talk about the gateway and then you talk about your comment or recommendation that recognises monitoring of care outcomes, are you talking about that in terms of the gateway? I was a bit confused by that.

MR CHAPMAN (ACQ): I think what happened is in our review I think COTA had mentioned that there needed to be some sort of care assessment service to see that what was promised to be delivered had actually been delivered, and we thought that that was duplication, but it wasn't a recommendation he had made.

MS MACRI: Okay.

MR WOODS: Thank you for that clarification. Age-friendly housing and retirement villages.

MS TAYLOR (ACQ): Yes, I'll talk on that one. Subsequent to our original submission from Aged Care Queensland we actually provided a response, that you would have received in March, and I'm not going to revisit what we have already provided to you, except to stress some points. Having noted the early discussions on age-friendly retirement housing this morning to you, I want to stress the industry we are in is a service industry, not the housing industry. There may be a number of retirement village providers who do believe that that's all they are in, in a housing environment, but because it attracts people commonly over the age of 70 who are going to have that decision to move there as a destination site for the rest of their lives they will age in place, and for the majority of them they'll receive some sort of care either from the facility or through community care providers.

If people want to downsize to a lifestyle with no care whatsoever, then they can move into a strata title unit in the city, on the Gold Coast, or somewhere. But if they

have a notion of care and are preparing for their future, they will consider retirement villages, indeed some consider manufactured homes, and some consider pensioner rental models as well. From my perspective - and I have only been in the industry since 2004 - the retirement village sector is very much a fledgling industry. I am somewhat surprised and I would support the fact that we definitely need a code of conduct for the industry and we need some other - - -

MR WOODS: Do you mean a mandatory or a self-regulated code of conduct?

MS TAYLOR (ACQ): Most professional organisations do have a professional code of conduct that they develop from their industry. So you never put a dead hand of mandatory regulations if you can have something that is developed from a professional status. What I would say is that I believe the current accreditation standards that are run internally through the retirement village association are of minimal standards, and I would believe at this stage of the development of the industry and in light of a number of concerns, of in fact consumer-driven concerns, we should be aiming for a much higher standard of accreditation, much more objective, much more independent, at arm's length. That includes having consumers on the standard setting and that they are operated, as I said, at arm's length.

MS MACRI: Can I just ask you with that, would you see that accreditation still staying as not coming in as a mandatory requirement, or are you talking about like residential aged care, that that accreditation should become a mandatory requirement?

MS TAYLOR (ACQ): Again, I believe it should not be mandatory, unless the industry cannot regulate themselves. Certainly I have been a hospital surveyor at teaching hospitals for a number of years in the past, and I am now a retirement village surveyor. I saw very much in hospitals what accreditation does when hospital administration started their accreditation program, it actually raised the floor of how hospitals operate. It didn't solve all the problems, you never solve all the problems in the dynamic environment in which we live, but what it did do was raise the floor.

It actually gave some public confidence. If you can see that you have an independent accreditation program that is not minimal standards, it's appropriate standards, and that's the badge, then that should give the public some more confidence. It should also give the industry more confidence, including the people who work in it, that they are working for an ethical organisation, because there's absolutely no doubt that the retirement village industry is going to continue to be a provider of accommodation and care going forward, and it will be a provider of accommodation and care for more people because of the growing numbers of people over the age of 75. Even if they are hale and hearty when they move into the retirement village, they will be providing care.

So I would want to stress, and I just have stressed, that we actually do need to increase the compliance issues as they relate to quality and quality outcomes for the people who live in them. That is not going to stop people complaining about anything and everything in a retirement village, just as people complain about anything and everything in most of life. But it should actually make life easier for the Queensland Consumers' Association, in that the complaints that they may receive are genuine complaints. Quite rightly, to date state governments have tackled the consumer rights perspective in their various pieces of legislation but they haven't addressed any other policy considerations and they do seem to have a limited understanding of the economic benefits and the useful roles that retirement villages do play and other forms of congregate housing do play in providing accommodation for older Queenslanders.

Those older Queenslanders, as we know, even for the foreseeable future, are going to be pensioners. Even with the baby boomers coming through, they are not going to have loads of money to splash around in very ritzy retirement villages. They're going to be people requiring a reasonable quality, probably an aspirational quality accommodation and living environment for the rest of their lives. The media tends to highlight the worst-case scenarios. They do it for residential aged care, they do it for all sorts of industries. But certainly as a previous member of the Institute of Company Directors I have been quite surprised and my eyebrows have been raised at some of the contracts that I have seen that have been signed by people over a number years. I believe that probably a lot of these contracts were signed in the past but we would stress the benefits of moving to some standards contracts.

I think it would be somewhat idealistic at this stage to have just one standard contract across all the eastern seaboard states but certainly we should be looking at more transparency, more simplification and indeed, Aged Care Queensland have been involved in discussions with the Queensland government along with the Retirement Village Association and no doubt providers in looking at simplifying what is a very confusing and absolutely mind-numbing public information document that is about 125 pages at last count. I think if I have trouble reading it - and I'm used to contracts - someone who has only ever had one house or maybe two houses, it is incredibly difficult.

In that regard I do think that there is a need to try and upskill the legal profession in their understanding of retirement village contracts and the benefits or otherwise of people moving into such forms of congregate housing. In a previous role when I was working as a consultant in the industry in a brand new village we actually got in the legal profession in the catchment area and provided with a representative from the New South Wales state government, because this was a New South Wales village, and actually went through what the contracts were, what they meant for that particular village. Then we also had the village management present what were the benefits of moving into that environment from a care

perspective and security perspective. So not all lawyers are skilled in that understanding of contracts.

The retirement village consumer bodies talk about the large numbers of complaints they receive from their members. But we can't actually just say that they are genuine complaints. Just in the general community there are the very sad people, the very mad people and very bad people. There are also, particularly in retirement villages, a number of people who have had - may have been teachers, they may have been small business owners and when they move into a retirement village they actual go through a grief and loss situation also because their past life is finished. They may have been quite powerful, very active in a whole lot of community activities and then move into this other environment where they are part of a wider group. So people actually have to come to grips with that changed environment.

There are wonderful residents in our retirement villages and people do say that they are satisfied with their lives there. There is also an issue that many, many retirement village managers have come to their position from other forms of activity and there is no professional development for retirement village managers that I am aware of in Australia and that is something that Aged Care Queensland is looking at because until you can actually have effective and quality based management you will often have problems in communication, in interpretation of rules and contract.

Let me just talk very quickly to the key recommendations. There are going to more and more older people moving into congregate housing. Because older people are living long, as we've heard, they will be living longer but they will have chronic diseases and we know that the majority of people who reside in them are women and women actually have higher rates of morbidity than men. Therefore, they will require care either provided in-house or from community care providers. Ageing in one's home is ideal but often families actually want their parent or the person for whom they have responsibility for to move into a safer environment. Residential retirement villages do provide that.

So I would argue to strengthen your quality considerations. I would argue that you need to acknowledge that in many good retirement villages they do provide care and even if they're not now, they are going to be providing care in the future. Finally, as I do have a background in regional and rural policy, I am delighted to hear your comments today that you're going to try and strengthen options for people living our three R areas.

MR WOODS: Thank you very much. Certainly we are trying to devise a new policy framework where people make a choice about where they want to live, including those who want greater security from congregate living from various forms of social housing and the like, as well as a decision about what care they need and their assessment through the gateway. Hopefully this will broaden the diversity of

accommodation options where people live and have the entitlement to care to be delivered to them in those situations. Clearly there still comes a point for some people and it's by no means anywhere near a majority where their frailty and other circumstances point to them being in a residential aged care facility as distinct from being cared for in the community. But that's not for the majority, the majority can continue to live - we want to, by breaking open the care and the accommodation, encourage a diversity of accommodation. I personally don't have any particular additional questions.

MR FITZGERALD: Just in relation to two things, one is the accreditation. Clearly if a retirement village provider applies to become a provider for community care - which in our arrangements that will happen - one, they will need to be approved and second, they will need to be accredited as a community care provider equal to everybody else.

MS TAYLOR (ACQ): That's right.

MR FITZGERALD: So the dovetailing of those we need to be careful of. If we're moving down a strengthened accreditation scheme within the retirement village many of those villages will also have accreditation to another process. I just want to make sure that people understand that we're not trying to turn them into aged care facilities. We're not doing that, we want to treat the accommodation separate. But the care will certainly be subject to more fulsome mandatory accreditation. Can I ask this question about that and it goes to the code of conduct. You have said there should be a code of conduct. Your preference is to go for an industry based one. Generally with industry based ones they turn into mandatory ones. There's a journey that one goes through in this.

Is there a commonality of agreement between the providers and the residents and their various advocacy groups as to what that needs to cover? Is there any work being done on a code because a code, at the end of the day, is trying to facilitate a better relationship between providers, residents, prospective residents? So where are we in Queensland in the development of this dialogue that could lead to, if initially an industry based code but ultimately something even more substantial than that?

MS TAYLOR (ACQ): Can I say - I use the term - the industry is in a fledgling state and certainly I would say that the discussion on this has been very limited and the industry in Queensland is divided between large for-profit independent operators and - but 60 plus per cent is not-for-profit, and I would believe that in Queensland we could actually have a very useful discussion and accelerate this, at least for Queensland, because of the ethos and the fact that a lot of the not-for-profits actually do operate within a code of conduct. But certainly the consumers need to be involved in that - this is not just the industry, this is the code of conduct - it needs to be a wider one.

MR FITZGERALD: The second thing related to that is at the moment, correct me if I'm wrong, in Queensland I presume the retirement villages legislation is monitored by the Fair Trading Office.

MS TAYLOR (ACQ): It is.

MR FITZGERALD: And any complaints go to that office. What's your view about the complaint mechanisms that exist within the retirement village area?

MS TAYLOR (ACQ): Firstly, there are not very many that go to a full tribunal hearing.

MR FITZGERALD: Sure, but below that.

MS TAYLOR (ACQ): I may let Barry talk about that.

MR ASHCROFT (ACQ): Yes, complaints resolution in retirement villages is normally conducted in a similar way to the complaints investigation scheme is conducted in residential aged care and it's an escalation process, so through the local village manager, maybe through the corporate office and then more broadly. We receive as an organisation lots of complaints from consumers and it's very difficult to deal with them when we're a member representative organisation. What we often do is try and provide them with some advice about where they may seek some additional information and part of that is Fair Trading, but the other one is the consumer association that spoke earlier on today, so we work hand in glove with them to try and resolve the issues. That's an informal process but it's one that tends to work on some fairly difficult matters, I might add, where you've got a disenfranchised resident arguing very strongly with a provider. We can provide some support to the provider in those circumstances, as ARQRV can provide support to their member. So it's a collaborative process but it's informal at this stage.

MR FITZGERALD: I know we're out of time, but just my last question on that: is there a formal dispute resolution mechanism in the state to actually deal with those more contentious issues, because at the end of the day, the provider and the consumer generally need to live together - - -

MR ASHCROFT (ACQ): That's right.

MR FITZGERALD: - - - not always, but is there an attempt to actually deal with these complex issues which are naturally part of these arrangements?

MS TAYLOR (ACQ): Under legislation, there is dispute resolution mechanism in each village, so that is a process that has to be gone through first, and as Barry said,

usually the resident involves the consumer organisation.

MR FITZGERALD: But beyond that, when that doesn't work?

MS TAYLOR (ACQ): There can be mediation, a formal mediation process before it goes to a full tribunal.

MR WOODS: Thank you very much.

MR ASHCROFT (ACQ): Thanks for the opportunity.

MR WOODS: Thank you very much. Could each of you individually for the record please state your name, the organisation you represent and the position you hold.

MS MOHLE (QNU): My name is Beth Mohle and I'm the secretary of the Queensland Nurses Union.

MS DORRON (QNU): My name is Cheryl Dorron. I'm an enrolled nurse from Bundaberg.

MS WILEY (QNU): Jeanette Wiley, registered nurse in Brisbane.

MS STRANAGHAN (QNU): Mary Stranaghan, I'm an AIN.

MR WOODS: Will there be anyone else making a presentation?

MS MOHLE (QNU): No, I'll give a brief introduction and then I'll hand over to our members who will speak from their personal experience. There are other expert officials from the QNU present here today, so if you had any particular questions about our submission, we thought we'd bring them along.

MR WOODS: Thank you.

MS MOHLE (QNU): Thank you very much for having us here today. As I said, my name is Beth Mohle and appearing with me, I have three members from various facilities across Queensland, registered nurse Jeanette Wiley, enrolled nurse Cheryl Dorron, and assistant in nursing Mary Stranaghan. We think it's very important that you get to hear from the experience of our members directly, given that they are caring for older Australians on the ground every day of the week.

MR WOODS: Yes, thank you.

MS MOHLE (QNU): So we thank you very much for your time. We appreciate that time is limited, so we won't revisit our submission or the submission of the ANF federal office in any detail. I'm well aware of the time constraints, but I would really like to highlight a few issues about the nature of nursing that I think need to be stressed and particularly the need for nursing in aged care.

As you'd be aware, we conduct longitudinal research with our members, Your Work, Your Time, Your Life survey which we've undertaken in 2001, 2004, 2007 and again late last year. We can provide some of the findings of our most recent survey at the end if you are interested.

MR WOODS: Yes, please.

MS MOHLE (QNU): It does actually highlight a deteriorating state of affairs for our members working in that industry. We've only got preliminary quantitative information but we thought it might be of interest to you. Following our first two lots of research in 2001 and 2004, it really became apparent to us that key decision-makers really didn't understand nursing. We weren't communicating what it is that nurses do and the contribution that they made to our health and aged care system, there was basically a disconnect there. Nurses understood what nurses did but then assumed everyone else did.

So we undertook a project following that called Let's Talk Nursing where we tried to strip it back to what are our core values, what underpins what nurses actually do, so that we can clearly articulate to decision-makers what the profession is all about and what our practice is all about because we think that there is really a fundamental misunderstanding about that. It's unfortunate that we have to undertake that, but we think that we do because decisions are being made about our members and about health and aged care that are affecting us and unless they understand what our values framework is that underpins the work that we do, we think that we're forever going to be talking at cross-purposes.

So I'll just briefly outline the four nursing values that we identified through this work called Let's Talk Nursing. They're of particular importance to the aged care sector as they are to all others. They are: professionalism, advocacy, holism and caring. Now, in terms of professionalism, nursing is accountable as you know to the community and it's diverse in its response to community needs. The failure to adequately regulate nursing, of all of those who are currently engaged in nursing work in aged care, is in our view a significant hole in the regulatory framework and it places vulnerable Australians at risk.

For the record, at the heart of our argument is the need for appropriate clinical governance and risk management and it's not one about industrial turf as such. We only want to claim, as our members, those who are undertaking nursing work and that gets back to the core problem that we have in terms of the understanding of what the definition of nursing is and hence our work in that area. On this note, it is important to restate that QNU covers all categories of nurses employed across all sectors. That's registered nurses, enrolled nurses and assistants in nursing, howsoever titled. It's been claimed, we understand, at some other hearings that AINs, for example, are not employed in other sectors, for example, not in the public sector. I'd like to just place on record - and I've got some materials that I can hand up later on, so I'll do that at the end - - -

MR WOODS: Yes, thank you.

MS MOHLE (QNU): - - - that there certainly are a significant number of assistants in nursing who are employed at Queensland Health, for example, and the most recent report that we've done at Queensland Health, and the QNU put together as part of reporting for our enterprise bargaining agreement, was at 30 June 2010, there were over two and a half thousand assistants in nursing employed in Queensland Health. We've also got a number of position descriptions from both the public sector and the aged care sector, other sectors, which we thought might be of interest to you because it's just to demonstrate that assistants in nursing work across all sectors.

It must be noted that AINs are an integral part of the nursing career and classification structure not only in Queensland Health but across all sectors and this is important not only because we need to establish a framework to ensure quality of nursing provided that is cognisant of the appropriate delegation and scope of practice arrangements but also from the perspective of creating a meaningful career path for nurses from AINs through to ENs and then to registered nurse. That greatly assists in the retention of a skilled workforce in all sectors.

I won't go into any details but the report that I've provided about Queensland Health I thought might be of interest because in that sector, we adopted a problem-solving approach to the issues of workforce and we're doing additional work on models of care and, in particular, nurse and midwife-sensitive indicators. That's work that has been undertaken that we thought might be of interest to your inquiry.

MR WOODS: Thank you.

MS MOHLE (QNU): In terms of advocacy, nurses keep the health and aged care system safe and we take our role as advocates very seriously for patients and residents, as we're shepherding them and their families through the complex and often overwhelming health and aged care systems. Nurses work in partnership with the community to deliver optimum health care. You will recall that in our initial submission, we provided evidence of our commitment to that through the adoption of a social charter for nursing in Queensland. We were fundamental in getting that adopted in Queensland. You will hear more about that from our members who are giving evidence today. It's really important to stress that we work in partnership with residents and patients and their families across all settings, so it's acute hospitals, aged care, in the community and in people's homes to bring about optimal health outcomes. Now, that's important because nursing is very diverse in its response, as I've said, and is changing in response to community's needs and expectations.

In terms of holism, nursing provides continuity of care 24-7 and keeps the system human. This is especially critical because it's not only that nursing provides continuity of critical care within a facility around the clock, nursing also provides continuity of care across settings, so that's from acute care to aged care to other

settings. I'd like to stress there in particular the surveillance role that nurses play in this regard.

Lastly, caring, we of course admit that nurses are not the only people that care for people in the aged care system, there are many others that do, but nurses provide a particular type of indispensable, knowledgeable human caring and the complexity of the clinical decision-making framework that nurses provide across all sectors must be recognised. The community knows when they need nursing and when they need other types of care or assistance and that's a fundamental issue that I think needs to be acknowledged. But currently there's insufficient richness of skills across aged care and this is causing huge problems in terms of lack of continuity of care and appropriateness of nursing that is being provided.

I was at an aged care facility in Ipswich last week and had a lengthy conversation with the director of nursing there. She was incredibly excited that finally she had been able to get the funding to employ sufficient enrolled nurses to allow one of their residents to come home from the Ipswich Hospital who required traction. She just did not have the nursing staff there available with the necessary skills to do that. It took some time to get that in place. So that just stresses to me the importance, that we need to address this in a comprehensive manner.

Now, it might sound esoteric talking about the importance of nursing values to this inquiry but we think it's really critical to ensure the health needs of older Australians and ensuring continuity of health care across all sectors is of critical importance and is crucial to ensure the economic sustainability of our health and aged care system into the future. Economic sustainability also necessitates the establishment of models of nursing that incorporates an appropriate robust delegation framework and that is why the QNU has since its inception always advocated for the incorporation of all three levels, AINs, ENs and RNs in the definition of nursing work and to not do so fundamentally undermines the integrity of nursing.

So in our view, these four core values are the foundation of nursing, no matter where it is delivered, and the values framework provides an important context and counterbalance to economic considerations. Important as economic considerations are, they are only part of the picture. These core values are important to consumers of health and aged care services also. These values resonate with them because when they are articulated, they understand that this is the essence of nursing. I can turn to our visit - - -

MR WOODS: They're on the record and we've read through those, so you won't need to read through them.

MS MOHLE (QNU): You've got that for the record.

MR WOODS: There are some very helpful statistics in terms of understanding the situation that you're facing.

MS MOHLE (QNU): Certainly the final report will be ready in July if you would like a copy of that.

MR WOODS: Excellent, yes, please. We will put our hand up now.

MS MOHLE (QNU): Yes, so we'll provide that as soon as that's been finalised.

MR WOODS: Because even though our report will be concluding in June, we do maintain an active interest in this area.

MS MOHLE (QNU): Absolutely, so we'll provide that.

MR FITZGERALD: Can I just ask one question on one dot point: it says 15 per cent indicated they had contemplated leaving nursing. Is that only in the aged care area or is that across all the nursing areas?

MS MOHLE (QNU): My understanding, we had asked the researchers particularly about aged care - - -

MR FITZGERALD: So that's an aged care figure.

MS MOHLE (QNU): Yes. I will clarify that but we said in particular, because we were appearing before this inquiry and wanted data on it.

MR FITZGERALD: I wasn't sure, because some of them refer to aged care only and some of them refer to other areas.

MS MOHLE (QNU): Yes. He did comparisons where it might be of interest.

MS MACRI: Can I just ask quickly before your colleagues tell us about their experiences, in terms of skills mix which comes up quite a lot, and there seems to be some concerns around when we talk about enrolled nurses who are integral and really important, but the number of people being able to go through enrolled nursing courses. I just cite New South Wales, but I'm wondering if Queensland is a little bit different.

MS MOHLE (QNU): Queensland is different and we've worked for some time to increase the number of enrolled nurse training places and they have doubled in recent years, so there's quite a fair few going through.

MS MACRI: Good.

MS MOHLE (QNU): We have lobbied for many years to make sure there's appropriate articulation through all of the qualifications, from the certificate courses to the diploma, through to the degree level. That's very important. We've done a lot of work on that and working with government on that.

MS MACRI: I was going to say how did you manage to do that because one of the biggest issues in the other states we've been to is it's not about people not wanting them, it's about people having access.

MS MOHLE (QNU): The courses are oversubscribed indeed and there's great interest in the enrolled nurse course - a lot of political lobbying over many years and a lot of budget submissions and that's how we've been able to secure that outcome. We still think there's more work that needs to be done in that regard though. We still don't think the articulation between the courses is really quite right, to such an extent that we co-funded the nursing and midwifery workforce summit for Queensland last year, where the Office of the Chief Nurse tried to get all the players from across all sectors together, not only Queensland Health, but aged care and private hospitals and the education institutions to talk about these issues because we think it's really critical that we address those for the whole of the nursing and midwifery workforce.

MR WOODS: Do you have an incremental progression so that an AIN might then also take on a module in medication management, but that's as far as they want to go, whereas others might - so they have done their cert III, they then take on one or two additional modules and then others want to move to the cert IV and the advanced diploma?

MS MOHLE (QNU): There is a module, but not in regards to medication management. Poisons regulations in Queensland - - -

MR WOODS: That's the threshold issue in that one.

MS MOHLE (QNU): Yes. I will hand over to Jeanette Wiley who will address now.

MS WILEY (QNU): My name is Jeanette Wiley. I'm a registered nurse as against an enrolled nurse and an AIN and I do appreciate their roles in the system, but I would like to put it from my perspective as a registered nurse. Most elderly people entering an aged care facility will have medical problems which change from time to time and ultimately lead to their death. Therefore it's vital in my opinion that they receive daily reviews by competent registered nurses who can in turn inform a registered medical officer. Symptoms can then be treated promptly, comfort given to the resident, peace of mind to the relatives and hopefully avoid transfers to hospital, as we're hearing a lot about hospitals being clogged up by aged care people. It's not

always the fact that there's not a bed for these people; quite frequently there is a bed but there's not the competent staff in the aged care facility to care for these people.

MR WOODS: And it's an inappropriate activity if it can be avoided and the disruption to them.

MS WILEY (QNU): Absolutely. We had a wonderful system here called Hospitals in the Nursing Home and funding to that that I felt was pretty disastrous. Only a registered nurse in my opinion has the skills to know her residents so well that she can pick up changes promptly. It has been mooted that untrained staff could do medication rounds, not so. Only trained staff know what the medication is for, what signs to look for and pick up side effects and benefits. A registered nurse knows what to look for and this instils confidence in the resident by giving effective pain relief and being able to notice the change.

We've talked a lot from the staff's perspective and the owner's perspective but we're resident focused and, in my opinion, a registered nurse has a professional aura that gives these people the confidence they need when they enter these places, and their relatives as well. Aged care is not seen as an attractive path for young registered nurses, mainly due to the pay structure and also their lack of understanding of how fulfilling it can be.

I was a representative recently in enterprise bargaining and I believe there are major difficulties in achieving significant wage increases through this method of wage fixation. Obviously our management representatives want to keep their offer as low as possible and as long as the wage based structure remains low, we will not achieve change into a way of encouraging registered nurses to enter the profession. My nurses tell me that they would not be prepared to take any form of industrial action, because they are their to care for their residents.

I've heard of problems with skill mixing at other facilities. We are fairly fortunate in our facilities, but it's only because we have older registered nurses, like myself, who will stay in the profession. I think the average age of a registered nurse in Queensland is now - and I don't know about Australia - certainly well into their late 40s. There are certainly fewer registered nurses employed in the 12 years since I've been there, making our workload a lot more. Also our residents are much frailer than they used to be. Mine is a special service facility - not that that would make their relatives any different - but because they pay a large bond, their expectations of the staff also are a lot more than they used to be. The ratio of staff to resident has changed and because in Queensland we have no legislation that is not likely to change.

From a registered nurse's perspective, our amount of paperwork has increased. We were told when we moved from the RCS to ACFI that it would be less, in fact it

is certainly more. Every time I do my care plan assessments the moths fly out, because nobody reads them anyway. There's a lot of wasted time and paperwork. I would love to give my residents more time and get to know them better and try to improve the quality of their life. My role as a registered nurse differs from that of a carer: a nurse is a professional with an aura of confidence; they require knowledge, which gives the residents and relatives a feeling of safety. A carer fulfils the role of basic care with little ability to assess changes of conditions, level of pain, and they often have poor communication skills as more and more of our staff have English as a second language.

Aged care is the most fulfilling type of nursing I have ever done. In an acute setting one has a patient for a short period of time; we have them for the rest of their lives. What a wonderful responsibility that is. We care not only for the resident but their family and their friends. We try to create an atmosphere which fills them all with trust; we try to give the resident a loving home, with activities that suit them, meals they enjoy, and a quality of life they deserve. When the time comes, our ultimate goal is to help them to a peaceful and dignified death and a family left with no regrets. If only more powers that be would visit facilities and see how much effort every staff members puts in every day through love, it is certainly not because of their pay packets; and all of our older residents deserve better. Thank you.

MR WOODS: Thank you very much.

MS DORRON (QNU): Thank you. My name is Cheryl Dorron. I'm an enrolled nurse with endorsement for medication. I'm employed by Blue Care Riverlea; it's a 120-bed, high-care residential facility in Bundaberg. I'm currently working in the secure unit for residents with dementia. Just a bit of background: I completed two years of the three-year general nurse training at Wellington Public Hospital in New Zealand back in 63, 64; then I left to get married, and women couldn't do both back in those days. I moved to Bundaberg in 1969 and started working as an AIN at the Pioneer Memorial Hospital, and that's now known as Riverlea. I'm still there and that's the personification of ageing in place. I gained my enrolled nurse registration in 1979 and completed the course in aged care update for ENs through the Australian Institute for Care Development in 1994. In 2003 I completed medication endorsement at the Moreton Institute of TAFE.

Enrolled nurses are the vital link between what is happening on the floor, the translation of this to care plans, ACFI, and ultimately the level of funding. As in every evolving process, each is crucially important to the other. Enrolled nurses bring an extra dimension of learning, knowledge, and skills, particularly important given our residents present with a multitude of diagnoses and a plethora of medications. My statement addresses skill mix, medication management, workloads, and nursing care.

For the first 34 years at my workplace, on day shift we had RN for 20 residents. In 2003 we moved to a new facility with four communities and this increased to one RN for 28 residents, then one RN for 56 residents. We have since added eight beds to the facility and increased to one RN for 120 residents. This is the same on evening and night shifts. On a weekend there is no nurse management or administrative staff. Whilst it could be argued that this reduction in RN employment is because of a shortage of RNs, I believe it is directly linked to ENs attaining medication endorsement and an opportunity this gives employers to reduce the wage bill. ENs now take the place that RNs traditionally held at the helm of each ward/community.

This is my role now, managing a community of 30 residents with dementia-specific diagnoses and staff. My role encompasses but is not limited to organising and supervising the care given to the residents; administration of the medications; wound care; regular observations such as VGLs, BPs; doctors' rounds; making appointments - for example, pathology, x-ray; organising transport for those either through QAS, family, or staff escort; liasing with GPs, pharmacy, dieticians, speech therapists, diversional therapists, podiatrists, hair dressers, physiotherapists; CNCs; mental health unit; and documentation; progress notes; three-monthly care plan reviews; and ACFI. I also help with fees, transfers, toileting, showering, and making beds on a needs basis and as I've got the time. Any one shift can be disrupted by a resident falling or displaying aggressive behaviour and the following of protocol for each instant.

Prior to enrolled nurses receiving medication endorsement, we worked alongside the AINs, giving direct care to the residents. There was always an element of supervision at the bedside on how and why care was given. Legislation decrees that enrolled nurses work under the direct or indirect supervision of a registered nurse. With the decrease in registered nurses hours and the EN taking on an expanded role, the level of supervision down the line has been minimised, the capacity to oversee care has been given has been minimised. For the residents this can manifest in instances such as a breakdown in skin integrity or aggressive behaviour.

Medication management is so much more than just administering from a pack or sachet. Medication is a component of the listed care of the resident and cannot be looked at in isolation and, for this reason alone, it needs to be confined to RNs and ENs. Residents in aged care have multiple diagnoses and the potential for interaction between their prescribed medications needs to be constantly monitored. This can be compounded by well-meaning relatives and friends bringing in over-the-counter products. Just by virtue of their licence to practice, RNs and ENs are obligated to continue their professional development to ensure safe practice and this includes keeping abreast of the medications being prescribed, their effect, and potential for adverse effects. AINs and PCs do not have the accountability that licensing brings.

The very idea that services should be delivered by staff with the most cost-effective training and qualifications is fraught with danger and undermines the value we place on residents in care. They deserve better than this and the solution is simply more registered staff and licensing for AINs.

On reading the top paragraph at page 358, re: Enhancing Productivity, the Productivity Commission's report discusses enhancing the productivity of the workforce. I cannot see how this could be achieved without an increase in staffing levels, because we have no fat. Workloads have changed drastically in my 42 years, because intrinsically the persona of the resident has changed and certainly some of the residents I first looked after would now be looked after in their home. So we have a much more dependent resident, with all that entails; we have documentation which must stand up to strict scrutiny; we have obligations to meet the individual rights of residents; we have health and safety requirements; and we have policies, protocols, and regulations coming out our ears.

My experience of an increased ratio of residents to staff began way back when we were granted penalty rates and, in order to pay for it, staff numbers were cut. This continued to happen with each successive wage rise; the most recent and obvious change has been with the RN role and the substitution of ENs. Sadly, my workload means that the most time I spend with the resident is when I'm giving them their medication or attending to wound care. I have a wish list that I would like to accomplish if I had the time: give me the time to talk and interact with the residents and their families, instead of always looking for the quickest way to exit in order to get on with my work; give me the time to support my work colleagues and work with them, not just organise; give me the time to enjoy my work. I want all this before I too suffer the three dreaded Is: immobility; incontinence, incognisance.

How does nursing differ from care; what do you do as a nurse that differentiates your level of care from that of a non-nurse carer. There is a marked difference between nursing and care; it is in the what, why, when, how. Nurses know what they are doing, why they are doing it, when to do it, and how to do it. At the end of the day, we need to remember our residents are real people, not just statistics on the end of a balance sheet.

MR WOODS: Thank you very much. If I could move to Mary, please.

MS STRANAGHAN (QNU): Thank you. My name is Mary Stranaghan. I work at the Sisters of Mercy. I'm an assistant in nursing at the Sisters of Mercy aged care service at Nudgee in Brisbane. I've nursed for 30 years, but currently 15 years in my current position. I have a certificate III. I work in the hostel section of the facility, where there are 38 residents. The high-care section has 90 residents. There are usually RNs on each day shift for the 120 residents in the whole facility. On the night shift and weekends there is one RN and one EEN for the whole facility. There

is a manager who works at the facility, but she does not work in the role as an RN. My statement will concentrate on medication management and workloads.

The work I do as an assistant in nursing involves taking temperatures, giving medications, doing observations, minor dressings, and taking progress notes. Unfortunately, workload constraints limit the amount of time I can spend with each of my residents. In my position I am responsible for giving medications to residents. This requires the use of Webster-paks, which is a blister packs that allocates tablets for breakfast, lunch, tea, and bedtime for a whole week. I also apply transdermal patches for heart conditions and pain relief. The only drug I do not administer is morphine nor do I give injections. This is done all unsupervised; on my own.

I do not believe that it is safe or reasonable to expect AINs to administer medications. I undertake a range of tasks as well as nursing and this means that time pressure can cause errors. Tablets can be missing and there are times when residents aren't seen taking their medications. I am aware of the use of a blanket consent for AINs to assist with medication. Under this practice, residents sign over the use of medications to the facility. I am very concerned about this practice and the requirement of AINs to give medication at all. There is no adequate training given to these staff and I am aware of many medication errors that have occurred. Dementia residents are quite often not aware of their medications and are not able to remember if they have taken them. I would like the task of giving medications taken away from AINs and carers and given back to the qualified persons: EENs and RNs.

During my 15 years at this facility I have seen a significant increase in workloads. My employer uses agency staff regularly to fill in when staff are absent; this can occur two or three times a week. I work in a large facility and agency staff frequently don't know where to go, they also require information on the residents; both of these factors take up the time of the existing staff and add to workloads. It also causes stress for the residents and their families as they are not familiar with the residents and their needs. I support any moves to improve the delivery of safe, quality care, but I feel that this can only be made by increasing the number of staffing hours on each shift. It is just not possible to fit in any more activity into the day based on current staffing levels. Workloads need to be addressed to give the quality care and dignity our elderly residents deserve and are entitled to. Thank you.

MR WOODS: Thank you very much. It is quite valuable to us to have these sort of experiences documented and presented to us, and on the record so they can be read by all others. We're grateful for the time and effort you've gone into, making those presentations. We do spend a lot of time going in and out of residential aged care facilities as well as talking to providers and others in relation to community care, so a lot of what you talk about resonates with us, because we see it on the ground. Robert, you had one particular question?

MR FITZGERALD: It's the issue about the mix of skills that are necessary. If I can use an analogy - and I don't want to divert to it - in the disability area, as we move from highly regular, very large, nurse based institutional care to, fundamentally, group homes, we have to come to grips with the fact that you need to provide an adequate level of nursing service, but you couldn't possibly have nurses in group homes; the model doesn't allow it. So there's a conflict between what people with disabilities desire and what is able to be delivered. It is of a similar nature, because in aged care we've got the reverse: we've got to increase in quality of care, larger numbers, so we've got exactly the same thing but the reverse happening. I suppose the question is, how do we actually know what is the right mix going forward?

Firstly, you do have to deal with the expectations and aspirations of the consumer groups; you've also got to deal with the reality that, for example, a small facility, a 15-bed facility, cannot have three nurses on three shifts, it's just not viable. How do we deal with that? I don't know whether we're the right body to deal with that, by the way. In fact we're probably a very inexpert body to deal with it. But I understand; we share the aspirations. We may differ about how you get there, but I'm not sure about the evidence that actually informs well enough the skill mix that you need in smaller or larger facilities and, at the end of the day, they will have to be somewhat different.

MS MOHLE (QNU): That's exactly the reason why the ANF had lobbied for so long to get the research funding to do that research into skill mix. We're also doing that, as I mentioned before, with Queensland Health, in terms of looking at models of care and where they might differ, and the ongoing work we're doing there and on nurse and midwife-sensitive indicators. So that work, I agree with you, has to be done, and we're in the process of doing that. To our knowledge, we've done research internationally and we can't find that it has been done anywhere else either.

But it is absolutely critical, going forward, because if we really do want continuity of care across the acute care and aged care system, we have to address this issue of skill mix and have the appropriate skill mix there so that care is delivered by the appropriate people in the appropriate setting, and that people aren't getting shoved from pillar to post back to acute care facilities. It is absolutely critical issue, in our view, that needs to be addressed.

MR FITZGERALD: I think it's exacerbated in Queensland. All morning we've heard about the three Rs: regional, rural, and remote.

MS MOHLE (QNU): Absolutely.

MR FITZGERALD: As a consequence of that, we've heard about the

multipurpose services, which you've got both health and aged care together; that's one model. But on the other hand we have a lot of old, low-care stock which now have high-care residents in them, but they are small in nature: they are, nominally, 50 to 60, 100, 120 beds; they're quite small. So there is an issue about that. How do we deal with that? It's not a simple issue.

MS MOHLE (QNU): Absolutely.

MR FITZGERALD: But you and people in WA particularly have this issue.

MS MOHLE (QNU): Yes, we do. The role of nurse practitioners, for example, that they will pay going forward. I provide at the end of the submission the number of nurse practitioners we have in Queensland and they are increasing, but they're a big part of the answer here too, I think, particularly in rural and remote areas.

MS MACRI: I think the other answer to that, because again we're looking at things nationally, it seems to me we've left out the middle level a little bit around the clinical nurse specialist and clinical nurse consultants.

MS MOHLE (QNU): Indeed, we're doing some work on that currently with Queensland Health about reviewing our career and classification structure, picking up that very point, because we've acknowledged that we do need to pick up those clinical nurse specialists.

MS MACRI: We sort of seemed to have jumped from RN to nurse practitioner.

MS MOHLE (QNU): Absolutely.

MR WOODS: Which has been a good initiative in its own right, but it has left this.

MS MOHLE (QNU): Yes. As I said, that's the work that we're doing now in the lead up to the next - with Queensland Health, the project is underway now. We think that those projects have got lessons for the rest of Australia and other settings as well.

MS DORRON (QNU): There are people working in those clinical nurse consultant roles, but they're being paid as a registered nurse because - - -

MS MOHLE (QNU): That was one of the findings of our research, in fact. The lack of career progression in aged care in particular was as a result of a lack of those sorts of positions.

MS MACRI: Even that hospital in the nursing home and the wound care specialist, the stomal, so you start to look at that specialisation in a particular area, where a

facility is not going to need or have the capacity to employ that person full-time, but should have the access to that person on a needs basis and how that's paid for and coordinated.

MS MOHLE (QNU): I actually think a big problem is that innovation in health and aged care is not funded appropriately. You get seed funding for little projects like, "Let's do a hospital in a nursing home," then it's just dropped. So stuff happens and there's no ongoing funding for innovation, which I think really does have to be factored in.

MR WOODS: We agree.

MS MOHLE (QNU): Thank you.

MR WOODS: We have run out of time, unfortunately.

MR WOODS: That concludes our scheduled presentations for the day. Is there anyone present who wishes to make a very brief, unscheduled presentation? Yes?

MS CLARK (CP): I didn't wish to make a presentation. I just wanted to raise a question.

MR WOODS: You'll need to come forward and state your name. Thank you very much. Could you please state, for the record, your name and organisation.

MS CLARK (CP): Vivien Clark from Clark Phillips, independent consultant. One of the questions that I would like to raise for consideration is the role that we've talked about in terms of mix of skills in the community. We see an increasing desire for people to age in place in various settings, be it urban, rural, remote, apartment blocks, or caravan parks. I am concerned that we will have divides in accreditation and quality assurance, but certainly the skill mix and capacity in the community is a far greater issue which we really do need to respond to. I commend you with this report, you've covered such a breadth, but the breadth of the next 10 years is occurring in the home, wherever that may be. So with our nurses and isolated workers, I don't believe there is a framework around that. We focus on where we can see and that's in residential care, and where we can see it in hospitals or even in retirement villages, but you cannot see homes. So I just wanted to make that point.

MR WOODS: Thank you. No, a very important point and we are conscious of that. That being the conclusion of presentations, we will adjourn and resume in Darwin. Thank you very much.

AT 12.44 PM THE INQUIRY WAS ADJOURNED UNTIL
MONDAY, 11 APRIL 2011