Transcript of Proceedings

PRODUCTIVITY COMMISSION

CARING FOR OLDER AUSTRALIANS

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

TRANSCRIPT OF PROCEEDINGS

AT DARWIN ON MONDAY, 11 APRIL 2011, AT 9:00 AM

Continued from 07/04/2011

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MR WOODS: Welcome to the Darwin hearings for the Productivity Commissions inquiry into Caring for Older Australians. I'm Mike Woods, I'm the presiding commission and I'm assisted by Commissioner Robert Fitzgerald.

Following the release of our draft report the Productivity Commission is undertaking hearings to receive the views of participants on its strengths and weaknesses. We've travelled to all states and territories and have visited metropolitan areas, regional and rural areas to understand aged care issues in all of their settings. This is our second visit to the Northern Territory for this inquiry, but of course we're regular visitors to the Territory as we pursue the various work of the commission.

We are grateful for the support and contributions offered to us in the course of this inquiry and to the very high level of participation and considerable thought that has gone into the preparation of submissions and presentations.

At the end of the scheduled hearings I will invite any person who wishes to come forward to make a brief informal presentation. I welcome the ANF, could please for the record state your name, the organisation you represent and the position you hold.

MS FALCKH (ANF): My name is Yvonne Falckh, I'm with the Australian Nursing Federation Northern Territory branch, and I am the branch secretary.

MR WOODS: Welcome.

MS FALCKH (ANF): Thank you.

MR WOODS: We have, as we were remarking informally earlier, had the benefit of understanding the different situation of the different states and territories from the perspective of the workforce and from the members that you represent. So it's a pleasure for you to be here to do the same for us in relation to the Northern Territory.

Please talk to us.

MS FALCKH (ANF): I have – you have my report/submission, and I'll just talk on some of the key points that I brought up in the submission. As I had written, it's not my intention to discuss the full range of the ANF's submission federally.

MR WOODS: Yes, we have those.

MS FALCKH (ANF): But rather to discuss issues that I think pertain to the Territory and that I can see is a problem for now and for the future. The first thing in my submission was referring to skill mix and the need to have correct skill mix, and I made reference to Christine Duffield's paper on the requirements of the more RNs and nurses the less incidents of injury or health problems to their patients, residents, whichever title you wish.

So from that it's the ANF's view that there is a need for more nurses within aged care rather than less. We do recognise that the workforce, the carers, the patient care

assistants, the assistants of nursing, whichever title you wish to use, that the numbers in aged care for this group of workers will increase significantly in the future and it just seems that in proportion the number of nurses will decrease, and that is a concern to the ANF because we feel that the clientele is – they have more comorbidities, they live longer, they're on a huge range of different medications that affect being able to do what they do.

So having a – you need to a nurse to be able to understand what they're giving out and what mixes with what and what times can be given of certain medications, – so we believe that it's important to have a nurse in the workforce.

But we also - having said that, we also believe that it's very important to ensure that the assistants of nursing or the carers are adequately trained to provide the best quality care possible. We do recognise that they will be the bulk of the workforce because they are the cheaper option and it is technically, you know, apart from care, it is about money to. So we need to ensure that they are adequately trained to provide that best care.

MR WOODS: Can I just clarify, when you're talking nurses, are you talking RNs specifically or are you talking also endorsed enrolled nurses, how are you defining - - -

MS FALCKH (ANF): I'm talking about both. We do - - -

MR WOODS: As you talked about medication, management and things, so - - -

MS FALCKH (ANF): Well enrolled nurses do - - -

MR WOODS: Yes, registered enrolled nurses do - - -

MS FALCKH (ANF): - - - mediation endorsement.

MR WOODS: Yes.

MS FALCKH (ANF): And are able to give some medications out. But all facilities must have a minimum of one RN on a shift, and that's to be able oversee the whole – I mean they're responsible at the end of the day. So I'm talking about both the RNs and ENs.

MR WOODS: Okay, thank you.

MS FALCKH (ANF): I've spoken about closing the wages gap. Now I think the problem is the same everywhere, but especially in the Northern Territory when there is such a wage differential between what is being paid in the aged care sector to what is being paid in the public sector. There tends to be a constant march from the aged care into the public sector or even the private sector that actually do paid public sector wages and there's a steady stream of carers, PCAs, AINs, RNs, ENs, that go over to the public sector to the better wage group, and so there is a need to recognise that those that work in aged care should be renumerated. It's a hard job. And those that work there are there because they actually love the work, and they love caring

for the older residents, but as far as remuneration compared to what they could be getting in a close by public hospital it's not a surprise that there is such a migration towards that area, and I'm sure that if you discuss with – even with the aged care providers, they will agree that there is a core of staff that will stay, but there tends to be quite a movement through their facility into a better paid positions.

We feel that – we have a concern about that because it's probably not good for the residents, especially as you get older. There's some need to have some regular conformity and to recognise and to have the people you know around you all the time, and it can be disorientating and confusing. So we feel that by assisting in bridging that wages gap that that will go some way towards assisting in the care and it will also go towards actually being able to find staff because it is my view that aged care facilities do struggle to get staff because of that wage differential.

Now in my paper to you I also talked about the ANF's view about licensing of the AIN or PCA, however you wish to title it. The reason for that is for the quality care and protection of the public. Nurses, ENs, and RNs and midwives and a whole range of professional groups are registered and licensed for the purpose of ensuring that the public is properly protected by the standards and quality of care and skills of the person providing that care.

You know, we have the largest sector – largest workforce group are the AINs, PCAs, and this is a group that have hands on care with the older residents, yet they're the ones that can move between worksites and states with no proper checks to ensure that they didn't do something wrong in another workplace and bring those faults and errors to a new workplace. A person can go and apply for a job somewhere and not actually state that they worked for the last two months or three months in a facility where they may have had something go against their name or a reputation, and they can bypass that and you miss what is the concern.

We're talking about a group in that many respects may not be able to voice their own concerns. Our older residents that they are debilitated in some way to be able to communicate what's happening and what their feelings are, so even more so it's important that this group get protected and as nurses we feel very concerned that this particular group of workforce can move around and nobody knows what is it they were up to.

So it's in a push to make sure that they're properly – that residents are protected by ensuring that those that are delivering care are qualified and safe and that they haven't got something that – a practise that they're into that may cause a risk to the resident. I guess that's what this is all about, the risks of the resident.

As I said that workforce group are going to be the largest in the future, and therefore even more so there's a need to ensure to that they are adequately monitored. I don't know how else you'd put it. But just checked to make sure that they are the right person for the job and that they have the right skills and are well protected.

The other thing with the workforce, I think there's a need to attract younger people into the workforce into aged care - - -

MR WOODS: I was going to raise that, yes.

MS FALCKH (ANF): It's not a trendy place. It's not like, you know, theatre, and ED, and the places that are depicted on TV. We don't see TV shows about aged care facilities. It's all about that high push glamour areas in health. So it's – it hasn't got that look about it. So there needs to be – we need to somehow encourage younger workers, nurses, carers to come into these workplaces.

I'm pleased to see that within Northern Territory that new grads will be starting in some of the aged care facilities, doing their grad – part of their grad program with a rotation in aged care, and that during that time they will actually be funded, paid at the same rate as the public sector to encourage them to go there with the hope that they will then find that type of work enjoyable and want to come back to that workplace to continue, and that's what we need. We need to encourage and have ideas on how to encourage within that workforce.

There was a comment I read in one of the reports that talked about that there was no need for aged care - - -

MR WOODS: If you could just pause for a second until you come back to the mike, thank you.

MS FALCKH (ANF): In the – I read in one of the transcripts that it was mentioned that there was no need for as many – I got the gist, there was no need for as many staff or clinical caring in aged care facilities because the residents went in there and wanted to be more like their home. Well that's all great, if they are wanting it to be more like their home, but the problem is if they were able to be cared for at home that's probably where they would be.

I would expect that the reason they're not cared for at home is that they have become – their co-morbidities have probably become too extensive for the family to care for or maybe the care – the family have to work, have commitments and can't be in the home to care for their elder relatives. So having multiple morbidities and a huge range of medications makes it very difficult to be exactly like at a home and just treat them like as if they are at home and have an occasional person around. These people need hands on helpers to assist them for mobility and maybe for feeding and for a whole range of other things.

I did make a comment that one of the things that I saw that was needed was a recognition of more funding for aged care facilities to assist in programs to residential programs to - occupational programs, I don't know what you call them. But the things that they can do within any social events.

MR WOODS: Live as much a normal life as possible.

MS FALCKH (ANF): Lifestyle programs. So I think that there might be a restriction on the amount of social lifestyle programs that can be done because of the cost, high cost, of providing that. My view, is that if there was more funding to assist

in that it would probably help better socialising and better home feeling within aged care facilities.

So, I guess, you know, I think, one of the statements you made in your draft report was that you wish to ensure that that best use of scarce workforce resources wherever possible, service should be delivered by staff with the most cost effective training and qualification to provide safe quality care, and my comment back to that is that the only way that outcome can be achieved is through the introduction of professional practice framework under a national licensing system which can – which ensures the mechanism of protecting the public, and that's what we're all about ensuring the public get the best quality care and are protected.

MR WOODS: Thank you very much, and it is good to have you here because there are a range of issues, some of which you've touched on in your presentation and expanded in your submission and thank you for that. But there are a range of other Territory related issues that we wouldn't mind bouncing off you and if you're happy to either offer a view or come back to us later or however you want to respond.

But we could start at one of the hard ends, and that's the smaller more remote communities, and I've been to a number and you go to whether it's at the Tiwi Islands or you go out beyond Katherine or down Yuendumu, or wherever it is, that the staff who are providing care and it's not just aged care, but let's focus on those communities that are attempting to provide aged care. Quite often the local community members, the women, the older women in particular, are trained to a certain level and are able to offer community care, so they're PCWs in a, you know, variant of that.

But as I speak to them many of them are saying that they are getting older, they're getting tired, they're shouldered this burden for quite a while, and they too feel that there isn't the younger generation coming on to take over, which is touching on a point that you made about even more so at the professional level, but even at that community level there's this sense that the older women who have been doing this for, you know, quite a long time, would like to see the younger generation.

Do you have any thoughts, ideas? I mean is some of it to get more training to the younger generation? Is it to make sure that the scopes of practice that we have are realistic in the circumstances without reducing the quality of care? Where does one go in this situation?

MS FALCKH (ANF): Well if you're referring to remote - very remote areas, in communities where the people in the community are the carers of those that of the aged. It's just as unfortunate that we see a young – the young people from those remote communities want to come into the city, into town because they don't see anything out there that's of attractive nature to them, let alone caring for an elderly person. So as far as – the scope of practice, I think there needs to be better defined, what is the scope, what does it mean?

MR WOODS: Yes.

MS FALCKH (ANF): What is included in that scope of practice, and who is responsible for what?

MR WOODS: Yes.

MS FALCKH (ANF): And I think responsibility is a big thing. You can give somebody a task and say, 'Look after so-and-so', but the point is, if they don't understand or if they don't know what they can and can't do or where are the – where are the - - -

MR WOODS: Boundaries.

MS FALCKH (ANF): - - - boundaries - - -

MR WOODS: Absolutely.

MS FALCKH (ANF): - - - then first of all it's going to scare them away, or you might have those that are gun-ho and think they can do everything and then they go over the mark and then it leads of wealth of absolute terrible experiences for all concerned. So I think defining and boundaries, better articulation of what is that – that carers in remote can or are expected to do and again how are they supported? What support networks are there for them to be able to provide that care?

MR FITZGERALD: Can I just get a bit of an understanding of where the Territory is going in terms of health and aged care outside of Darwin in the regional and rural remote areas. In this sense, I mean, when we've gone around we see that in a lot of regional communities that are quite small, we've seen the development of these multi-purpose centres which have a health centre and a smaller number – and a small number of aged care beds attached to them and there are different models from Tasmania right through to, you know, Queensland and – but what's common to them is that they've got health and they've got aged care co-joined.

So that's just – so that's one model that's emerging. In the Indigenous we see these multi-purpose or flexible centres, you know, for example, the one in Katherine, you know, it's bulked funded, it's a flexible service, it's got respite, it's got high care, low care, it's got lots of different ways in it.

So just from your point of view, where are we headed with aged care into the regional remote areas of the Northern Territory? What's the model that's emerging?

MS FALCKH (ANF): I can't answer that, I'm sorry.

MR FITZGERALD: What about these new health districts that are being established throughout the Territory, are they going to be health and aged or are they just going to be health, do you know?

MS FALCKH (ANF): I had not heard whether they were going to be health and aged.

MR FITZGERALD: All right.

MS FALCKH (ANF): I've only heard discussions in relation to just being the health centres. But in remote communities where the community does the caring where in many of those places it's the older women that – the leaders of the community elders do the caring. I've not heard - - -

MR FITZGERALD: We're having a meeting this afternoon with the Northern Territory Government, so they can clarify it. But I – just from your point, I just thought that this – the reshaping in health services in the Territory seems to me to have at least some relevance to the reshaping of the aged care system as well. So we'll probably find out a little bit more this afternoon about this.

But one of the reasons for that was that in these multi-purpose centres this pay differential isn't a problem because they're all paid according to the health services that's - - -

MS FALCKH (ANF): Well as I said to you – well I didn't actually mention it. A number of the indigenous health corporations.

MR FITZGERALD: Yes.

MR WOODS: Yes.

MS FALCKH (ANF): Or health services do pay wages on par with the public sector. There are occasional ones that don't and do it really badly, but again the question is how are you still going to get people to work and care for the aged in very remote communities when you're expecting the local community, Indigenous community, to take up that role. I think it's going to be very difficult.

MR WOODS: You raised a very important point about how are they supported and that's part of the key. Do you in the Territory sort of have a sufficient flexibility in terms of use of nurse practitioners, clinical nurse consultants, you know, those sorts of next layers to provide support rather than relying on GPs or medical staff, is there a model emerging because I know the Northern Territory was one of the earlier doctors, albeit in very small numbers, of nurse practitioners, but there's also, I'm thinking of the next layer as well. Where can that head that can provide some innovation and some quality support?

MS FALCKH (ANF): The use of nurse practitioners in aged care, there is – it's just – it's there, it's obvious to see that there is a big need.

MR WOODS: Yes.

MS FALCKH (ANF): In remote communities in the – within the Northern Territory there's been a push to try and get nurse practitioner candidates and nurse practitioners within remote because there is an absolute need there, and the nurses and midwives that work in remote health are pretty much doing that to a degree and you want them to get the authorisation to do it, to get the right credentials for that, but it hasn't been taken up.

MR WOODS: No, having - - -

MS FALCKH (ANF): Nobody wants to do that.

MR WOODS: - - - had talked to the staff at Hermannsburg and things, there is the potential there, and as you say in fact if you look at what they do do in terms of the model of care and scopes of practice somewhat ambiguously defined in some case, I would have to add, they're doing a lot of that anyway. So it would be good if there was that process then of – of regularising and professionalising and recognising all of that.

MS FALCKH (ANF): I fully agree, and if you – if I think of the nurses and midwives that are out remote that have been there for a long, long time - - -

MR WOODS: Yes, and their skills capacities is fantastic.

MS FALCKH (ANF): Their skills – and they are nurse practitioners.

MR WOODS: Yes, they are in practice.

MS FALCKH (ANF): And it's a case of getting, you know, properly authorised and getting the correct qualifications to support that, but having said that they don't want to. They're not taking it up, and it's – and the funding has been there to say, 'Well, you know, we will support you financially to go through this process'.

MR WOODS: So what's the barrier?

MS FALCKH (ANF): I don't know whether it's the responsibility, I don't know whether they are just unhappy with the way it's going. There are nurse practitioners in the emergency department in Gove a little bit of unhappiness there about their – about what they do and what they get renumerated at. But at times, you know – in Gove we had a period of time where they had difficulty getting any doctors over there and they were very dependent on the nurse practitioner to assist and they had to use the manual to – you know, so – it's very difficult to attract medical practitioners into remote areas. So it's a mystery to a lot of us about why we can't encourage the nurses and midwives to formalise what they already do.

MR WOODS: Yes, well it would be good to sort of explore what those barriers are because if they could be overcome it seems to unlock an awful lot of not only potential, but just as we were saying before regularising the actuality of the skills that they have.

MR FITZGERALD: Can I just deal with the wages gap, specifically you've got an attachment to your submission, which is obviously on the public record. You've indicated in that attachment very substantial differentials between what is paid to public sector nurses and what's paid in the non government sector. You've contrasted both Masonic Homes and Frontier, and I think Masonic is presenting later and we're meeting with Frontier later this afternoon.

Why do you think there are such substantial differentials, I mean between – even between Masonic and Frontier, these are very substantial differentials particularly in the nurse area and less so, interestingly enough, in the personal care workers area. So what do you think is driving the very substantial differentials?

MS FALCKH (ANF): Good question, good question. I would presume that the funding that they received may be needed for other areas, I'm not sure, I can't tell you. But when you look at the differential with the patient carer attendants or the AINs and they're generally the bulk of the workforce and the differential isn't that bad with – with that group compared to the nurses. I don't know, I think you'll have to ask those particular aged care facilities about why, but I would think that their costs are substantial and don't allow them to be able to pass that wage difference to the employees.

MR FITZGERALD: But there is a strangeness about it, and that is this, that if you have very substantial differentials then what you find is, as you said, people are migrating, they don't work for particular agencies or they don't work for not for profits, they move into the government sector unless there's a particular reason not to. So in a sense these paid differentials would like they're completely unsustainable that in fact why would anybody work for an organisation where they're receiving 34% less, 10% less, yes, but 34%, no. So why isn't there any – notwithstanding the costs restraints that the organisations are under and no doubt we'll talk about those with those particular organisations, it doesn't seem to be a sustainable position for people that work for a third less than they get elsewhere.

MS FALCKH (ANF): As I said earlier the people that work in aged care are exceptional and they love what they do. The problem is attracting others to come into aged care because of that differential, and, you know, our public hospitals and private hospitals just technically almost across the road in many instances, so they don't have far to go. It's not like they have to go huge distances. So I think that you will find that there is this migration and it does – I think it proves to be a problem because the aged care facility spends time and effort training these individuals for only for them to turn around and go where they're paid better.

MR FITZGERALD: Well just – seeing as you've mentioned training, and I know we're running out of time, but just training. Can you talk to me about your view about both the training of nurses and enrolled nurses and the training of PCAs, PCWs or assistants in nursing in the Territory.

MS FALCKH (ANF): I mentioned earlier that we're starting to see new grads out of university will be doing placements with aged care facilities. Enrolled nursing in the Northern Territory is at a standstill at this point. We do consider that there's a need for opportunities for clinical time, more clinical time in aged care facilities. We see the opportunities of spending – of having grad years, having their period of their grad year in aged care facility as a plus to give them an idea and a feel about this may be where they wish to go. But aged care is a specialty like many other areas in nursing and there is a need for specialty aged care studies to be able to provide the best care possible for the aged residents. So having grad years in aged care facilities I think is a plus, but there is a need to financially support specialty aged care training

so that – it's got to be recognised as a specialty, and I don't know how we can make it more attractive to those younger people.

MR FITZGERALD: Sure. Why is – why did you say enrolled nursing is at a standstill, the training of enrolled nurses?

MS FALCKH (ANF): Well because it appears that we were waiting for the university to sort of get it up and running and that sort of has – is way behind. We've got enrolled nursing going to be provided by a – by a private provider. It's just – it's just isn't being picked up in the same level as registered nurses through the university, and it just appears to all that it's at a standstill. And the other thing is that the discrepancy between medication endorsement, you know, those that go and do it, then they find that there's a problem when they go to register or there's a problem with what they did in their studies. It's just – we just need things to be uniform for enrolled nurses and it's something that the ANF are concerned about. We believe that there needs to be a little bit more standardising of the enrolled nurse education throughout Australia to assist with the easy migration between states, but the medication endorsement tends to be a problem, you can work in one area and be recognised and be able to fully participate with medication endorsement and you can work in another area and you have no involvement, and it's all subject to - - -

MR WOODS: But that's the Poisons Acts and the other features of the states and territories as well.

MS FALCKH (ANF): It can be, but even where it's allowed to happen it can be subject to the clinical nurse manager. It can be a local. You know, you can you have, I look at Royal Darwin, you can have on one floor one ward where an enrolled nurse is allowed to do far more than on the same floor at the other end. It's subject to management at that area.

MR FITZGERALD: And what about that - - -

MR WOODS: Management which includes your membership - - -

MS FALCKH (ANF): Yes.

MR WOODS: - - - being part of that.

MS FALCKH (ANF): Yes.

MR WOODS: So they're part of the problem as well as part of the solution.

MR FITZGERALD: And what about the training of AINs and personal care workers?

MS FALCKH (ANF): In the Northern Territory the ANF did provide training at some stage – at one stage, but we have now pulled out, withdrawn from that.

MR WOODS: When you are an RTO?

MS FALCKH (ANF): RTO.

MR WOODS: Yes.

MS FALCKH (ANF): And it's now being conducted I believe by Henge.

MR WOODS: And that's a private RTO?

MS FALCKH (ANF): Private RTO.

Again with ANs, PCA training throughout Australia there needs to be a standard because you can go in and do a corn flake course.

MR WOODS: Yes.

MS FALCKH (ANF): Cert III with not much - - -

MR WOODS: How would you describe the quality here in the Territory because certainly we find in other states where they have multiple providers they quickly know 'If you've come from this provider, yes, you've been well trained, you've had good experience, you've been, you know, supervised, mentored, and we're happy to have you' and 'if you've come from that provider, well thank you but I don't think that's up to scratch', so do you find that here or because of the limited number of providers that's - - -

MS FALCKH (ANF): Well I think the limited numbers is one, I think - - -

MR WOODS: Yes, exactly.

MS FALCKH (ANF): - - - two providers. I haven't had any feedback from the aged care facilities or from the nurses, ENs or RNs about the quality of those coming out of those private providers. So I can't make a comment about that, no.

MR FITZGERALD: I just wanted to ask about Aboriginal health workers, there seems to be – you can correct me if I'm wrong, a couple of issues, one is for a period of time that looked a very positive development, but as I understand it the number of Aboriginal health workers actually declined in the Territory, which was surprising and not expected. So I was wondering what your view about what's happening in that space, and the second thing is, is it so that they're still trying to ensure that Aboriginal health workers are in some way registered or licensed or is that not proceeding? You may not know on that area, but.

MS FALCKH (ANF): Okay. Let's talk about what's happening with Aboriginal health workers, the – there are apprenticeship programs, the government is encouraging and trying to increase the number of Aboriginal health workers. Yes, the number has been declining. There are a number of issues about – now I'm not the expert on this to be speaking about on behalf of Aboriginal health workers, and from my understanding within a remote community the Aboriginal health worker if they come from that community there are cultural issues that may affect who they can and can't care for or whether they can or can't participate in certain care without

repercussions. There are – it's a lot – it's very hard work, and a lot of demands on them and insufficient numbers of Aboriginal health workers. As a RN and midwife the need for Aboriginal health workers in a remote – in remote communities is absolutely essential for the provision of appropriately culture care, encouraging the Aboriginal community to be part of that, it's very difficult. It's a hard process and culture has a lot to do with it, I think.

Sorry, your comment about the register. They – I believe they are on a register in the Northern Territory, but under the new – under AHPRA, when they go under AHPRA they will be all registered throughout Australia. So that will be – I think it will be a case of the rest of Australia actually catching up to the Northern Territory.

MR FITZGERALD: Sure.

MR WOODS: The Northern Territory and a bit of the Kimberly was the sort of the leadership in this.

MS FALCKH (ANF): Yes.

MR WOODS: And we followed that. Robert and I did inquiry into the health workforce a number of years ago and actively promoted that mob.

MR FITZGERALD: Do you have coverage of Aboriginal health workers?

MS FALCKH (ANF): No.

MR FITZGERALD: Who does?

MS FALCKH (ANF): UV.

MR FITZGERALD: UV, United Voice, okay.

MR WOODS: Now I think given the time that's - - -

MR FITZGERALD: That's terrific, thank you.

MR WOODS: That's really been helpful to get those insights. Thank you very much.

MR FITZGERALD: Good, thanks.

MR WOODS: Can we ask the Alzheimer's Australia Northern Territory to come forward please.

Could you please each of you separately for the record, state your name the organisation you represent and the position you hold.

MS LESLIE-ROSE (AANT): My name is Ruth Leslie-Rose, I'm the CEO of the Alzheimer's Australia Northern Territory.

MR NORMAN (AANT): I'm Ray Norman, I'm here as a consumer, but I do have a staff role currently with Alzheimer's Australia as Manager of Education Services.

MR WOODS: Excellent.

MS SHORT (AANT): And I'm Kathleen Short, and I'm the chairman of the advisory, consumer advisory group for the NT.

MR FITZGERALD: Good.

MR WOODS: Thank you very much. Talk to us.

MS LESLIE-ROSE (AANT): You're welcome.

So the three of us are very pleased that you've come to the Northern Territory, that was great, we were really pleased about that.

MR WOODS: That's our second visit on this inquiry and we do come through regularly.

MS LESLIE-ROSE (AANT): Yes. One of the challenges that we see about the Northern Territory is that it's a small population over a very broad area which makes it very difficult to provide specialist services to all the people who need those particular things.

One of the things that I can think of for instance is younger onset dementia. So it's a very small group of people because it is slightly more rare than more older form of dementia. This then means that it's going to be very challenging to provide care for people in an aged appropriate setting for people who have younger onset dementia.

People with any form of dementia prefer to stay at home for a long as possible, but there comes a time in the dementia journey where it is very difficult to keep them at home because of the extremely high level of care that may be required, not always, but may be required. This affects people with younger onset dementia who may have children.

MR FITZGERALD: You just need to keep your voice so they can hear at the back.

MS LESLIE-ROSE (AANT): I'll move closer.

MR FITZGERALD: No. The microphones don't amplify.

MR WOODS: That only records, it doesn't amplify.

MR FITZGERALD: They're only recording.

MS LESLIE-ROSE (AANT): Yes. So people with younger onset dementia may want to stay home for as long as possible and that would be the ideal then going into an aged cared facility is probably not what anybody would want when they're younger.

So the challenge is how we provide those services to people in the community for as long as possible, and I guess that's means that we need to have some really good supports in place.

The other thing is that there is still a view that people with younger onset dementia are too young for dementia, so they're not diagnosed until quite late. This then means they don't get the supports that they might need, that their families don't get supports that they might need, and people are not cared for until a crisis occurs, which is well and truly not the best way of dealing with it.

So that's one particular thing that I see as a challenge, particularly in rural and remote Northern Territory and particularly as it affects Aboriginal people with dementia. There is an extremely poor level of understanding about dementia in Aboriginal communities. Aboriginal communities themselves don't recognise that there is dementia. Health workers don't recognise that Aboriginal people get dementia, this includes Aboriginal health workers along with the medical professionals that may be working with them.

It's very difficult to talk to somebody you see in a snapshot and decide that there is going awry with their impairment when there are so many other stigmatised things that – conditions that might people be thinking of instead, they might be thinking of alcoholism, they might be thinking of alcohol and drug abuse, they might thinking of poor behaviour as a result of substance abuse previously. They're not recognising that actually Aboriginal people do develop dementia.

Leon Flicker and Kate Smith in their study in the Kimberly determined that Aboriginal people develop Alzheimer's disease, not other forms of dementia, but Alzheimer's disease at a much higher rate than a non Indigenous community, and this is something that needs to be addressed.

I believe that there needs to be research in the Northern Territory by people who have experience the Northern Territory to look into this particular phenomenon and to begin to put services in place for those people.

We developed a resource in recognition of the lack of resources. We called it 'looking out for dementia' it's a basic what is dementia and how to reduce the risk of developing dementia and how to care for somebody with dementia in a culturally appropriate way for people in the Northern Territory.

One of the challenges that you see with any resources for Aboriginal people is that there is a tendency for somebody to develop something somewhere and decide that that will answer the question for all Aboriginal people. We know that Aboriginal people are different around the country and that a resource developed in Sydney or Melbourne or Adelaide is not going to adequately address the needs of people in the Northern Territory.

One of the things that we did was ensure that our resource was in different languages. We picked - we didn't have much money, so we picked four of the main languages in the Northern Territory in consultation with the Aboriginal Interpreter Service, and Ray can tell you a little bit about what happened when we went out to communities and provided that information.

Not only in communities, but in the prison system, we've been delivering information into the prison system and that has been very well received as well as Aboriginal drug and alcohol rehabilitation centres. That little bit of information has been life changing because people don't know what they don't know and as soon as they have the skills they can go, 'Oh, actually, aunty such-and-so, maybe that person actually has dementia', and they – then there is a cultural shift in the way that that person is treated. Those are two points.

In our consumer advisory group discussions we were looking at what would happen with fee-for-service.

Kathleen, would you like to talk about that?

MS SHORT (AANT): We thought that the idea of the fee-for-service was good, but concerns arises to exactly how it was going to work, and how people would qualify, for want of a better word, for that ability and it became obvious that in more remote areas it would be a good idea because they had no access to other things, but they might have somebody in the community who could provide the care or the respite or whatever it was.

I know that, you know, we – in some cases the particular services, or whatever they are, are being provided by kind and generous people in the community anyway and that's fine, we don't want that to go away, but there might also other people for who if they were able to receive a fee for the services they're giving there might be more people who could do it.

But how you assess: (a) whether the person – the client should be getting that service, or who's going to do that assessment. I'm talking about remote people, not so much, you know, in Darwin where we've got facilities for doing that, and then how is that fee going to be paid, who's going to pay to that person, is it the client or is a government body that is going to – you know, you send in the form for the application for eight hours, or whatever it is, and they get paid, and what safeguards are we going to have regarding the quality of that service?

If it's done in Darwin and it's organised by the appropriate people there is someone who you can keep a check. If you're in a small community, say Pine Creek, and who's going to assess that that is the right sort of service. The client will

know, even if the client is happy with the service then that's probably all that needs to be said, but if the client isn't happy, what resource do they have then to say, 'Well, look, you know, I'm not happy with this', then you're put in a situation where you're in a small town and, you know, 'You've said well you don't like Mrs Smith coming to do your bathing each morning', then you've got all sorts of social problems within

the community, which I guess you've got anyway if the person's proofed by some government body. But that's not quite the same, it's the client saying to Mrs Smith, 'I don't want you', as opposed to a government body say, 'Look, sorry, Mrs Smith, we need to terminate you'.

So in theory I think it's a great idea because it will open up services to a whole heap of people who currently probably don't get them, but, you know, there are always the complications about the quality and who's going to decide who the person is going to be to give these services and who's going to decide whether that's the service that the client wants. May be the client just says, 'Look, I need somebody to come and bathe me every day', but, you know, it's not just as easy as that. It is a problem.

MR WOODS: All right, we'll explore that when you've finished your presentation. I'd like to come back to that.

MS LESLIE-ROSE (AANT): The other thing about advanced – about the younger onset dementia and the scarcity of services and desperateness of the population in the Northern Territory and people moving in and out is what's going to happen a service is set up in a particular state and then that person moves to another state. We have those sorts of issues quite often.

People, for example, are now coming to the Northern Territory, they may have received a diagnosis of dementia in another state or territory and then moved to the Northern Territory to be with their family. There is a perception that our services are actually, although it's a very small population, providing quite good care, and so people are electing to bring their parent here.

However there may have been instruments put in place in that other state or territory that no longer applies when they move here. For example, if somebody has an enduring power of attorney or guardianship set up, and they move to the Northern Territory they may – if they already have a diagnosis of dementia and they may well have already reached the place where they've no longer got capacity, those people end up in a world of trouble when they get here because there is no ability for anything to be done quickly and the instruments they have in place no longer apply. So that's really big problem and we're seeing quite a lot of it.

There's also people in the Northern Territory, particularly in Alice Springs, who may develop a need for a level of care which cannot be provided in Alice Springs. You might think that they would be transferred to Darwin, but actually they're typically not.

MR WOODS: Adelaide.

MS LESLIE-ROSE (AANT): Adelaide.

So that then brings a whole of heap of difficulties in for people as well for families and carers, it's very hard.

The next thing I'd like to talk about is the gateway, and I understand that there's not a lot being formulated about how exactly the gateway is going to work. One of the concerns that we have as an organisation is how the gateway will interact with people who are we have just encouraged to start coming to us when they're worried about their memory before they have a diagnosis of dementia.

That for us is working very well because we're able to then support people as they go through that progression of diagnosis or not diagnosis. It means that people can come to us in a non threatening way.

When we talk about the fee-for-service, one of the other concerns that we have is that people are sometimes reluctant to come to us in the first place. If you then put a fee in place we might have difficulty getting them to come to us when there's no fee, if you introduce a fee that may impose another barrier and ensure that people are – or increase the likelihood that people don't receive services until they reach that crisis situation which we want to avoid at all costs.

If people come to us when they're worried about their memory then it's at a time when they're not talking about the 'D-word', the 'D-word' which is so negative, has such negative connotations, they can come to us and involve risk reduction activities which is much more acceptable to people. They then slowly can see that actually there are things that are in place that can help me, there seems to be emerging evidence that if people engage in risk reduction activities that it actually slows the progression. It keeps them in the community longer. It gives them that little bit more time to have a good quality of life, and if the right structures are put in place hopefully a good quality of death should they have dementia. So I don't want the gateway to get in the way, that would be really counter-productive.

Also the aged care assessment team has been basically – I've sent you a copy of the framework. The aged care assessment team has basically become the gateway in the Northern Territory if you like, and the feedback that we've been getting is that that's working very well. The doctors now have a point of reference that they can refer people to so that they – that the obligation is then removed from them. GPs in Darwin in particular are getting very frustrated with being the specialists for everything. They feel that there are not enough other specialists around and it's being left to them to do everything, and they really don't want that responsibility, they don't have time for that responsibility, they would like it if the right structures were put in place to support them.

So to be able to refer people to ACAT is very useful. They can – then ACAT then determine what needs to happen next. So we wouldn't like to see that broken.

The last thing that I would like to talk about in particular is workforce turnover, and I know that we've touched on that previously. There is indeed an extreme workforce turnover in the Northern Territory in the aged care system. We see it as we're providing education. You provide education to a group of people and all of a sudden that group of people is gone, really it's great for us, it's continuing business, we're going to have to keep going back and training them year after year after year because they won't be there.

The workforce is very multi-cultural, quite often doesn't speak English, and that is a particular problem with English speaking with dementia. But then the other way around, if you have non English speaking people with dementia you need to have people who speak their native language as well because they might not only lose their ability to speak English, but they are likely also to lose their ability to read and write in their own language, so providing them with information in written information in their own language is not going to address their needs at all necessarily.

What we see that the way to address, or one of the ways to address this workforce churn, is that there needs to be not only better pay for people in the aged care workforce, but that aged care needs to be seen as a valued profession that aged care needs to be seen as something that is valuable, and there needs to be a career path so that not only do you provide education to people in aged care, but there is a reward for participating in that education. So that if somebody has a higher qualification there is then an increase in pay to reflect those higher skills so that there is an incentive not only to enter the industry but to stay in it, and hopefully that will then provide a better quality of care for the increased population that we're going to see in aged care.

I lied, one more thing. I understand last week that there has been a comment from somebody that the figures of dementia from the access economics report that Alzheimer's Australia put together have been overstated because it doesn't reflect the possibility of a cure. I've attended in the last four years six dementia specific medical forums and in each one of those medical forums the question of a cure has been raised, and at each time the possibility of a cure in the immediate future has been absolutely discounted.

There is no chance of an immediate cure because there are a large number of diseases that make up the reasons for people developing dementia. We don't understand them, we don't understand the mechanisms, and we're not even close to it. So a cure is just not on the horizon.

Secondly, and just as importantly, mild cognitive impairment has now been reclassified as prodromal Alzheimer's disease. So all of those people with mild cognitive impairment that haven't been included in those figures now need to be included. So not only is not an understatement – overstatement, it's probably an understatement.

MR WOODS: Thank you for that.

Ray you were going to talk about some education activities.

MR NORMAN (AANT): Well, yes, I just at the risk repetition pick up on Ruth's comments first in the staffing of aged care. My first impression of having a personal involvement over the last six years was my wife in aged care, is that I'm amazed at how good residential facilities are at recruiting people with a good attitude towards their work.

Invariably I find that the newcomer coming in comes in with a good attitude. I also find in that they come in with this great willingness and attitude, but without any knowledge of really how to go about it. They may obviously get an induction from the carer, but they really don't understand the disease which many of them are looking after because there's a very high percentage of anyone in residential aged care that have high dementia.

Secondly, I find that when they do have a degree of education given to them, and we provide that education through the dementia care unit of aged care certificate III in the main, or certificate IV, that they return to their nursing home with a much better attitude and much more willingness to stay on. All my points are leading to try and keep them in and not have as much turnover, but the third thing has to be salaries, and to look at all three.

Recruitment which seems to be done, I think, pretty well, with education which is spasmodic nowhere near getting to enough of them, and then salaries to make this a package of three things that are required to keep them in the industry for a much longer period. We may have to accept that they're not going to stay for huge lengths of time, but I think these three things would in fact keep them there for much longer and reduce the amount of turnover would be my point.

On the point of Aboriginal knowledge of dementia and Aboriginal training, there is no doubt that the knowledge of figures of dementia in Aboriginal communities is way understated. The research that was referred to by Ruth gives them, I think, it's 4.8 times the national average, but it's unknown. I still go to a reasonable sized community and they say, 'Well we don't have any dementia out here', because they simply haven't recognised that it's some sort of aged behaviour or they may be hidden for cultural to keep them out of harm's way or for a shame thing.

But we've also found that when we do some training in an Aboriginal community with Aboriginal aged care workers we have had a phenomenal change of attitude in those Aboriginal aged care workers, and we've had written commendations from their registered nurses saying how much they have changed in their attitude toward looking after the aged persons and have been able to look after those changed behaviours. So my plea there is that we've got to have a lot more training which probably comes as no surprise to anybody.

My third point would be to talk about the education of the community generally. I think community awareness is of the disease of dementia is abysmally low. I frequently talk to groups, they may be a group of volunteers at the Salvation Army or Anglicare, or somewhere, or to a university of third aged or whatever community people are about. We do also once a month a radio interview for a few minutes to try and help with community awareness. I think if we could community awareness at a much greater level we would have the opportunity of much earlier diagnosis and that's where I think we would make a lot of savings both in costs because with greater awareness and earlier access to the services that are available we would be able to delay the intake into nursing homes, which would be a huge saving to the government.

But it was also would enable a greater quality of life to be held for a much longer period with that greater understanding of everyone involved, the extra services that would come in, the carer would have that much less stress. The carer themselves would likely to have less health problems and there would be savings all around, plus a better quality of health care if we could a much more in-depth service to community health with community awareness.

I think that's all I'll say for the moment.

MR WOODS: Can I pick some of that up? We will also come back to both respite and gateway issues and others. If I can start where we just left off, on the education, you made a point about teaching modules or units within the cert III and the cert IV, given the prevalence of dementia amongst the age: (a) Is the content of the course appropriate, sufficient, you know, the curriculum itself, is the delivery adequate in terms of its quality and then there's the point about its quantity, which you've made, but should dementia and behavioural issues be integral and a compulsory part of doing both your cert III and then extending that practice up through into cert IV rather than just being a, you know, one of an elective units?

MR NORMAN (AANT): I'm not sure about the compulsory. Perhaps if I address the first part - - -

MR WOODS: Sure.

MR NORMAN (AANT): - - - for (inaudible) of three as you probably know is 24 hour of contact time to do that particular unit, and by and large I think it covers a very – well it probably to tries to cover a bit too much in the 24 hours, but it certainly does do a good introductory. You work a lot harder and actually more than the 24 hours to get the Aboriginal carers who haven't got English very much at all, you do a lot more one to one on that to get to have them what we call competent in that particular unit of course.

But also we find that the benefits in that community with that bit of training is just amazing. We have been absolutely amazed at the feedback from that little bit of training.

MR WOODS: Do you and go train them in their community?

MR NORMAN (AANT): Yes.

MR WOODS: Or do you bring them to Katherine or - - -

MR NORMAN (AANT): Galiwinku, Elcho Island, Gapuwiyak.

MR WOODS: So you actually go out and over a period of a week or something to deliver that 24 hours?

MR NORMAN (AANT): Well we have to be flexible. We would love to do that for cost wise, four days at six hours a day which we usually do in town.

MR WOODS: Yes.

MR NORMAN (AANT): We usually don't do that out of town, we usually have to go out two weeks and do eight half hour days because: (a) they haven't got the staff to stop their program for the whole day.

MR WOODS: Yes.

MR NORMAN (AANT): And their span of attention we seem to get through better with having a three hour day.

MR WOODS: Sure.

MR NORMAN (AANT): So we must be very flexible and that in itself is additional costs, the airfare out there, the different accommodation.

MR FITZGERALD: So how are you funded to do that now? How's your association funded to provide those sorts of supports?

MR NORMAN (AANT): It's funded by the Commonwealth by the – you might have to pick me up on this – the national under to – Alzheimer's Australia nationally and that's paired out to the various states.

MR FITZGERALD: Right.

MS LESLIE-ROSE (AANT): But the National Dementia Support Program does the community education, the certificate III, the dementia module of certificate III and IV in aged care is through the Dementia Care Essentials Program.

MR FITZGERALD: But they're all Commonwealth.

MS LESLIE-ROSE (AANT): Yes, they're both Commonwealth.

MR FITZGERALD: And this national NT framework for action which is – this is a framework that's been put together by the NT government and various agencies?

MS LESLIE-ROSE (AANT): Yes. It was put together by the agencies for the government and the government have adopted it.

MR FITZGERALD: But not the Commonwealth?

MS LESLIE-ROSE (AANT): No, this is the Northern Territory Government.

MR FITZGERALD: So purely just for the – okay, that's fine. And is there any funding attached to that?

MS LESLIE-ROSE (AANT): No.

MR FITZGERALD: So it's a framework without funding. That's all right, that's a first starting point, you know, it's a bit like dreams, they have to be fulfilled in some other way.

Do you want to talk about the gateway?

MR WOODS: You can do the gateway, if you like.

MR FITZGERALD: The gateway, can I just talk about the gateway because it is a work in a progress. So thanks for your comments.

There's a couple of things that we can clarify. In the final report we will be very clear that there are a range of services such as those provided by your own association that should continue to be one block funded and secondly would be directly accessible by people with dementia and their carers, such as your own.

So they are services that provide information, assistance, advocacy, social supports, those sorts of programs. Nevertheless if you want to access some of the formal aged care services such as personal care in the home or domestic supports or residential care, you'll have to go through the gateway.

So the gateway will become the means by which all people in Australia will access formal aged care services to which there will be entitlements attached, taking your point before. So there's two types of services, the general supports which you access directly and then the formal aged care services for which you will need to go through the gateway.

We need to be very clear that people are aided and assisted in going through the gateway and the support of your organisation and other would be critical in that occurring. When they're actually within the gateway the best example I can – the best analogy, but it's not to be used as an identical system, is Centrelink. In the sense we have a national system which allows you to be able to access benefits. In this way there's a national system that will allow to access aged care services.

The assessments in that, we would think, initially the gateway may well choose to in fact subcontract the assessment function, for example to ACAT, so they could stay. Having said that, it will be up to the gateway to decide how those assessments will take place. Those assessments will be right from the most basic services right through to the most complex services including admission to residential services, and that will all be done at a local level.

So whether it's done through the existing ACATs or whether it's done through some other way the gateway will decide. But the gateway will operate regionally and locally in order to undertake the assessments, but people will need to go through that gateway to actually access those services.

The final comment I'd make and it links to the comment that was made previously about the fee-for-service, the gateway will also decide the level of co-contribution if anything, and that's effectively zero to 25%. If you're the wealthiest

in Australia it's 25%, and if you have no means it will be, you know, little – virtually zero.

So the gateway not only says, 'Here are the services you can access, but here's the contribution, if any, that you have to pay', and you then take to that provider of your choice. So I think that addresses some of the concerns because we don't want the gateway to be a barrier and you don't want it either.

On the other hand we are trying to deliberately create a system where people that are formally seeking aged care services there is some consistency, there's – and there will be an electronic record that will travels with this so that as you said when you move from state to state, if you've been through the gateway it doesn't matter, the states and territories no longer matter. You can move as much as like, and that record travels with you and the entitlement travels with you. So that all stops.

But I want to get back, we didn't do well enough in the draft of the explanation about these other services. Does that sort of gel with what you think would be a reasonable model?

Now at the end of the day the government will have to design it, and the gateway will have to work out how it's going to function, but that's the theory that we're putting forward, well the framework that we're putting forward.

UNKNOWN PERSON: Can I ask a question?

MR WOODS: No, at the end of the session.

MR FITZGERALD: At the end we can, yes, no problems.

So anyway that's the thing. But can I just ask this question at the moment, how do people access HACC services and other services in the Territory? In other words you've got – ACATs do the - - -

MR WOODS: (Inaudible) ACATs and (inaudible) HACC (inaudible).

MR FITZGERALD: ACATs do the – they do the packages and the residential, but one of the problems that we've got around Australia is that there is a myriad of other programs which are actually quite difficult to find and access depending on the state or territory that you're in, some are better than others.

MS LESLIE-ROSE (AANT): We deliver some HACC services and - - -

MR FITZGERALD: Such as?

MS LESLIE-ROSE (AANT): Well we deliver support and counselling and respite in Darwin and Alice Springs and a small extension service to Katherine and to Tennant Creek and those – people come to us through ACAT. So ACAT refer people to us for HACC services.

MR FITZGERALD: Well in a sense the gateway will do exactly the same, except respite. Maybe you want to raise some issues on respite.

MR WOODS: Yes, your idea of broadening out the base of who can deliver respite, we have been talking to the national office as well as a whole range of state and territory groups about that and we can see some merit particularly in rural provincial areas of having a wider group who can be eligible for delivering respite.

As you say, quite rightly, smaller communities also have stronger social networks and ties and issues, let alone then overlays of cultural issues. So both of those present their challenges. There's a further challenge in the sense that you also want to ensure that the provider of respite is a safe person who delivers quality respite services, and we have a fairly blunt instrument called a 'police check' is one part of that process, but of course for a number of communities interaction with the law is, you know, more often but for issues that are unrelated to the quality of care they can deliver, and so you need some way in which the community elders make a judgement that that person despite the fact that they had this interaction on this has got nothing to do with the quality of care that they would deliver as a deliverer of respite services.

So, you know, we need to devise systems that are relevant to the communities that are being delivered. So, you know, your further thoughts on whether you have some blanket rules and I just raised the one about the police checks and can see some problems there, other rules of not – if it's paid respite not by a family member, but how do you define family in the broader context, not a family member who is living with you, but in some case there can be very transient definitions of who's in the household and living and who's not.

So how do we craft an appropriate model that recognises the benefit of a wider interpretation of who could deliver formal respite, but still provide appropriate checks and balances.

MS LESLIE-ROSE (AANT): It's more complicated than just respite though, because respite - - -

MR WOODS: Absolutely.

MS LESLIE-ROSE (AANT): Respite is not just for the carer, it's also for in the case of dementia for people with dementia as well.

MR WOODS: Absolutely, we've said that, we understand that.

MS LESLIE-ROSE (AANT): And respite is a break for the carer which allows them to go and do the things that they might not otherwise be able to do. But it is also an opportunity for the person with dementia to receive good quality engagement.

MR WOODS: Yes, I quite agree.

MS LESLIE-ROSE (AANT): People with dementia do much better if they're kept oriented in the community with meaningful activities. So one thing that you wouldn't really want to see is people saying, 'Right, well we can provide this respite service which is basically a babysitting service', because that's not what's needed.

MR WOODS: I mean we fully agree with you on those. It doesn't help me progress how you define who can be a person in that broader group.

MS LESLIE-ROSE (AANT): Well those people that are delivering respite need appropriate education and skills.

MR WOODS: Yes.

MS LESLIE-ROSE (AANT): So not just anybody who can respite.

MR WOODS: Totally agree. That's what we're trying to define.

MS LESLIE-ROSE (AANT): So they need to be able to understand that perhaps the person they're caring for might wander if – or become lost if they're not looked after carefully. They might also – they also need to know that perhaps that person needs to be prompted to drink for example.

MR WOODS: Yes, hydration, fundamental issues.

MS LESLIE-ROSE (AANT): So there's people that are providing respite need to be appropriately skilled.

MR FITZGERALD: Well and who – the other way to do it is to say that the person providing this more informal respite needs to in some way be approved by an agency such as your own or any other agencies that are approved and accredited.

The difficulty we found there is that the agencies may well be reluctant to take on the liability and unless there are fairly great safeguards, so we're struggling with this, and if you look at the report the productivity commissions done on the National Disability Supports where the disability lobby is much stronger about entitlements being able to be cashed out, and for them to be able to acquire services from their informal network of supports. Operationalising that is actually proving to be quite tricky, quite difficult.

Kathleen.

MS SHORT (AANT): I was thinking about this and I'm thinking of smaller communities. For me the first and foremost about whoever is going to provide this care has to be that the client likes them.

MR WOODS: Yes, accepted.

MS SHORT (AANT): And that the client accepts them and is happy to work with them. If that happens then by all means give the carer, whatever you like to call them, all the help we can which up here is very difficult. I mean you can't – you

can't go to every little community and give the teaching and the education. You can't bring those people into Darwin to give it to them. So you're relying upon the community to give that support and the fact that the client knows what they want, the person employed needs to be aware of, as Ruth said, the difficulties. They will already know that this person wanders, he's probably been wandering around the community every day and somebody rescues them and brings them back. They will know those sorts of things. They will probably know the sort of activities that the client wants to do because they're part of those small communities and they're aware of those things.

I agree with you about the police checks. I mean it's just – by all means do it, I suppose, but, you know, in some of these places that's not going to work, and I'm not even sure that here in Darwin that should necessarily work because you happen to be for speeding, or whatever else, doesn't mean that you won't be the loveliest carer for someone. So I think that – that police check has to be – well I don't know if 'modified' is the word, but it's got to be looked at carefully and not necessarily be something that stops a person from being a carer because if the client particularly wants that person, you know, it's going to work.

MR FITZGERALD: It's this difficulty where we've obviously recognised the role of the carer, the family member, and we recognise that in a number of ways. We recognise it by benefits and allowances and we recognise it through carer support services increasingly. So that group is not fine because they're under great stress, but we understand their needs.

It's when you move to this next group the ones that don't live at home, but as you say, they're familiar with them, they want to use them, and now for the first time people are saying, 'And we want to be able to renumerate them', and that is the changing dynamic.

MS SHORT (AANT): Well I would think that the way that would be done – well a way that it could be done is that the person who is normally the carer, the fulltime carer, family member, makes application the same as you do to Centrelink. You know, if you earn't that – make any earnings in the fortnight you ring them up and you tell them.

Now in a small community maybe it's – well you don't do it every fortnight, but you might say once a month, there's a very simple form that you fill in that simply says, you know, 'You already have on computer the information that you require so Betty Lake has done six hours in this month' and you pay that.

MR FITZGERALD: I think that parts okay. The problem – I think we can look at that, the problem really is the approval and monitoring of the individual. So that's an issue. So we're still working that through. It's tricky.

MS SHORT (AANT): That – and I see that as a problem if you're – you mean the person you've employed or is being paid.

MR WOODS: Yes.

MR FITZGERALD: Well, yes.

MS SHORT (AANT): I don't know – only the client and the fulltime carer really can make an assessment of whether that's fine or not.

MR FITZGERALD: Yes.

MS SHORT (AANT): And this is where I see the problem in a small community. If they decide that this isn't the person they want.

MR FITZGERALD: Well that's right.

Can I talk about the residential aged care services up here and what we now know is that the vast majority of people within aged care residential services going forward are likely to be people with significant dementia. In fact it's already the majority in some services, not all services.

Your associations view about the way in which residential care is being accessed and provided for people with significant dementia requirements, if any, you may have no views.

MS SHORT (AANT): I can only speak about the one where my husband was, and I could not have asked for better service. Now I mean I knew the staff. Strangely I – as director I taught in the school how terrible. But anyway the point was that I did know the staff, and I made it my point and I know Ray does, to go and, you know - - -

MR WOODS: How long was your husband in the - - -

MS SHORT (AANT): Four years. And I couldn't have asked for a better result. But across the board, I in all the times I've visited and I might have gone six/eight times a week, you know, just when I was passing I'd call in. In all that time I only ever heard one member of the staff raise – slightly raise her voice to a client once, you know, they were just splendid, and that's my experience and my – you know, from what I've heard of other places generally that's the experience up here, which means that's there's an ethos amongst those people of true caring and, you know, with the going of all the problems and the moving and all this sort of thing, but I think that, you know, generally – I've not heard anything which would lead me to suspect that, you know, it's not as good as it should be. I'm not saying it couldn't be better.

MR NORMAN (AANT): Well my wife has been in care for six years, she's at quite a late stage, and I would support what Kathleen has said there, that they give good physical care. However with the hindsight and in the last few years doing a fair bit of reading and educating myself a little bit about the disease and what good care should be, and I've always been very happy with the place that my wife is in, but I do recognise now that there are a lot of shortcomings to the real care. They do all of the physical care quite well. They are generally as I said good attitude people trying to do the right thing.

But for instance the – particularly in the early stages, it's not the case with my wife now, activities, stimulating activities, anything that would delay or eradicate boredom, if you like, and boredom can bring about many of the challenging behaviours. I know change of behaviour is an old fashion term these days.

MR WOODS: That's all right. We understand exactly what you mean.

MR NORMAN (AANT): And I think they fall short on giving enough activities, and they probably fall short in the carer's not having sufficient time to do a little bit of TLC at various times. So think there are – whilst we would have, I think, as good a care system as anywhere in Australia. I mean they probably all go up and down a little bit, but we have good care. I've been very happy with the care that my wife's had, but I have to say with hindsight and with a bit more knowledge there are a number of shortcoming that are occurring.

MS LESLIE-ROSE (AANT): And from an organisational point of view I would support that and say – just add that it's frustrating from our funding model. We are able to take people in very early on in their disease process, support them until they get to the residential aged care door facility. As soon as they receive, as soon as they go into aged care our funding stops and we don't have any ability to be able to support that person anymore. We can support their carers for a little bit as they're going into the shared care model, but really we don't have any funding after that.

So for a person with dementia change is challenging anyway because they're already struggling to cope with the changes within their own bodies. So changing the external environment is not helpful, and it means that there's a disconnect for them and it means that there's a disconnect for us, and just as we've gone and put proposals to government for funding to provide activities into residential aged care facilities, the answer is, 'No, they're already funded to do that, we're not giving you any money to do it'. So it's frustrating to know that there is more that could be done in a social support model but that we're not able to.

MR FITZGERALD: Are you able to access easily residential respite for family members that are, you know, experiencing severe dementia or is that not a preferred model? I mean obviously flexible respite, everyone talks about flexible respite, but do you – do you wish to access – do your members wish to access residential respite and if they do are they able to find it?

MR NORMAN (AANT): Well for a start it's a very individual thing.

MR FITZGERALD: Yes.

MR NORMAN (AANT): Some people just – some clients will not accept it under any circumstances, which was the case with my wife, others do. But my understanding is, and I'm not an expert in this, that's it quite difficult to make the arrangements because there are not many openings to get residential care.

MS LESLIE-ROSE (AANT): I think that Les might be able to say something about that.

MR FERN: This part - - -
MR WOODS: If you are, you will need to come here and - - -

MR FITZGERALD: Yes, join us, we've got a couple of more minutes so that's okay.

MR WOODS: So if you could give your name and the organisation you are representing, please?

MR FERN: My name is Les Fern and I am with the Alzheimer's group as a consumer and also on the CAG committee. My wife has early Alzheimer's. It was diagnosed in 2003 and I didn't – had I known before that I would have gone to them because they provide excellent services better than in Perth where her twin sister has Alzheimer's and doesn't recognise her husband.

I look after my wife at home. She's in early stages of dementia and Alzheimer's. She's excellent. She goes out twice a week. She looks forward to going out to Alzheimer's. What they do is marvellous and we get – she gets assistance from ACAT as well. They assessed her two years ago and that's the point I was trying to make before now. In future her assessment of her regression or whatever the situation is what we have to pay at the moment is free - - -

MR WOODS: No, not for assessments.

MR FITZGERALD: No, not for assessments.

MR FERN: At the point of – from a residential point of view I also get the ACAT package where I get cleaning once a fortnight.

MR WOODS: Under HACC.

MR FERN: Through the team health and they also associate – also affiliated with one with the other. I also get my gardening done because I'm over 88 years of age now and they come and do it for free. It's not income based. So from that point of view, but purely from residential care I think I've got a lot of information, not just the patient, but I as a carer have got excellent help from Alzheimer's and NT Carers Australia and they've given me a lot of counselling, a lot of tips on how to handle my wife.

Fortunately she is very good considering that she's been 10 years in Alzheimer's and she's only dropped one level in two years, a point, which is very good, and but what my concern is she loves being at home. She doesn't want to leave the place. Now I'm doing the place up and I want to look after her as much as I can, but as with other carers, like Ray and Kathy, there comes a time where she will have to go out.

But I would like to find out how much assistance we can get for people because I'd love Clare to come be with me as much as possible, and this is the point, are the services that you're going to provide going to be any better than what we got now?

MR WOODS: Well certainly our intention is to remove the limits on things like the EACH-D packages at the moment so that people are delivered services according to: (a) where they – what they need, and: (b) where they want those to take place.

So the point of our reforms in fact will be for a lot more people to stay at home for a lot longer while ever that is an appropriate level of care and that the carer can provide the support.

MR FERN: Yes.

MR WOODS: I mean that there are limits as to what is appropriate, but at the moment the current aged care arrangements have supply limits, you know, so many CACP packages, so many EACH and EACH-D packages and the like, well our reforms would remove all of that and so that once you have an entitlement then you'd be working with the ACATs in making a choice as to how much support can be provided at home for how long. So, yes, it will provide additional capacity for you to do that.

MR FERN: Will it provide additional charge as well?

MR WOODS: Well the charge will depend on your financial situation. I mean for somebody who has high wealth and high income, yes, they would be making a charge and in our draft report we suggest it could be up to 25% of the cost of care for somebody at that extreme end, which means the tax-payer is still picking up 75%.

MR FERN: Fair enough, yes.

MR WOODS: And in actual dollars, you know, if you're on the highest EACH-D package and it might cost $50,000 a year, even for that person in that high wealth, high income situation that would only represent $12,000 a year for them and remember we're talking about the high end. But we also have a proposal that nobody over their lifetime has to pay more than $60,000.

So even if you're on high intensity for many, many years there is a limit and as I say even those is only for the, you know, very high wealth. Most people would get nowhere near that. Your payments would be a lot, lot less.

MR FERN: Yes.

MS LESLIE-ROSE (AANT): I think with regard to the question about accessing residential aged care and also it reflects with the accessing packages as well. There can be packages and aged care available, but it's the staffing issue. It comes back to the staffing issue.

MR WOODS: Sure, absolutely.

MS LESLIE-ROSE (AANT): So I know that in Alice Springs it's difficult to provide the packages because of the churn in staff and the quality of the staff and the part timers and the casualness.

MR FITZGERALD: Well this is part of – this is the exact dilemma. We can increase the level of supply theoretically. We can remove the rationing that's currently in the system. It's a heavily rationed system. But at the end of the day you'll need the workforce and the appropriate financial structure for provides to provide that service and that's exactly the other issue. That's why it is supply and it is demand and it is really trying to work out how to provide the provide the appropriate workforce and the appropriate models of financing to ensure that, and that is difficult, and in the Territory that is very difficult. But it is also difficult in other parts of Australia as well I might say. So that's the challenge.

MR NORMAN (AANT): Just a quick one.

MR WOODS: Yes.

MR NORMAN (AANT): I presume there's no thoughts of having an accumulation cap on residential care?

MR FITZGERALD: On the care there is.

MR NORMAN (AANT): (Inaudible) regulations.

MR FITZGERALD: The care - - -

MR WOODS: The care would be capped at $60,000.

MR FITZGERALD: - - - For the accommodation. The accommodation is separate fees.

MR NORMAN (AANT): Not the fees.

MR WOODS: Well the accommodation is a personal choice as to what standard. I mean if you were a supported resident then that's provided by government anyway. But if you're not in that category then you choose what standard of accommodation - - -

MR NORMAN (AANT): If you're income tested, you're paying an income test fee on top of the base fee.

MR WOODS: On the care side you pay income tested fee - - -

MR FITZGERALD: Yes, that's something - - -

MR WOODS: - - - on the accommodation you choose what level of accommodation you want to live in just as you do at the moment.

MR FITZGERALD: Are we making ourselves clear? Going forward what we've done, fundamental principle, and everybody agrees with this, I might say, is we're trying to say accommodation and the charges for accommodation are set this way, and then you've got the care costs and they're separate.

Care costs wherever you incur them, in the community or in residential care, will have a lifetime cap, absolutely. Accommodation costs don't have a cap, and that's different and we are separating them so that we can actually deal with the accommodation in one way and look at the care in the other way.

As Michael says, if you're on a full pension and you don't have, you know, a substantial family home, or what have you, you're likely to be fully supported by the government. But there are many people that have significant wealth and we just want to make sure that there's some contribution coming from those, but the accommodation will be treated separately and that is not capped.

MR NORMAN (AANT): No, I didn't think so.

MR WOODS: Do you have a reaction to that? I mean what's lurking behind your question?

MR NORMAN (AANT): Well I am a self-funded retiree. I would accept that I'm currently gone back to work - - -

MS LESLIE-ROSE (AANT): Not retired.

MR WOODS: Yes, I was thinking retiree not quite sounding right, but a busy person.

MR NORMAN (AANT): Well I've gone back to work to pay the nursing fees because to be very blunt about it you get super – I've got a Commonwealth funded super, which would allow me and if my wife was living with me in my own home to live quite comfortably.

MR WOODS: So it's CSS in the old days.

MR NORMAN (AANT): That's right. But with the complicated way it's all worked out it always comes out that you the nursing home takes more than half than the super and that makes it a very tight budget.

MR FITZGERALD: Yes.

MR WOODS: We are trying to remove some of all those complications so that you understand what the care is, how much it costs and what your co-contribution for that is and then separate out the accommodation, so you know exactly what you're paying for and why, and you can make decisions about accommodation that care will be the one standard of care throughout the whole system.

MR FITZGERALD: I think the point you raise is interesting. The average length of stay in a nursing home at the moment is about eight months, except for people with dementia where the stay is much longer. And so if – what we've got is – we just got to be – we just got to look at this very carefully as we are, you've actually got two very different types of people in aged care residential services now. Their length of stays are very different, and that – and we just need to look at that carefully and we are.

And then there's a third group which are only in their for respite, sub-acute care, transition care, other care. So there's a third group. So we're just looking at those and the implication of what that - - -

MR WOODS: And certainly for the non dementia, the stays are becoming shorter because people are going in frailer and in greater need - - -

MR FITZGERALD: Frailer.

MR WOODS: - - - and that would be a common experience for a lot of homes that people are staying at home for longer and then move into residential care if they need it for - - -

MR FITZGERALD: Just at the later stage - - -

MR WOODS: - - - a very short period of time.

MS LESLIE-ROSE (AANT): There sounds like that there might need to be a safety net though.

MR WOODS: Well I think there is a safety net on the care.

MR FITZGERALD: Yes, it's the accommodation.

MR WOODS: It's the accommodation that is the separate question.

MR FITZGERALD: And, look, I think people should and are now raising that with us and it is because of the long lived nature of people with dementia. So we are conscious of that and we just have a look at that further.

MS LESLIE-ROSE (AANT): And extreme high care costs.

MR FITZGERALD: Yes, well that's - - -

MR WOODS: Well the care is hard - - -

MR FITZGERALD: The accommodation – yes, anyway - - -

MR WOODS: (Inaudible) solved, yes.

MR FITZGERALD: We're looking at that, yes.

MR NORMAN (AANT): I presume we're running out of time?

MR FITZGERALD: Yes.

MR WOODS: Yes.

MR NORMAN (AANT): Could I just make one comment totally different to that, nothing to do with it. I don't think when I made some opening remarks I mentioned about prevention or delay in lifestyle factors, which if we had greater education there is no doubt the increasing evidence if they can be supported and they're not being supported very greatly by government finance to educate people in their lifestyles, and it's got lifestyle matters which will actually delay dementia or delay the progress of dementia, and at the same time, of course, it's beneficial for the other chronic diseases. I mean what's good for you heart is good for your brains is a sure thing.

MR FITZGERALD: And we'll pick that up, your national association has raised with us that issue as many other organisations have, so we will try and deal with that a little bit more fully, and it's not only related to dementia, it's generally about preventative health and this whole notion of healthy aging or aging well, whichever one you want to use, we're going to just concentrate on that a little bit more. Although having said that is starting to develop and there's a national dementia framework, isn't there, as well, that's got some funding, which has some preventative elements attached to that as well.

MS LESLIE-ROSE (AANT): Yes, what we're talking about really though is a public health education program.

MR WOODS: Yes.

MS LESLIE-ROSE (AANT): Which is not just looking at older people, you need to have the healthy lifestyle from the time people are born.

MR FITZGERALD: Yes.

MR WOODS: Indeed true.

MR FITZGERALD: There's been a lot of us around who have advocated preventative health measures for a very long time.

MS LESLIE-ROSE (AANT): Keep doing it.

MR WOODS: And keep running and keep walking and - - -

MS LESLIE-ROSE (AANT): Because if you don't do it the cost is just going to get totally out of hand.

MR WOODS: Yes, we do understand that.

MR FITZGERALD: Thank you very much.

MR WOODS: Thank you, we'll take a short break and resume at 11 o'clock. There's tea and coffee for people if you care to join us outside.

ADJOURNED AT 11:00 AM

MR WOODS: For the record, could you please give your name, the organisation you represent and the position you hold?

MS LESLEY (COTA NT): Thank you, very much. My name is Robin Lesley. I'm the executive director for COTA, counsel of the ageing in the Northern Territory.

MR WOODS: Excellent, thank you very much, talk to us.

MS LESLEY (COTA NT): Thank you very much for the ability to be able to talk to you. COTA has been actively engaged in this process from day one and we have some fairly extensive documentation which I won't go into all the details other than to say I support it.

MR WOODS: I describe to Ian and Jo the other day that we have about three feet of paper from them now.

MS LESLEY (COTA NT): Yes. It's been our very much focus for COTA right around the country.

MR WOODS: It has. And we've had excellent contributions.

MS LESLEY (COTA NT): Thank you very much.

But I think that one of the things that I say and which irritates my colleagues around the countryside considerably is that the Northern Territory is different.

MR FITZGERALD: Thank you.

MR WOODS: That's why we're here.

MR FITZGERALD: I have heard that a few times.

MS LESLEY (COTA NT): And it does irritate people event to the extent I ask the question of Jo the other day why have got some clinical people going to Alice Springs and not to the capital city of the Northern Territory, and I was told, 'Well they're going to western Sydney they're not going into Sydney', and I thought, 'That probably demonstrates some of the issues'.

The things that I predominantly wanted to focus on today is around the difference of the Northern Territory and I suppose in the capacity to implement some of the issues that – the broad cross section of issues.

I'd first of all like to say that the submissions that I've heard this morning I would totally support what has been said in all of that area, and so capacity to implement I've identified is skills, geographic and cultural.

The skills sets is not only in the – how I see, I suppose, the whole of area of seniors and being dealt with in a fragmented and solo driven environment that impacts on the way in which, say for instance, as our representative from nursing

indicated that the way in which nurses within the aged area is not given the full recognition for the depth and level of skill required to do a good job. The issue of, I suppose, across the medical field recognising that aged people can come in to almost any part of the system and unless you've really have some insight as to the issues that need to be addressed that problems can go undiagnosed or can be treated completely inappropriately and in an area like the Northern Territory where such a significant number of people who access say the public health system are Indigenous that becomes even more complicated.

So it's a cultural and a social issue as well as a communication issue within that framework, and skills therefore need to be really honed because there is such a strong turnover of people in the Northern Territory. We have in almost every environment we have skills shortages as well as labour shortages. How we then are dealing that, I know that the health department is doing, you know, an enormous amount of work by trying to recruit overseas nurses so you then have people coming from areas of English as a second or third language, even within outside of our own more recent history context whether it's from the African nations, etcetera. So there are ways in which all of those things impact on what is already a fragmented approach to that area.

It also means that the Northern Territory is competing for not only those people, but also our own local people being called to bigger environments in building careers, getting experience of a social or other aspect that means that trying to retain people is just really, really hard.

The level of volunteers also available in the Northern Territory is a challenge. We would advertise at least once a month in COTA to try and recruit volunteers, and if you ask any person who's retired from the fulltime workforce you would find that they're really busy. They're already involved with in two or three organisations, so it's just the arms and legs is really hard to recruit in an urban environment.

In a rural environment and a remote environment there's no such thing, it's just, you know, of all the cultural commitments and family commitments, and part of the problem that I'm seeing in the Northern Territory and particularly in the Darwin region is that infrastructure of service delivery in remote areas means that people are coming – are being drawn to particularly Alice Springs and Darwin, the issue of homelessness that occurs here in Darwin. I'm an alderman on the Darwin City Council is another one of my roles, and I'm chairman of the Cultural and Community Services Committee, and the numbers that we understand that are on the streets every night in Darwin alone, not including Palmerston, is in excess of 2500, that's Indigenous as well as non Indigenous.

In my role in COTA because I've been trying to get a survey going of the over 50s in the Territory and I've got very networks into the homeless community, there's at least 50% of those homeless in the over 50s age category. Recent experiences are that there are problems about getting people whose behaviour appears to be demonstrating dementia or some form of dementia and in talking to aged and – health and aged – health and – I refuse to say it's a senior moment.

MR WOODS: (Inaudible).

MS LESLEY (COTA NT): I've just got too much on my mind.

MR WOODS: Is it the federal department.

MS LESLEY (COTA NT): DOHA, that there is a gap in the system where the issue of protection of people's privacy and being able to get people assessed when they're not interested in accessing off those sorts of services means that people get completely – they get treated by people like our public places roving offices, inspectors, or the police department and there is a complete absence of any form of infrastructure to deal with them at the moment.

The geographic – I mean the issue of people moving to urban environments in order to access services I think is a trend that we've been seeing for many years, at least 20 years, but I think it's on the increase and unless we're successful in building up within the shires services to some extent that reflect back to the traditional way in which families are held together and having the skill transfer into the communities with some capacity to have the housing also accommodate people staying at home. And then in the context of conversations I had in Alice Springs where Indigenous people saw the questions of, 'Do you need respite care for your parent?', they said that some people have seen it in a shame-job environment. So that they think the answer is yes. They then feel like they're relinquishing the power and control over to the authorities. They think that that's in the best interest because the authorities obviously know the best answer, and because they come from a lack of confidence in their own social structures, etcetera, and we're not reinforcing that.

In fact part of the problem in remote communities today is that many of the seniors not only are dealing with growing old and trying to stay healthy, but they're assuming the responsibilities of maybe their grandchildren or their great-grandchildren because of the dysfunctionality of the middle groups, and therefore the whole issue of who is available to support this family network in remote communities is very problematic.

I see that as a major problem when dealing with public housing, planning and business, that if you don't connect the dots in Aboriginal communities about the relationship of all of these things, you have things like the major – what is it – the SIHIP Program where you've got masses of money being poured into housing and yet I'm told there's a separate waiting list for handrails and things for seniors to go into those very houses because they haven't thought about it as part of the original design or who's actually using the houses in the first place.

The other issue of planning in a urban environment is that after the recent Cyclone Carlos there are a number of stories that came out of people, seniors, who were released from hospital because they were now able to go home, only to go home and find because it's a single lift, either the lift has broken down, or the power is out, or something's happened and they can't access their home. The issue that was addressed to me specifically, the wife had been stranded upstairs for four days, the fire brigade had to come in to bring her down and they had to move into a hotel for 10 days because the local business people didn't have the parts to mend the lifts because the business environment was keeping their bottom line intact and having

stock takes, stock it locally, to have 24 hour turnaround didn't even occur to them as part of the business plan.

And of course the issue of the number of seniors tags that gets put on to planning applications, whether it's also got the tag of affordability means that while there might be lots of accommodation being built its relationship to people who might need services or at least might not be able to access a stairwell that that's another area where it's, you know, the dots aren't being met.

I know that this is all quite peripheral to your specifics, but the issue, I suppose, I'm really trying to say is that particularly in smaller communities where the infrastructure and the resources aren't as plentiful as in denser populations, you really have to be very smart about bringing all of these things together to minimise the duplication of costs, but also thinking through the style of service delivery.

In terms of the question of service delivery, the issue of the medical model or the clinical model is really important, but I think that sitting alongside of that is that there's got to be a community model that brings this sort of intelligence together as well as promoting the, you know, consumer directed choices, and consumer directed choices is meaningless unless you've got a good access to exactly what the choices are and what the services are that are available.

I believe that the engagement of the NGOs specifically in seniors in things like peer educators, advocacy groups talking together, and for that purpose COTA has recently formed a round table where it's bringing together the non service delivery organisations involved in seniors like senior sits, youth (inaudible), COTA obviously – national seniors and a component of NT Carers so that we can actually talk about where are the barriers or the gaps that exist in the system so that we can feed those into government and perhaps get better outcomes at this point in time when so much change is being planned and so little knowledge is known about the detail of how it comes out at the end.

In the Territory we do have a really young community, and we have a public service which is losing its over 55s at a massive rate in business, we're losing them in senior positions also, and out the door is walking a whole lot of corporate knowledge as well as the detailed understanding of the consumer groups that we're talking about.

MR WOODS: And how the community interconnects.

MS LESLEY (COTA NT): And it how interconnects, absolutely.

MR WOODS: All that, yes, which you just have to build up over time.

MS LESLEY (COTA NT): Yes.

I think that if there was some – in the gateway if there was some way in which the pre-gateway was also understood as how we actually funnel people to the sources of information, particularly in a small community. I think the NGOs have got a really good place to play in that and people like ourselves we're in the middle of

formulating a webpage which has a comprehensive list of all of the of service providers across the board as well as events. If there are – so that we can actually start tapping into people who aren't as well engaged through their community involvement, but are warehousing themselves to some extent because the groups of seniors that we come across fall into two bags, and we would have at least one person walk through our door every day of the week, and they're coming in as a result of, 'I want to know because I or my family are going to be facing these problems or there's already some signs of problems'. So people are actually seeking out information or they're coming to us and they're very fearful and they know that they should go and see their doctor or somebody in that sort of environment, but they think if they talk about it may be it will all go away.

So a whole range of the – what's the word – they've come through being – through young people and through their middle years and come to being seniors and are struggling with what that really means. They see people around them who are dealing with the age process better than others, and we also see government departments start to put definitions around who's eligible for services. So they pick up things informally and then don't dig any deeper and then go back into their house and warehouse themselves, sit in front of the television or may be go out to do the shopping as the only form of engagement.

My personal belief is that the Territory and its infrastructure and its capacity to produce more resources both at a community level as well as within those special areas of service delivery is a major challenge and I can't see it get any less, and for that reason I would advocate that there are special needs of consideration that put the issue of the skill shortage, the labour shortage, the massive geographic disbursement, and then the cultural diversity as being three areas that need to be seen all together as part of the challenge.

MR FITZGERALD: Good.

MR WOODS: And, yes, when you look at the numbers, the skills, the turnover, the dispersion, and the cultural diversity, I mean it's a very powerful - - -

MS LESLEY (COTA NT): It's a powerful – it's a perfect storm.

MR WOODS: Yes, yes.

MR FITZGERALD: Could I ask a question about just the role of council in all of this, your first point is really about trying to link, you know, and in one sense the local government is not a bad level to try to get some of those linkages occurring. So what's your view in the Territory of the role of local government going forward?

MS LESLEY (COTA NT): Are you talking about local government council as opposed to COTA?

MR WOODS: Yes, as in Darwin City Council.

MR FITZGERALD: As in Darwin City Council and the shires that have all been established. I mean you've gone through this massive reform with your shires, and I'm just wondering what you see as their role, if any?

MS LESLEY (COTA NT): Look, COTA approached the local government association and has done a number of presentations to the CEOs of all of the councils across the Territory basically trying to raise the consciousness of local government that they are already to some extent major service providers within the community to the aged. But it's not necessarily packaged in that way.

I believe that if we can get greater understanding by local government and the differentiation of the constituencies that they better be able to design services in the future. The issue – the challenge for local government is that the services that they're providing are not only – they're most focussed probably on infrastructural services, that's their comfort zone.

MR WOODS: Parks and local roads, and - - -

MS LESLEY (COTA NT): Yes.

MR WOODS: - - - swimming pools.

MS LESLEY (COTA NT): Footpaths and all that sort of stuff.

MR WOODS: Yes.

MS LESLEY (COTA NT): And I'm trying to bring about some changes in terms of that saying that if you design for seniors and disabled you actually pick - in the first place, in a wide context, you then pick up the whole community. You pick up mums with prams and all of those sorts of issues.

It really comes down to the two things in the Northern Territory which separates traditional local government in other states from the Territory, and that is that local government doesn't have responsibility for planning, it's constrained to things like collection of garbage, storm water drains, you know - - -

MR FITZGERALD: Basic services, yes.

MS LESLEY (COTA NT): Yes, ingress and – and then the other major issue is that we're not engaged hardly at all in transportation, and the issue of public transport and seniors even in the capital city of Darwin is problematic, and there is currently a number of committees going to look at community transport which focuses on the aged and disabled to get them to specific destinations.

MR WOODS: So do you have HACC funded community transport groups who – as volunteers or under the auspices of one of the NGOs or?

MS LESLEY (COTA NT): Look, we've got a lot of NGOs and there are a number of them who have HACC funding, there is at least five NGOs that I can think of who have been funded in the past for buses, for one service or another, but again as part of

the fragmentation there isn't a cross agency – I mean we're working on that as an objective to try and get the utilisation of the important resources like the buses and drivers to service across organisations, but – and I think Mission Australia is currently doing a project as is COTA and NT Carers, but we're a long way off that in the Darwin environment.

COTA operates a transport service from Batchelor, Adelaide River to Palmerston and Darwin and the hospital, and that is done with the assistance of Coomalie Council providing the bus.

So there are ways in which local councils are playing a bigger and bigger part, buy it's not systematic, and it's – it goes budget, time and has to compete with everything else, and of course in the Territory probably like everywhere else in Australia despite people paying huge amounts of money for all sort of things, rates is a very vexatious issue, and does impact on the way in which people try and contain the costs.

I think that local government and the NGO areas in the Northern Territory are the way of the future for both the Commonwealth as well as the Northern Territory Government, but we've got to be able to understand how they fit together without duplication and that the consumer and the needs of the consumer are prominent in the way in which those things are designed.

MR WOODS: Can I go back to homelessness. Are there specialist providers of residential aged care that focus largely or solely on the homeless aged cohort, or are they to the extent that they are able to be attracted into those facilities and encouraged to sort of, you know, develop more regular patterns of hydration, nutrition, health care, etcetera, operate and become part of those facilities? I mean what – what happens for the very frail elderly homeless?

MS LESLEY (COTA NT): They die on the street many of them, and there have been a couple of successful transitions from the street to aged care, but there was a lot of intervention by quite a few people in that process. I suppose that's one of the reasons I'm raising it is that I've been trying to interrogate the system now for three months with the assistance of some people who live on the street, and if the person on the street is not willing to go to a doctor then there appears to be no system that actually will enable them to connect.

MR FITZGERALD: But there are in many of the other states and territories there are in fact homeless person – sorry, there are aged care facilities exclusively for homeless people.

MS LESLEY (COTA NT): We've got – St Vinnies do a really good job and Salvation Army are involved in that area as well.

MR FITZGERALD: Do they actually have aged care facilities?

MS LESLEY (COTA NT): But I don't think that they have aged care. I think that there is something built quite recently by St Vinnies which has only just opened, which is designed for seniors and disabled.

MR FITZGERALD: All right.

MS LESLEY (COTA NT): But I don't – I still don't think that it fits within the aged care licensing provisions. So there are people like NT Shelter and those agencies, Mission Australia, etcetera, who are working with that constituency but I don't believe there is in the non Indigenous community or within the Darwin region anything that fits that bill.

I think there might be some assistance in Katherine. Katherine and Alice Springs might through Tangentyere might direct people to Hetti Perkins or somewhere like that, but again it's still an agency doing an intervention and connecting them up.

MR WOODS: And so they'd have sort of episodic relationships with the hospital and then discharge and basically back out in the streets.

MS LESLEY (COTA NT): Yes. And I have tried to get, for instance, some – the sobering up shelter where people might be taken into protective custody and taken there so that they can have food and shelter, etcetera, but that might be a good point of intervention to referral to the hospital or for the hospital to come to that point, but I haven't been successful to date.

MR WOODS: Volunteers, and I mean COTA is very good rounding up volunteers, but is it that a lot of people when they retire go back down south or are they staying here, but are actively for those who do want to remain connected with community work are sort of over committed? I mean what's the pattern that's happening?

MS LESLEY (COTA NT): When COTA did a survey back in 2006/7 there was a strong trend that people were once they got to a certain they're moving south, and the reasons that they were choosing to do that was either reconnect with family or cost of living was a substantial reason.

We believe that that trend is significantly changed, and we believe that –and we're preparing to do a survey of the sort of 47,000 over 50s in the Territory in the next couple of months to test some of that data that was collected. Anecdotal evidence would seem to indicate that while there are still quite a few people who are moving down south particularly at the middle and upper management level when they retire from public service and particularly if they retire in the age – around the age of 55 rather than 65.

But the evidence is that because families are now staying, choosing to stay here, children and grandchildren are now evident and where they might have gone down south to join them they're staying here. We've actually got in the non Indigenous community the first – probably the first three generations of significant non Indigenous people in the Top End. That trend isn't the same in Central Australia where there's been a lot more stable environments.

The other thing that we've anecdotal information about is that when children have moved to the Territory for career purposes, they've then made a choice to stay

here and that their parents are now joining them. So it looks as if there's – I had a look at the statistics the other day out of ABS and if you looked at the under 45s the growth in population was around the 20/24, but it was by .2%. If you looked at the over 45s the growth was at .9%. So we – everything that we've done in terms of interrogating the demographics seems to indicate that the over 50s is the fastest growing demographic in the Northern Territory, that it's likely to reach 50,000 by the census time this year.

While the Northern Territory Government is still only talking about seniors as being 65 and over, we believe 50 is a really good point to look at because that's the time you're trying to encourage people to look at their superannuation and retirement issues. We must be – I would totally support what's been earlier said about the social behaviour of people prior to 50 and what the impact on their health and their capacity to live productive and good lives. We've really got to start talking to the people about how they remediate themselves.

MR WOODS: I totally agree. Are there things that you'd like to pursue further that we haven't raised? I think we've covered quite a field, but.

MS LESLEY (COTA NT): Within the context of the report I think – I'm eagerly awaiting how the Federal and State Governments will come to the table with the detail and I just really reinforce that if it is done as a solution by governments then I don't think it would be successful.

MR WOODS: No.

MS LESLEY (COTA NT): This is going to have to be about governments and also the community sector.

MR FITZGERALD: Yes.

MR WOODS: Yes. We understand that point strongly. Very good.

MR FITZGERALD: Thank you.

MS LESLEY (COTA NT): Thank you very much.

MR WOODS: Thank you for your evidence.

Masonic Homes.

MS MARLBOROUGH (MH): Thank you.

MR WOODS: There's a clean glass here if you do want one.

MS MARLBOROUGH (MH): Yes, I'll just swap it over, thank you.

MR WOODS: Please talk to us, if you could give your name, organisation who you represent and position you hold.

MS MARLBOROUGH (MH): Thank you. My name is Jan Marlborough, I work for Masonic Homes and I'm the regional manager for the Northern Territory.

MR WOODS: Thank you.

MS MARLBOROUGH (MH): Thank you.

Commissioners, first thank you for allowing me to present a late paper.

MR WOODS: That's fine.

MS MARLBOROUGH (MH): Thank you for travelling to the Northern Territory and allowing us the opportunity to have direct input into your important deliberations.

Before I make specific comments, I would like to remind you that Masonic Homes made a submission in response to the original call for the commission for papers, and we also provided comment on the draft report.

MR WOODS: Yes.

MS MARLBOROUGH (MH): Also our CEO made presentation in Adelaide.

MR WOODS: He did indeed.

MS MARLBOROUGH (MH): To provide some context for Masonic Homes here in the Northern Territory, as you're aware we're a not for profit organisation. We have – we are the Northern Territory's largest and most modern residential aged care facility, being 135 beds. We are the Northern Territory's only private retirement villages which in total provides 64 retirement villas along with 12 rental villas, and all embracing adaptable seniors living options that allow ageing in place. We have the Darwin's largest group of formal in home aged care packages now totalling 65 and that is clinical aged care packages EACH and EACH-D.

I first submit that I can speak to you with considerable experience also having worked in aged care in the Northern Territory since 1999. In relation to the support that we give to Aboriginal and Torres Strait Islander people, we do people coming into our facilities, but we do not support services in remote communities at all.

I would now like to turn to two specific matters addressed the commission's report which impact on aged care and accommodation services in the Northern Territory. First the cost of services delivered and accommodation. Operators in the Northern Territory face very considerable additional costs in developing and delivering aged care services.

We spoke a little bit earlier about the cost of providing infrastructure, a brand new facility obviously has – brings with a lot of cost and the other considerable costs involves the risk of cyclone. Every year we face the threat of cyclone and every few years we actually have a cyclone event touch our services. Though fortunately this is

not extended to actually having a cyclone pass across our city in recent years, aside from Cyclone Carlos the even that passed nearby us earlier this year required us to prepare our community for a potentially catastrophic event though fortunately it extreme potential did not eventuate. Despite this the cost to us was considerable and this is no way taken into consideration in our funding.

Darwin is also a location that is remote from all others, and I'm sure that you would appreciate this given your own long journey here today. Nearly everything - - -

MR WOODS: I should add that I lived here for a number of years, from the 70s, so I do understand.

MS MARLBOROUGH (MH): So you're aware.

Nearly everything comes from south and everything of course from south attracts a premium.

Secondly the challenging of staffing, whilst across Australia and probably regardless of industry, staffing presents as a challenge. Here in Darwin it's exacerbated due to the scale and depth of the population asset available. We face a transient population resultant from both the holiday nature of the community along with the large military presence, where two or three year posting cycles impact on staffing tenure.

Some specialist skills such as areas of allied health and senior nursing appointments are most difficult to access sometimes due to competitive pressures, but often due to the near total absence from the region, and this has forced us to reach outside Australia to recruit advanced nursing skills.

Masonic Homes in Darwin has developed a very significant mentoring program to skill up our personal carers. These carers have utilised the skills gained to assist their progress through nursing pre-registration programs through the Northern Territory university, and from the skills gained through the university and consolidated through our mentoring program some of these carers have progressed to become very competent registered staff. These staff are lost to us once completing their courses because they are bound to enter a post-graduate year. If they don't enter that post-graduate year they're not able to work in the hospital system for five years.

So in closing I would like to re-affirm that the loss of these skills from a recruitment and retention perspective is again very expensive. Our turnover in our particular facility is 40%. The incredible energy and intellectual investment that it takes to keep people in aged care is significant.

So just in closing I'd just like to re-affirm Masonic Homes already expressed support for the near wholesale adoption of the Federal Government of the recommendations made in your draft report, and I trust the comments that I've made, although very insignificant in comparison to what others have presented today, merely highlights the appropriateness of them, especially the need to establish a truly independent Australian aged care regulation commission which can take account of

the uniqueness and characteristics that regional locations such as Darwin present and we can thus shed the near one size fits all approach to funding which currently exists.

Finally, may I re-affirm Masonic Homes' commitment to ensuring the best of accommodation and care is made available to senior Territorians and we believe that near wholesale adoption of your draft report without any political interference will greatly assist us in be able to continue to do so.

MR WOODS: Thank you very much.

MR FITZGERALD: Thanks.

MR WOODS: I appreciate that. While we have you here, if we can ask just a couple of brief questions, on staffing do you – have you ever mused over what the on cost to you is as a consequence of that turnover? I mean, you know, do you think that it probably adds 15 maybe 20% either through loss of efficiency because they're learning or the mentoring rather than delivering service directly, the cost itself of the time and the effort of the advertising, culling, interviewing, orientation. I mean, you know, you start to add all of those up and if you're talking about a 40% turnover - - -

MS MARLBOROUGH (MH): Yes.

MR WOODS: - - - what added cost is that adding? Do you have any sort of sense of magnitude?

MS MARLBOROUGH (MH): Look I think it's probably closer – it would be between 30 and 40% I think personally because just – we are going through the process now of looking at how much that does cost. Our mentor program costs a minimum of $6000 just to provide – we've had to put on an educator in our facility and we've had to put on what's called a documentation co-ordinator, and that documentation co-ordinator assists in the education program to help us with our ACFI obviously which is our funding, our one size fits all funding.

MR WOODS: Yes.

MS MARLBOROUGH (MH): And so when we started taking into consideration the cost of our educators, then the cost of our turnover we would have six carers who were personal carers who have just become registered, who are personal carers who have just become registered, who are now in this month, in the middle of the month, going to Royal Darwin Hospital. So all of the training that we've virtually put into those people are now being lost to us. But if we were to participate in the new grad program we could get those skills back, but again there is the cost of actually paying the same price for those post-graduates as the hospital do. So again it's an increased layer of funding that we don't have.

The recruitment of overseas nurses, we've just employed three from Ireland, and the reason for the doing that is because we've been able to lock them into two year contracts with us. They are skilled aged care nurses and so therefore we are hoping that we can – we're able to provide that continuity of care that provides us with better care at the end of the day.

MR WOODS: Absolutely.

MS MARLBOROUGH (MH): But again there isn't any funding for that so, you know, you're continually juggling all the balls and trying to keep them in the air.

MR WOODS: But there must come a point though where the savings you make on reduced turnover start to offset whatever high investment you make by way of wages and professional development and other things that keep and retain staff and make you a preferred employer. So there have got to be cross over points.

MS MARLBOROUGH (MH): Absolutely, and we totally agree with that, which is why we've really invested so much in our mentor program. And the mentor program has already realised so many benefits because the carers themselves have got a level of confidence, they go out there and they are spreading the word. There is feedback from our relatives and resident groups that they're seeing difference and we see difference which were commented on by our accreditation team last week that it's quite evident that these people proud and it isn't always about money, it is also about being recognised for who you are and the value you give to an organisation.

MR WOODS: Can I just – one other one briefly from me.

MR FITZGERALD: Sure.

MR WOODS: And that's you do have a broader accommodation base that you offer, with our reforms which would enable people to, should they wish and their circumstances allow, receive care in their home more, do you see that as the way of the future and where do you see you fitting in that market space, are you going to be building a lot more sort of independent living units or congregate living options or social housing options, what sort of vision does this open up for you?

MS MARLBOROUGH (MH): I think it basically allows us to support people in their own homes. At this stage we don't have any future plans to open any more independent living units or aged care – or independent living units or affordable living housing because at the moment we're seeing that the trend is providing that but also providing care in the home which allows for that transition for us at a higher level of care into the nursing home and certainly not providing – not building any more nursing home beds at all.

You made a comment earlier about the homeless and the ability of facilities to pick up on those people. It brings with it a whole lot of other issues in that those people, the homeless people, end up in Royal Darwin Hospital at a very critical end of their – at the high end of their care needs. They end up staying in hospital for a long time whilst they're comorbidities are being sorted through. But by the time they reach the level of where they require a nursing home bed the process of then identifying whether they have a level of dementia or whether or not they don't, they can make decisions for themselves, depends on whether or not they then need to have a guardianship order put into place. And in the Northern Territory and I'm not quite sure what it is in other areas of Australia that can take up to 12 months. So those

people do end up staying in hospital for quite a long time. They don't – there isn't a stream directly into nursing homes.

MR WOODS: That's a huge cost.

MS MARLBOROUGH (MH): It is.

MR WOODS: And disruption for them. I mean total disorientation, disconnect from family, you know, the whole the bit.

MS MARLBOROUGH (MH): It is, yes.

MR FITZGERALD: In terms of the accommodation costs that you refer to, and you're right we're looking at the issue of regional pricing, regional funding, to what extent did you – your facilities has 135 beds, I think you've got, accommodate cultural needs of Indigenous people at all, and if so does that add to the costs or not? We visited some of the facilities in the Katherine, The Frontier one and others, but have – is that a cost that you've borne so far or is this a stock standard aged care facility that would serve the needs of everybody, but not especially Indigenous people?

MS MARLBOROUGH (MH): It is. It's a stock standard facility that doesn't specifically cater for any one particular cultural group. We do have something like 16 Indigenous people in our facility, and they are part of the community, the nursing home community.

MR FITZGERALD: But there hasn't been – so the cost that we are talking about here are really the costs of simply the location of where you are, the costs of building, the costs of materials those sorts of issues.

MS MARLBOROUGH (MH): Yes.

MR FITZGERALD: You said that you're not going to build anymore ILUs, independent living units, because of the community care. But there is a view, I suppose, that people will still need to move from their current housing into more aged friendly housing of which retirement villages, independent living units, by whatever means, would become an attractive option.

MS MARLBOROUGH (MH): Yes. I guess for an organisation again it comes back to the cost of building in the Northern Territory.

MR FITZGERALD: Sure.

MS MARLBOROUGH (MH): And it is significant.

MR FITZGERALD: Yes.

MS MARLBOROUGH (MH): And so that's something that – I know Masonic Homes have been looking at providing other options in other areas of the Northern

Territory, say Palmerston. At the moment, you know, it's looking at whether or not we can afford to do that.

MR FITZGERALD: Yes, okay, good.

MR WOODS: Thank you very much.

MR FITZGERALD: Thank you very much.

MS MARLBOROUGH (MH): Thank you.

MR FITZGERALD: That's been good, thank you.

MR WOODS: Are there any other persons present who wish to make a current formal, past, new, scheduled statement or have reprieve or reprise.

Please, could you state your name, organisation.

MS FALCKH (ANF): Yvonne Falckh, Australian Nursing Federation position of branch secretary. Just a couple of things that I thought I wanted to make just comment with and if you visited aged care facilities around the Territory you would have noticed that the workforce is mainly overseas nurses. And the point that I wanted to make was that in the remote – in the aged care facilities, Alice Springs, Katherine, Tennant Creek, that the majority of the residents are Indigenous where English is third or fourth language and they have their – they're very Indigenous. You know, we talk about Indigenous about – elsewhere, but these are real Indigenous - - -

MR WOODS: Yes, we understand exactly.

MS FALCKH (ANF): And so they have in themselves a whole range of cultural issues and having such a large migrant workforce within these facilities they have their own cultural – very intense cultural issues from where they've come from. I believe there's a real need to have a very intense cultural training for the workers coming in so that they can have a closer association with the Indigenous residents.

MR WOODS: Client group, yes.

MS FALCKH (ANF): Yes. I just see – I see that such an intense group of the two different cultures at times could be a problem trying to understand and trying to communicate in a manner that they both understand. That really was my main point.

The only other thing is, when I gave you the price of the existing wages, I didn't included Southern Cross, which is coming up, mainly because they're in process of negotiating. We have no staff here in the Territory at this point, nursing staff. So I can't give you the comparison because I don't know where they're going to be at.

MR WOODS: Okay, good.

MR FITZGERALD: Good, thank you.

MR WOODS: Thank you.

MS FALCKH (ANF): Thank you.

MR WOODS: Anyone else present who wishes to – why not. Name, rank and serial number.

MS LESLEY (COTA NT): Robin Lesley, COTA Northern Territory.

Just picking up on that cultural training issue. COTA is funded by the Commonwealth under – to do a PICAC program which is delivering within the multi-cultural community a culturally appropriate service delivery principles, and I find it interesting that there isn't a corresponding one for Indigenous.

So when we're talking about cultural appropriateness that is a – it needs to be redefined, and in the Territory I personally believe that the Indigenous culturally appropriate delivery of services training as is important as the multi-cultural aspect.

MR WOODS: Absolutely. That was an interesting observation. Thank you, I appreciate that.

Yes – no, finished, last chance.

MR FITZGERALD: Good.

MR WOODS: All sold. That completes our public hearings into the inquiry into caring for older Australians, thank you.

MR FITZGERALD: Thank you. Thanks very much.

ADJOURNED AT 11:55 AM