
PRODUCTIVITY COMMISSION

DRAFT REPORT ON CARING FOR OLDER AUSTRALIANS

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MR R. FITZGERALD, Commissioner
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TRANSCRIPT OF PROCEEDINGS

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

In developing the draft report the commission travelled extensively throughout Australia, holding over 150 visits and receiving nearly 500 submissions. I'd like to express our thanks and those of the staff for the courtesy extended to us in our travels and deliberations so far and for the thoughtful contributions that so many have made already in the course of this inquiry. These hearings represent the next stage of the inquiry and the final report will be presented to government in June this year.

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

MR YOUNG (ACAA): Rod Young, chief executive officer, Aged Care Association Australia.

MR SHAW (ACAA): Bruce Shaw, national policy consultant, Aged Care Association Australia.

MR WOODS: Excellent. Thank you for your multitude of submissions and for your ever-willingness to take part in workshops, meetings, consultations, and for helping us to organise meetings and visits with a number of your member organisations. We are very grateful for your significant contributions, it certainly has helped us come to grips with a number of the more detailed points. It would be helpful if you could state a summary of your responses to our draft report, and then we can take it from there.

MR YOUNG (ACAA): Thank you, commissioner. The association has provided a full response to the draft report of the commission and it has been delivered to the commission. We have tabled this morning a summary of our main submission, for your assistance. I'd like to make a brief statement gathering a number of those points together in a fairly short statement. Overall, the ACAA has been very supportive of the general directions and the principles surrounding the draft report and we commend the commission's general directions in endeavouring to create a new

framework for aged care service delivery in the future.

We are supportive of the principles of accommodation being the responsibility of individuals, with an appropriate safety net; everyday living expenses also being the responsibility of individuals, with a safety net; health services should have universal subsidy; and that individuals should contribute to the cost of their personal care, where they are able to do so. The Aged Care Industry Council has, with the commission's approval, sought to add additional detail to the reports, to which you referred a moment ago, detailed analysis of the financial impact. The commission has extended our submission time for that and we are most appreciative.

Areas we are including in that study include the option for the index to be used to convert daily periodic accommodation payment to a one-off lump sum; the mechanism for its determination or periodic adjustment. Providers' access to capital from the Australian Pensioner Bond Scheme is an area which we think is worth exploring at an interest rate that would either be set at zero, similar to the current zero real interest loans, or some variation on that theme. Included in our consideration of that option, we think that the commission might give some consideration to the use of the pensioner bond scheme as a source of funding to assist in the transition of providers who will potentially find it difficult to migrate from the existing scheme to the new.

We strongly support the removal of regulatory restrictions of accommodation payments, including the cap on high care accommodation charges, and believe, as has been recommended, that those changes should be implemented during phase 1. The current ratio between residential community care places should be abolished at the beginning of stage 2, if not earlier, and before any increase in the ACAA residential allocations occur. Early legislation to abolish regulatory restrictions between residential and high care and low care should be implemented.

Process for increase in the Commonwealth contributions for supported residents should commence, we believe, in stage 1. Single-person rooms with shared en suites should become the minimum funding level for supported residents, and establishment of the proposed Aged Care Regulation Commission should, we believe, be a high priority and be enabled within phase 1, as we believe that the creation of the commission is integral to the adoption of the reform process and the early implementation of some of the other reforms.

We have got some concerns regarding the capacity of the Australian Seniors Gateway Agency to adequately undertake all entry point assessments and on the ability within the current scheme, as outlined in the draft report, for the utilisation of the assessment capacity, knowledge and capabilities of aged care providers and their staff to be an integral part in that assessment process, particularly follow-up assessments, given the experience of the industry with existing ACAT assessments

and the accuracy of those assessments and the need for providers to undertake extensive additional assessment shortly after admission to a program or as a person's needs change radically over time.

We believe that there is a strong need for aged care to have an intimate and strategic relationship with the other parts of the health system, primary care and hospitals in particular, and there is a need for aged care networks to be created to provide focal points for Medicare Locals and Local Hospital Networks to be made available. We are concerned that in the guided limited market environment that is being proposed, of which we are highly supportive, there needs to be special block grants maintained or some other specific funding source, that it won't operate adequately within even a limited market environment for special needs groups, particularly socio-economically disadvantaged and in rural and remote communities.

We are highly supportive of the commission's recommendations that the AACRC link future index and cost of care with wage costs. We believe wage movements and economic indicators that allow competitive wages to be paid in this industry are essential. Given that projected growth in workforce is a threefold increase over the next 35 years, there are a range of strategies that will be needed, but competitive wages is an integral part of being able to attract and retain sufficient staff. We have put in our submission some comments regarding fringe benefits, as a number of our members are in the for-profit environment and believe that they are disadvantaged by not being able to have the same benefits where fringe benefits apply. We do not wish to in any way diminish the fringe benefit that applies to the for-profit sector, but we do want to create a level playing field.

We were disappointed that there was not further consideration of the opportunities for information technology applications across the sector. We see that there is enormous potential for service delivery changes for workforce implementation changes and efficiencies to be achieved by a coordinated delivery of information technology, both within the residential setting and the community setting, and the deployment of home based monitoring and assistive technology devices. We were not supportive of the commission's recommendation in its draft report that the accreditation agency be included within the ARCRC. We believe that accreditation should be treated as a quality improvement integrated system and not be part of compliance and should be separate from it.

Our preferred position would be to have accreditation provided to the industry by several providers in a contested market, which goes then to accredited quality systems providers, of which the aged care accreditation agency could be one, but there should be an opportunity for others to provide a similar service. We now have many providers in the industry who operate in the community care domain, the retirement living domain, as well as residential care, and the efficiencies that those providers could obtain in integrated strategic outcomes for their services would be

enhanced if they were able to have a single accreditation system rather than multiple providers.

If it were not the opinion of the commission that the accreditation should sit outside of the ARCRC, then our preferred position at that point would be that there be a third commissioner appointed to have that responsibility. Transition, we believe, will attract much greater attention by the commission in its final report, and we are supportive of it being a multi-layered endeavour which will have various stop-loss components within it that will address certain outcomes and maintain opportunities to take a slightly different course if the initial projected outcomes for some reason meet a barrier or are delayed. Thank you.

MR WOODS: Thank you for that, and thank you for structuring your responses the way you have. It makes it very clear to us where you support in full or where you support in principle but directs our attention to particular issues that would encourage us to either extend or modify in some respect. I'll probably leave transition to towards the end. But with some of the other current issues that I'd like to raise, you talk about recommending that the current ratio between residential and community care places be abolished in the early stages. Do you see as a consequence of that that some current approved licences would be converted to community care packages? Is that what is lying behind some of your proposal, or is there a further change that you would anticipate?

MR YOUNG (ACAA): The current system has approximately 50,000 un-utilised allocated places or vacant places, about 17,000 vacant places. That's hugely variable across Australia. But certainly in most of the metros, many regional and rural locations, there is now quite a gap between previous 98 per cent occupancies plus and the reality today, which is approaching 90 per cent on average. So we have already got a high level of vacancy or decreased occupancy across a large part of the existing system. There's about 33,000 of what they call AIPs, approvals in principle - that is, previous residential allocations - that are in the system. At this stage nobody has an absolutely clear idea on how many of those will be developed. We believe if the current scheme stayed as is, most will remain undeveloped.

You then have the situation where the department changed the rules last year in respect of extra service, and that has then impacted even further upon the development of, particularly, high-care facilities. So in the current formula of 113 places, with the 25:88 mix, where we're still allocating 44:44 of low care and high care, in our opinion that makes absolutely no sense at all. The 72 per cent of the system now has high care classified residents. That transition to a substantially high care system continues unabated, it has been occurring for over a decade, and the next decade will see a diminishing of low care equivalent today, constricted to what we would call high care low care, and the low end of the low care almost exit the system altogether.

Therefore, the issue that we're raising is, what is the sense in maintaining that ratio when the reality of what is being provided on the ground no longer bears a great deal of relationship? At the same time, some people contend we should simply flood the market with community care, and our belief is that if we simply did that, then we would end up with an excessive impact upon residential care and exacerbate the existing oversupply situation. So there needs to be a balance, and that balance, probably in many respects, needs to be driven by what providers, both community and residential, see as their demand in local communities. There's probably little evidence, I think, that continuing to have that allocated in a centrally-controlled manner is necessarily serving either government or provider benefit and, certainly, consumer choice.

MR WOODS: Thank you. I find that a useful way forward of opening up all of the places that are currently available but not utilised, to then let providers work out where the demand lies. We will certainly discuss that in the commission.

MR YOUNG (ACAA): There is a second component to that, if I might, and that is we do have those excess supply situations. Should we be actually asking the question, "Do you wish to convert these, as providers? Do you wish to indicate under the new scheme whether you will be utilising them and deploying them and, if not, should we be putting them back on the open market?"

MR WOODS: Yes.

MS MACRI: Can I just ask in relation to that, in talking with one provider there was a little bit of a thought even taking it beyond that and saying, in terms of that vacant bed, that there should be capacity for greater flexibility for that care to be then provided in the community and, at a later stage, recommissioning the bed. So greater flexibility around the whole principle of licences. What are your thoughts around that?

MR YOUNG (ACAA): Given where the draft report, in its final form, is likely to go - and that's making a prediction - but logically at this stage, if we are going to say in the future, "There will be no licensing, other than maybe in quite specific targeted areas, either geographic or service type. But there will be no licenses in the broad." Therefore, what you are suggesting is what the system is to become in time. So the first step down that path in some controlled way, that lets some flexibility occur, obviously makes some sense in our view.

It is quite ludicrous, I believe, at the moment, for providers in particular locations, of which I'm aware, who actually can't fill their residential care places and have applied to the department to allow them to use those places for community care purposes, of which there is a client base, and they are told, "No, you can't. It will

breach the ratio rules." That, in my opinion, makes very little sense. To free up the provider's choice to meet their demand, to meet the client's wishes, would make a great deal of sense, and to do that gradually as we transition into the final outcome, which is going to achieve that objective universally anyway, would make sense for the system to be able to modify itself over time.

MR WOODS: Is the second stage of that then, given that we now have gone into transition, for future offerings, if we're going to do a phased five-year period of progressively opening up the quantum of places, packages, until we move to the new system, to allow all of those again to be open for providers to suggest whether they be community or residential? If so, does that have a potential impact on the residential sector who have got significant investment in their built environments, or would you support or propose that there still be some differentiation so that residential can be opened up in a more controlled manner?

MR YOUNG (ACAA): There are arguments in favour of both propositions. However, I think that there is a need for us to allow the system to evolve and do that in a controlled fashion over time. I absolutely agree that there is considerable investment tied up in residential care. However, at the moment, just using an example I gave a moment ago, if you want to convert, you can't. To allow providers to have that option to meet their local need is part of what I think could be a controlled release over time and take us into the transition process.

If we look at: will government have an ACAR round in 2011 - that's still uncertain at this stage; let's assume it's 2012 by the time we get to the next round - does it make sense for government to actually say to the industry, "We're going to release 12,000 places, tell us what you think what your local needs are," without specifying that must be so many places in high care, so many places in low, etc.

For many years we have recommended to government and Department of Health that there needs to be a whole-of-business approach to the license allocation; that if you're a corporate operating across multiple regions and multiple state and territory boundaries, it makes no sense to say, "You can have community care places here, none of them there, and 100 over there, or residential." It really makes much more sense to be able to say, "Tell us what your business plan is. Where do you think you need places, where do you think your demands are, and what sort of demand do you think you're going to have."

Which leads me, I think, into the whole area that tends to get ignored in this process, the whole retirement living, seniors' housing environment, the provision of a range of services into congregate communities is an evolving environment in which we're already living; it almost gets ignored in the decision about allocating places. In reality it is significantly changing, the demand upon residential care, the type of servicing that's happening. You're getting groups like Seasons in Queensland

claiming that they're providing an almost total whole-of-life solution. That is disputed in some quarters but, nonetheless, that's their claim.

So I think we need to be far more flexible as to how we are able to join those dots in the future and allow providers to meet local demand, and remove some of the restrictions that have historically been there. I would really make a plea that, in this transition process, the department actually looks at any future allocations in a whole-of-business approach, and what the business is endeavouring to achieve over a three to five-year time frame.

MR FITZGERALD: One of the issues that's arisen in the hearings so far has been that once we remove licenses for residential care, how do we guarantee the equitable spread or distribution of those facilities? Currently people can argue the licensing arrangement is not achieving that either, because people aren't taking up the actual beds or building the beds. But I was just wondering whether you have a view as to how you answer that question: how will the government ensure that there is equitable spread, in a distribution sense, of residential aged care facilities? It links to the issue about block funded and, what you call, targeted licensing. But just your views on that?

MR YOUNG (ACAA): We haven't got an equitable spread now. The best balanced state is probably South Australia, between supply and demand. There is far more demand in north and far north Queensland than there is supply. But you go further south, Gold Coast, South Coast, Brisbane and there is excessive supply over demand. So the spread at the moment is uneven. I don't think there's any way that you can absolutely guarantee that service provision will occur, except that we know that the demand upon services are going to grow because of the demographic change. That will in itself drive providers to service markets that are the most - certainly cost effective but also where their client base is going to be. There will be some variation in that, as we touched on a little while ago. There will need to be some direct government support for specific needs groups, for specific geographic groups to ensure that service provision is maintained. But I think there will be enough demand at a variety of service levels across most metros, regional areas et cetera for that market drivers to ensure that there will be sufficient capacity.

I think probably the more important question is what's the mix going to be and where are the drivers from the client base going to occur, because they've got a particular view that baby boomers, about which we know very little in this space at this point in time except what they are doing by way of purchasing for their families and parents, will be - we've done a couple of surveys jointly with Bankwest and Fujitsu. Some of the information out of that clearly indicates that the boomer group are going to be a group who will want to have consistent supply, a continuum of service provision - that is when they get past the avoidance of the issue altogether, because they're not going to need services of any sort. But they will need to have a

strong and useful and effective relationship with a service provider over a continuum of care when they get to the point of actually requiring a service.

MR FITZGERALD: Moving on just a little bit in relation to block funded services. Do you have a clearer view as to what sort of services, either community care or residential, should be block funded? Obviously we believe that there are some circumstance where block funding should remain, but we haven't been getting too many submissions that have actually been very helpful in saying, "These are the sorts of services that should remain block funded." I was just wondering whether you or your members have a view as to what the criteria for block funding would be.

MR YOUNG (ACAA): I think this is a fairly broad answer, but a couple of examples are put on the table. A service such as Wintringham in Victoria, which you would be aware of. It fares fairly poorly under the ACFI funding arrangement because of the nature of their client base. When you think about what it actually was designed to do that's not surprising, because it was meant to shift funds to high-end care. So services like that that are specifically targeting lower socio-economic groups with a particular focus on maintaining their services for that group rather than 10 per cent of the client base or something like that - they obviously need some sort of additional funding beyond the standard subsidy from government. The additional component is that there almost will never be in that group any individuals who will be making a co-contribution, for instance.

MR FITZGERALD: Sure.

MR YOUNG (ACAA): Services that are truly rural or remote, indigenous et cetera will almost certainly require some sort of additional funding. I think our viability supplement at the moment is fairly inadequate at actually addressing some of the cost differentials for those services; needs to be better targeted. Probably needs to have some sort of ongoing budgetary submission from those groups to indicate what their cost bases are and to be able to put government as a block funder into a better position of understanding what their needs are, rather than a universal viability supplement that has some fairly interesting outcomes when you look at the sites that are a certain distance from capital cities, which are actually quite large cities in their own right, still getting viability funding. That doesn't make a great deal of sense.

Some of the future groups - as we move from disability into aged care, some of those issues may well attract the need to have block funding for special needs groups that have particular disability or long-term care and support need beyond the standard.

MR SHAW (ACAA): Robert, our submission was sort of - our submission, the bigger one in response to the draft report, has a page and a half on pages 8 through to 10 talking about those sorts of issues.

MR FITZGERALD: Thanks.

MR WOODS: Can I then move on to the issue of the periodic charge and associated bond. Some of your response to us looks at how that relationship could be established and whether it would be appropriate or not to have some form of adjustments and indexation. Could I explore with you an alternative proposition and get your views on it. That is that given we are proposing that the periodic charge be set by the operator of the facility for non-supported residents in a market context, and that that be a mandatory offering and that it be a published offering - so that people can fully understand what is the price being charged on a daily or weekly rental type basis and can examine the quality of the accommodation and compare it with other offerings - is there merit in adopting the same approach for bonds? That is, rather than try and form a formulaic relationship to the daily charge, that similarly provided the bond is published and known that providers can set that bond independently of the periodic charge?

Clearly, to the extent that there's some gross distortion between the two, you're going to drive behaviour one way or the other. If the real impact of the bond was twice the equivalent daily charge of the periodic charge you're not going to get too many takers, especially as we remove the other incentives to adopt a bond by way of retention of eligibility for the aged pension et cetera. But what are your views on that?

MR YOUNG (ACAA): One of our concerns was the lack of incentive in the draft scheme for future clients to pay a lump sum contribution, so I think what you're suggesting is certainly well worth substantial exploration. Our research would indicate that bonds in the main are reflective of local property values in the order of 60 to 80 per cent - so call it 70 per cent - of local property values tend to be the sort of average that providers will attract by way of a lump sum payment. That's already substantially the case. I won't comment on obviously part of the commission's objectives, and that is to remove the Super Bonds. We don't believe there are that many of them but we certainly do understand the rationale for trying to remove those from the system.

But there are lots of circumstances, particularly in metropolitan areas, where you will get the local housing prices well over \$1 million, and you will see providers attracting a bond in the \$800,000 range, for instance, in those sorts of circumstances. So it comes back to that roughly 70 per cent type of market reflection of local property values. I think if we're aiming to sort of have something that will produce a result in that type of arena without legislating and regulating it to that extent, that would be a very acceptable outcome. The requirement that you tie the periodic payment specifically in some formulaic way with the lump sum may often be rather limiting to the actual cost of construction and capital, in particular, particularly

high-cost inner metropolitan areas.

MR WOODS: Because in fact one of the potential advantages of not tying the two together is that it would allow the individual provider to look at their balance sheet and their debt management, and if they felt that they needed to encourage more bonds it could offer them at a discount relative to their periodic charge; whereas if you introduced a formula, that would not produce that outcome. On the other hand, if the offerings of bonds are significantly higher than the periodic charge, then behaviour will tend towards the periodic charge anyway, so there would be some self-regulating behaviour of most people.

MR YOUNG (ACAA): I think the intent of the commission's draft paper that both amounts be published will in many cases have quite a controlling effect because, provided there are two providers in an obviously geographic location and if one person is offering a \$200,000 bond and the other 500, you are going to have to significantly differentiate your offering in the market, otherwise you're not going to get very many clients, I would suggest.

MR FITZGERALD: I was going to talk about entitlements. One of the issues that we still need to look at is the nature of the entitlement that the consumer can take to a provider, particularly in relation to community care. I was wondering what your association's view is to what that entitlement should look like. One of the issues that we haven't resolved at the moment is exactly how prescriptive or how flexible that entitlement is. We've looked at this notion of a building block approach in terms of assessing the need, but as we've been going around, there has been some concern that that doesn't translate into very precise prescriptive entitlements; rather, it's more flexible and the notion of bands or layers would be sort of mooted again. So I was just wondering whether your association has any view particularly around the nature of the entitlements or not. I'm not sure if it's in your response.

MR YOUNG (ACAA): I don't think we did address - we addressed the issue of entitlement and supported it, but I don't think we addressed what the entitlement should encompass. I think our view to date had really centred on the assessment process and what that would detail as far as somebody's entry into some form of care recipient status. The next stage is something that we do need to avoid being prescriptive because if we really are going to give future clients choice, there needs to be, "Yes, this person needs some level of support," but that level of support may vary significantly from person A who gets exactly the same assessment at entry and person B, who gets exactly the same assessment at entry. So I think there's got to be two quite different processes; one is an assessment that you have met the criteria for entry and that you now are entitled to some level of service. But if that person determines that they want X, Y and Z, and this person determines that they want A, B and C, if the prescription simply says, "You can only have these suite of things," do you radically change from what you've got today by way of our service

offerings within HACC and CACPs? Probably not.

So if we are going to let clients have much greater choice, I think we have to leave that case management service selection process negotiation far more flexible than actually having prescribed services that will fit each band of assessed service need.

MR WOODS: Can I pick that up in the context of one of your points there about the role of providers in reviewing assessment after entry, and that can include entry into community care as easily as entry into residential care. We certainly see, particularly in residential care, that current arrangements - whereby it's the provider and more particularly their staff that are intimately aware of the situation facing the resident and therefore best placed to trigger a change in service delivery - that that would continue and probably to either the same or similar extent in community care, although it is a slightly different context in which the care is being delivered. So we don't see significant change in that. But it does raise the question of, at the moment, managing the 64 points in the ACFI, whether that drives the behaviour of trying to identify a change that will produce a different financial outcome and whether that's taken away the general intent of caring for that person in their circumstance and their various fluctuations around a sort of mean position for a period of time and then a significant change in circumstance triggering some additional quantum of care. So we can see some value in what was behind Robert's question of how can you broad-band it but still make it relevant to the situation of an individual. Your providers would play a role in that, just as they currently do, but it would give you more flexibility. Does that give you some assurance about the post-entry process?

MR YOUNG (ACAA): I guess there's a couple of things that need to be considered there. One is if the gatekeeper makes an assessment and the assessed needs of the person, then deign that they are entitled to a level of service - let's take the example of a person who would maximise their voluntary care environment if the voluntary carer can be released from their caring every weekend so they can visit or socialise, whatever their needs may be. Do we have a service provider who actually has in their offering a weekend live-in carer support offering? Maybe, maybe not, if you've gone to provider A. Is it provider B that you actually need if that's the only service support that that person needs? So it's that front-end case management that we really need to I think have upgraded to a significant level to assess what those needs are and then to determine a system and negotiation with an appropriate care provider to meet that person's choice of service offering.

Now, there will be many circumstances where you will have community care providers who won't offer that type of service, but that will maximise that client's outcomes if you can provide it because that's what they're really after. I think it's how we actually generate that sort of extended service offering across our provider base to provide that level of flexibility. If we don't achieve that out of this reform, I

think we've partly failed because it's that that we need to be endeavouring to try and deliver.

MS MACRI: I guess going with that is where it fits into the cost model of that as well. I mean, one of the things I guess that's been important is around still trying to keep some constraints on the cost of that care as well, because you're opening it up, in terms of the number of people accessing care, and there needs to be some rationale around what's constituted and what comes into the cost of that care.

MR YOUNG (ACAA): And I think that's one of the biggest difficulties for an entitlement program: how do you actually constrain the costs and protect the Commonwealth's exposure to future fiscal outlays because you are going to have an entitlement. If you look at an equivalent type of entitlement system, Medicare, the way that you manage that is you change the criteria at entry and you change the rebate you pay your service providers, mainly medical practitioners. I'm not sure whether the government will go with that, but at the end of the day, I think we're all supporting an entitlement for a range of systems' improvements. But yes, there will obviously be some pressure from the Commonwealth as to how you either control the criteria for entry or what they pay at the end of the day for service provision.

MS MACRI: Or the service provided and the cost of that service.

MR YOUNG (ACAA): Or the co-contribution that the client makes to offset some of that expense.

MR SHAW (ACAA): Could I give a couple of other examples. Rod referred earlier in the presentation to the fact that aged care is already evolving, so that when people, consumers, are in the system, their needs change and that needs to be taken into account and that's where the review system needs to come into operation and it shouldn't be distant. It really should be in-house. When, for example, people are deteriorating, they either are developing dementia or they have palliative care needs, for example, there needs to be the ability for the system to accommodate that, so that they don't just get forced out into acute care hospitals which is a sort of major cost impost for the whole of the health system, whereas they would be much better off staying within either the residential or the community care setting that they are in if that can accommodate it.

MS MACRI: There's the reverse of that, in terms of whether somebody is receiving needs initially or services.

MR SHAW (ACAA): And they may improve, yes.

MS MACRI: And they may improve.

MR SHAW (ACAA): Of course.

MS MACRI: The problem at the moment is that people hang on to services because if they leave them it's too hard to get back in. So there's a perverse incentive - - -

MR SHAW (ACAA): Indeed, you love perverse incentives, yes.

MR FITZGERALD: Just a final one, it's one that you've canvassed previously but I want to canvass just again, is the issue of the accreditation body. You've gone for the model which I think even the commission previously had looked at which was a sort of a competitive arrangement in relation to accreditation agencies. In our report we have now gone for a single accreditation agency within the regulator. I think we were going to put it under a commissioner, which is your alternative suggestion - so I think we were going to do that. Can I just explore again why you don't believe our model is appropriate going forward? We have different views about it but why are you so opposed to that sort of model?

MR YOUNG (ACAA): Basically because when you go back and look at most accreditation systems, such as the one we have in this industry, they are meant to provide frameworks for systemic improvement over time. They are generally not created to be compliance components of a rigour regulatory framework, they are meant to improve systems. So if you actually looked at what was intended back in the 90s, the agency was to become a partner almost. Where it found failure there's no doubt it has to report that to the regulator, and the regulator is the Department of Health and Ageing or, as recommended in the draft report, the AACRC, but the quality systems improvement environment should be in partnership with the industry. It should be transparent. It should clearly assist the industry to go on a path of improving its systems over time through a variety of different methods and a variety of different strategies.

When you mix that with compliance, then it becomes part of the compliance environment and it becomes a systems, "We must do this because the compliance regulators will come and bash us up if we don't," rather than, "We are doing this because it's for the benefit and improvement of our quality systems and for our clients." They're two subtle but quite different mindsets. There is no intention in our recommendation to avoid the agency having a reporting responsibility if they find failure. We like failure as little as the department does, or the minister of the day does, I can guarantee it, but nonetheless it does substantially, I think, change how the system operates and what you're trying to do to maintain and raise the quality systems and quality outcomes across the program.

MR FITZGERALD: Thanks.

MR WOODS: Lots of things that we could explore here but we know how to find you.

MR YOUNG (ACAA): Mr Mersiades is awaiting your attention.

MR WOODS: So thank you for that. Thank you for the very comprehensive nature in which you have responded to the draft and, as I say, it's easy to follow and we can see where your views are and where we should direct our attention. Thank you.

MR YOUNG (ACAA): Thank you very much.

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

MR LAVERTY (CHA): Martin Lavery; I'm the chief executive of Catholic Health Australia.

MR GRAY (CHA): Richard Gray; director aged care services, Catholic Health Australia.

MR MERSIADES (CHA): Nick Mersiadis; aged care adviser, Catholic Health Australia.

MR WOODS: Thank you very much. Thank you for your many contributions. I think your submission was either submission one or very close to, your very first one, and you have been providing us with extensive input ever after, for which we are grateful and it has kept us many nights, but not sent us to sleep I might add. Do you have a statement that you wish to make?

MR LAVERTY (CHA): If we can briefly, yes.

MR WOODS: Thank you.

MR LAVERTY (CHA): Can I take this opportunity to thank the three of you and the commission for the way in which you've gone about the consultation process that has led to today and hopefully leads to a final report that I have no doubt is going to be widely embraced by aged care providers and consumers. I was fortunate enough to be with the aged care minister on the morning that your interim or your draft report was released and the minister chose a very interesting set of words. He said that the report at that point had only just been received, the government hadn't had the time to consider it, but the government's eventual response would be to ensure three things: that consumers were given better access to aged care, that consumers would have better choice in the types of services they sought, and finally he said that he wanted to ensure a sustainable system into the future.

Now, you will appreciate these words share much in common with the aspirations of aged care providers and also of many consumers - individuals and consumer groups. We think the work of the commission that was released in the draft report meets those three expectations. That is the test that we've set for the type of aged care system we would seek in the future; one that guarantees proper consumer access, better choice for consumers and sustainability for the industry. We think you've done a very good job in providing those options.

We've given to you a submission in response to your draft report that points to some areas where we think some enhancements and focus could be given. Rather than wander through that I thought it would be useful to give you the response that the religious congregations, the heart of Catholic Health Australia - who run principally smaller aged care organisations - to give you their response to the draft report. You'll appreciate that the Catholic church has been involved in aged care in Australia for in excess of 185 years. There are 74 different organisations that run Catholic aged care services around Australia that form part of our network. Some of those run organisations that are very large, that have hundreds upon hundreds of beds, and then others, the ones that I'm focused on this morning, operate 40 beds or less.

We gathered those 17 different approved providers that operate 40 beds or less in Sydney in May. They're run by 16 religious sisters and one group of religious brothers. All present had read your report cover to cover. They were well possessed of the recommendations that you had put forward. Their response was what the commission is now proposing, what the industry, what Catholic Health Australia is supporting, is very similar to the types of changes that religious organisations went through in the 1980s when they were required to professionalise the way in which they ran their schools. They drew a similarity to say, "We were confronted in the 1980s with changing requirements of government, the requirement for us to professionalise our staff, but we are grateful that we were taken into that need for reform." The groups that were with us in Sydney, those 17 religious organisations that run small Catholic aged care organisations, they encourage the commission to continue the directions that you are heading in. They encouraged us to support you in continuing the reform agenda.

The discussion however did, not surprisingly, indicate a few challenges. The first is that even with organisations that were very experienced in running aged care over many years, in reading the report they were still in the process of unpacking the extraordinary impact that deregulation will have on them. Their tests were: how will low income Australians fare under this new model, and there was an immediate interest in the mechanism by which a new pricing authority would work to properly test and set the way in which aged care was costed and funded. They make the point that we currently have a mechanism within the Australian government that provides a price regime for the way in which aged care is funded, and that there's not a confidence that that system has in the past provided a subsidy or a regulatory environment that's provided revenue that actually meets the cost of delivering care.

So they were quite focused to ensure that if the interests of low income Australians, concessional residents in aged care, are to be properly provided for, that new pricing mechanism must genuinely do its job so that the funding available, either through consumer contribution or through public subsidy actually equals a real cost of providing that care. We know the commission is sympathetic to that, but to

hear that group underline this as important for the interests of low-income Australians I think is quite important.

They also spoke about what deregulation would mean for them as individual organisations. They recognise that the new competition that is coming is going to have benefits and downsides. The benefits, the overwhelming benefit, is that many of them as small aged care providers have been locked out from accessing community care packages. The immediate opportunity for existing and capable skilled providers to potentially expand into community care through a freer market they think is going to allow them to better respond to community or consumer need. That is an overwhelming benefit that we commend.

The downsides, which were the impacts of a free market, to them said, "Well, in some cases it means we're going to have to improve the quality of our offering. In some cases it means we are going to have to market ourself to our local communities and through the new Australian Seniors Gateway. That wasn't put by these small organisations, who are not flush with resources - that wasn't put as a barrier. Rather it was just put as a necessary part of providing aged care in our time. So you will hear from those observations of not-for-profit providers, of religious sisters and brothers, who are long established in aged care and who have been going through a process of professionalisation in any case. They are encouraging this reform direction that you have articulated to proceed, but they are pointing to some of the business implementation challenges that they will face. So their advice is go at a gentle pace in implementing this reform. Do your best as a government to put in place those mechanisms that make the reform process not unnecessarily painful for the consumer, who is a recipient of a service that is going to have to undergo certain amounts of change. So I will pause there if I can.

MR WOODS: Okay.

MR LAVERTY (CHA): But I thought that might be useful - - -

MR WOODS: Yes.

MR LAVERTY (CHA): - - - to indicate the interests of smaller aged care providers, religious-based, who are not-for-profit, noting that our larger providers within the Catholic Health Network also have a set of issues; but we think all of the challenges that are ahead of us can very easily be managed.

MR WOODS: Thank you for that. I might use, as a bit of a guide, the points in your executive summary as a checklist of things that we'd like to discuss with you. Your first and third points - the first being that your support for the package is conditional on accommodation payments actually reflecting market prices, either rental payments or bonds; then your third one about a conversion of daily rental to

bond equivalents. Could I explore with you that if we are proposing that the daily rental or weekly rental, the periodic charge, be set for non-supported residents by the provider - whether we could also do away with a formulaic nexus between periodic charge and bonds and allow the provider to also set the bond; recognising there would be some self-regulatory behaviour if the two got significantly out of step by a provider that it would drive behaviour one way or the other.

MR MERZIADES (CHA): In principle, if the provider is allowed to set the price or the accommodation charge or the daily rental, there is no reason why the same principle shouldn't apply to the bond. It should be the same - the same consideration would come into account: the depth of the market, the quality of the accommodation, the perception of the quality of the service. So in principle there's no difference. But at the same time there is a perception out there that the bonds have been, in some cases, higher than they need to be from a consumer point of view. I could understand the rationale for wanting to present it as there being a control there to control the level of the bond. But in principle - you know, if you apply just straight economic principles - there's no reason why you control one and not the other.

MR GRAY (CHA): Well, in effect, providers set the bond price now. I mean we know there's - under the act there's an asset test, but the reality is that when the consumer wants to access a service for low care and they ask what the bond is, the provider will say, "We want X amount for this bed." It's then the consumer's decision whether they are prepared to pay that or not. Now once, of course, it's extended into high care, well, of course that changes the equation. But the pensioner bond scheme and clearly the capacity to pay a daily rental as an alternative, a published daily rental, will be significant mitigating factors against, I would think, many people choosing to pay a lump sum bond. But again, it's a consumer choice, I would have thought, knowing that - the market price advertised by the provider is a known piece of transparent information which is not currently available. You've actually got to ask, "How much do I have to pay as a bond?" as opposed to it being publicly available information now.

MR MERZIADES (CHA): A concern with both the market rate and the bond would be the depth of the market at this stage, given we're coming from a situation of controlled supply. But that concern would apply to both means of payment.

MR WOODS: Yes.

MR MERZIADES (CHA): That's why in other contexts we think that the current process of having increased the supply of community care, which has been going on gradually now for quite some time, should continue, to give people more choice as well and to take some of that market power away.

MR WOODS: Given that the two issues of the offered cost, which is a transparent amount, and the market power of the providers are inextricably entwined, that raises the question of transition. It has been put to us that one option as a starting point would be that wherever there are unutilised or un-operated beds that current providers should have a choice of whether they convert them to residential care packages and also to abolish the relationship between high care and low care, which has largely become an operating fiction anyway. Would that make sense as a first step? Then your views on whether you would still have some form of progressive opening of the residential component over time to allow a more orderly transition, given the built investment at stake, over say a five year period.

MR MERZIADES (CHA): We would support that flexibility on the outset of the providers being able to convert residential to community, it's a logical step. Also, we would favour a gradual loosening of the supply constraints on community care. Bear in mind that is what has been happening, particularly in the last five years. We're now up to 25, and residential from its original 100 has dropped down to 88. So there has been this adjustment process going on, and all we're doing is continuing it.

MR WOODS: Would future ACAR rounds during the transition phase - is it an option to keep them open and allow providers to come with proposals that fit into their total business model, rather than prescribe how many should be residential or how many community?

MR MERZIADES (CHA): We think that for the next ACAR that we should start on the process of continuing that transition by not trying to guess what the market response will be out there. Providers are already in a situation where they're thinking over the implications of these recommendations. The sooner they get start responding, the better. Not only the providers, the bankers - they will all be having this mind.

On top of that we do know that there is an under-subscription, under-application for residential places and in the last couple of years, the department has had to modify its original advertised allocations anyway, so why put yourself through that same process. Instead, let's anticipate where we're going and opening the system up from now.

MR FITZGERALD: Just related to all of this, the supported residents thing, if we can just deal with that for the moment, as you know and as you've indicated, you support the notion of regionally set quotas for all providers of residential aged care but you've not supported the issue of tradability in those regions. I'm just wondering if you could explore your reasons for that position.

MR MERZIADES (CHA): Our first position would be that in an ideal world, we wouldn't have quotas, on the assumption that if the price was set correctly, there

would be an appropriate response. But we do recognise that during a transition period, you can't be certain of that and you need safety nets, and that's why we're talking about continuing the regional quotas at least through the transition period, but taking up your suggestion also that those quotas be modified to the socioeconomic circumstances of each region rather than arbitrary 40 per cent across the board.

MR FITZGERALD: But the tradability of it?

MR MERSIADES (CHA): I guess the biggest issue around the tradability is that I'm not sure in a practical sense there would be much interest in it, because there's a financial transaction involved, there's a significant assessment of your business directions involved and if I understand your proposal correctly, it would be subject to review within a few years. I'm not sure that people would be interested in making those sorts of financial commitments when they don't know what the ongoing arrangements are going to be.

MR GRAY (CHA): Also, I think the provider that actually decides to acquire the traded places would then be regulated about having to actually fill those places with supported residents, so I think that would impose a higher regulatory hurdle for those providers. They would have to be sure they're going to be able to meet the traded level of supported residents and I think that would be a bit of an unknown quantity, given the potential changing nature of how supported residents would be identified with the home becoming an element of obviously - well, certainly not being excluded any more from determining a supported resident.

MS MACRI: Would you see then, Richard, just in terms of this, that providers would all be required to take a proportion, and how would you see the transition perhaps around extra service and non-extra service facilities through this period?

MR GRAY (CHA): I think there is certainly an argument for an extra service being able to accept supported residents and receive the supported residents' supplement. I can't see why, if a supported resident is placed in a residential aged care bed, that person shouldn't be able to attract the same level of subsidy as if they were in a non-extra service, because they're getting the advantages and benefits of being in the extra service and they're getting a place. Surely that's the critical key factor, actually ensuring that they are placed in an appropriate residential aged care service.

MR FITZGERALD: Just on that, you're saying that you open up the option for extra service providers to be able to take supported residents but you don't actually compel them to take supported residents, although one of the peak bodies the other day indicated that after a period of 10 years, that should disappear and that everybody should be on the same playing field.

MR GRAY (CHA): Under your proposed reforms, extra service will effectively disappear.

MR FITZGERALD: Disappear, so that will happen anyway.

MR GRAY (CHA): Yes.

MR FITZGERALD: That's right. In relation to the supported residents, the other issue, and you've canvassed it there, is how it should actually be set and the price that the government should pay for that and whether it should be based on the current specification of 1.5 beds or should be on two, as we suggested, or should be on something else. Can I just clarify your position as to what the basis of that payment by the government should be, what it should be paid on?

MR MERSIADES (CHA): Are you suggesting we nominated a different ratio or a different - - -

MR FITZGERALD: No, I'm asking what ratio have you got.

MR WOODS: You've got a view there of a combination of single-room en suite and two single rooms sharing an en suite. I mean, is that an end claim or is that a firm belief based on some evidence of something that we're unaware of?

MR MERSIADES (CHA): It really reflects what has been built in recent years in terms of where providers are responding to where they think the market is going, and bearing in mind they're building something that's going to be there for 30 years or so, so they don't want to be left with standards which are yesterday's standards. But how you translate that into a formula, we haven't taken that step. We're just suggesting that you need to move further in that direction.

MR GRAY (CHA): It also fits in with Nick's earlier point about if you set the price right, you wouldn't probably effectively need quotas because access would be there, so it would ensure access. But I think at worst, it should be set at 1.5 places per bedroom.

MR FITZGERALD: Could I specifically talk about smaller facilities. You've indicated that you've had the meeting with the congregations and their general support of the arrangement. One of the issues I just want to understand is that a lot of the small facilities were originally low-care hostels and they have been increasingly taking high-care residents into them. But in many senses, they are on the surface not viable facilities. Now, you can argue about viability; some operators were able to make a 40-bed facility very viable, whereas others failed to do so, so there's a great deal of variability both in terms of location but much more significant in terms of management.

I just want to ask you - you do have in your members' ambit quite a large number of small organisation - what are the particular concerns that we need to be mindful of, both in the transition of the ultimate package for the small operators which really have quite old stock and frankly probably not appropriate stock for many more years?

MR LAVERTY (CHA): There is some thinking going on within smaller Catholic providers that I think is useful for you to have some insight into. Last year, we undertook a mere 18-month process; we engaged PWC for external support to look at the future viability of the Catholic aged care network and to make some very specific recommendations to different parts of the Catholic family about how they should be planning their future.

Many of our individual smaller aged care operators know that scale is relevant to their financial viability, that scale indeed is central to their ability to provide quality. There are different drivers in different parts of Australia as to where scale is relevant. I don't need to tell you that in a country town, a smaller scale is perhaps necessary than perhaps in a metropolitan city.

The response of the 17 small religious organisations who operate providers of less than 40 beds is that they recognise that they need to diversify their businesses to remain viable into the future. I think you should receive this news as I think a positive endorsement of the directions in which you are taking the commission, that this group of operators is not looking for a handout in the traditional sense that you might expect a small not-for-profit provider to interact with government. They're recognising that the impetus on them is around evolving their businesses so that they continue to be viable and continue to provide quality. What they ask out of that is the right phasing of change such that they can respond and cope.

They're also, in that, focused very much on how they can ensure that the system enables them to hold on to their staff to compensate and remunerate their staff appropriately during that process. There's a degree of - I don't want to stretch it too far - selflessness about where the organisations see their own future, but they are more motivated around ensuring that the care is available to the recipient and that the staff are properly remunerated than they are around their own participation in those services. So they have been very pragmatic and very practical, but they are saying, "Don't move too quickly," as a government - the Productivity Commission in your recommendations to the government - "Don't require us to move faster than we're capable of doing," so that there is an avoidance of business disruption for consumers, for our staff within local communities. So if you will take that as a global statement that is applicable to how their thinking is, they're not looking for government to do all the heavy lifting, but they are looking for some assistance in how they need to prepare their physical facilities to be more competitive in this new world. Very

particularly, how they're going to relate to the Australian Seniors Gateway; that's not yet clear as to the role that the gateway will have in the referral process as to the consumer coming into the service. We recognise that part of that is going to need to be the skill of the operator to establish that link with the referral path.

MR WOODS: It won't be a referral. It will be an entitlement and, "Here are a range of providers in your area, for your information," but not referral.

MR LAVERTY (CHA): Understood. But you'd appreciate a larger operator with a deeper pocket for greater marketing within a community.

MR WOODS: Yes, a separate question.

MS MACRI: So what's the smallest of these facilities, Martin?

MR LAVERTY (CHA): There is an approved provider that has six licenses on the south coast of New South Wales, up to - the average that we're talking about in these smaller are between 30 and 40, and most of them are located within metropolitan areas, still under the governance of religious congregations directly, professional staff employed and, obviously, meeting accreditation standards. But the religious, in these particular instances, are very much still attached to the oversight and delivery of the services, as they have been for generations.

MS MACRI: Would they see, in the smaller facilities, is that in terms of looking after their own religious people or is it community based?

MR LAVERTY (CHA): A very small proportion; there is certainly a component of care for retired religious, but that's a small proportion. Most of these are community-accessible services, long established, mostly with relatively old stock that in a new competitive environment would need upgrading. But how we and the approved providers are looking at their futures is to make the business changes that are going to be necessary, either through adjustment of scale, through expansion of services into community, and the necessary capital upgrade, but also the other side of the equation; the discussion has been had around whether or not those services continue to be in the years ahead. That's why we underline the appropriate speed in which, for these small providers, reform is achieved, so that they can progress under that new environment gently.

MR WOODS: While we are talking smaller providers, your second dot point is one-off financial assistance for eligible smaller providers to seek business planning advice. If you were to operationalise that, do you have other examples that you would call on to indicate the quantum of funds involved and what you would consider to be a smaller operator; is it somebody who has no more than 200 beds, which would mean that it's somebody with up to two or three facilities on average?

Also the danger, I recall, in some of my other inquiries, that where financial assistance grants were provided and, say, for example, it was a 20,000 grant, it was amazing how many financial advisers offered a \$20,000 financial assistance package. One wonders whether, if it had been 18,000, whether, miraculously, that the cost of the financial assistance would somehow turn out to be 18,000. So there are all sorts of distortions that these things can introduce, but what do you mean in a practical sense?

MR LAVERTY (CHA): If we can point you to the illustration that FaHCSIA pursued at the end of the 1990s, where they made an allocation of, I think, about \$90 million over a few-year period which supported disability providers funded by the Commonwealth to review their business practices. There's many illustrations of where these types of things have worked, but I think this one has direct applicability to what we're proposing.

That fund was available for the services you've described, for financial and business planning, but it was also available for small grants to achieve implementation of business improvements. So if we go back to the period of the 1990s, it was used by many services, one that I was involved with at that point, to upgrade IT services, to bring a new professionalism to the way that those supported disability providers were providing their service to clients. My understanding is that FaHCSIA were pleased with that process. I recall that 90 million allocation was under-utilised by a significant amount. I'd be surprised if even half of that amount was taken up.

What we think would be appropriate, if we think through the lens of the smaller providers that we've had the direct contact with, referring again to the 17 religious organisations, they're looking at how they develop marketing strategies - they've never needed to do that before - into the future, if they're to provide community care, where you need a profile within your local area to be able to attract recipients to your services. These organisations haven't had to do that before; they haven't had to think about, to the same extent, the way in which they engage in business generation. So we'd propose the type of quantum that FaHCSIA considered last time around, which is a modest allocation for a defined period for business improvement, of which business planning or financial advice is only a component. Small amounts to enable these small providers to transition themselves to prepare for this new world.

MR GRAY (CHA): There is some history in that, because in 1997 quite a number of facilities failed certification and the department arranged, I think it was Bovis Lend Lease were one of the organisations that provided advice to those particular operators as to what they could do with their service, because for some of them it just really wasn't possible for them to be able to achieve certification; they had to really,

virtually, change the whole basis of how they operated their aged care facility. It was generally nursing homes that failed the certification in many cases. So there is history of the department doing that. When ACFI was introduced, KPMG was made available to eligible organisations for specific advice, so it's not a new concept and I think it is a useful transitional concept for sure.

MR LAVERTY (CHA): What we'd perhaps argue, to avoid, Mike, the scenario that you propose where service providers define the \$18,000 package: if this type of assistance is to be made available, make it available to small providers, but have them, within a criteria, propose to the department for which purpose they are to apply it. If organisation A says they need to undertake a capital upgrade of something or other, enable them to apply for that within a defined financial threshold, rather than forcing these organisations into one path of financial planning advice, which may not be what they need.

MS MACRI: There'd need to be some accountability around it. Again, in the hearings we have heard about the industry and the IT handouts for organisations, and the dollars per bed, and no accountability at the end of it in terms of whether people are upskilled, whether there were computer enhancements or services, so there'd need to be some accountability around it.

MR GRAY (CHA): The ACFI has been the biggest driver of IT take-up in the industry.

MR WOODS: If you could come back to us, though, with a - because in the body of your report you still don't operationalise it. But how would you define what a small operator is and what criteria and what accountability would you put around it? Not extensively, but just drawing on your previous experience, that would give us some guidance.

MR FITZGERALD: I think there is an issue that is going to emerge; that is, if the occupancy rates are as they are or get slightly worse, in the short-term it is likely that effect is felt more in the older, smaller facilities. Not necessarily so, but that seems to be what's occurring. I think Rod Young this morning gave some figures about the current vacancy rates or occupancy rates, whichever way you wish to look at it. In this transition period, some of those services may in fact have greater vacancies than they currently do.

Firstly, you're not asking for viability funding to assist those people during that period of time, which is probably wise, but the second thing is, is there an assumption that these providers will suddenly become providers of community packages or community services, and that they will be able to wear these increase in vacancy rates as this transition takes place? There are a couple of assumptions in that, because we know over the long term, the need for residential care places

increases quite dramatically, even though it's less relative to community, it's still very, very substantial, so it's a growth area by a long way. But is there an assumption in this end that the community service area will become a greater proportion of their business or not?

MR MERZIADES (CHA): I don't think there's an assumption there. One of the purposes of the assistance would be to answer those sorts of questions, whether in terms of their future business planning, given the circumstances and the pressures they've been under - let's not forget about that - and the increase in pressures with the reforms, what is their best course of action. Is it to convert to community care, is it to go down to the next parish and do a deal, is it to sell up and accumulate capital to transition into a larger service.

They're the sorts of decisions which I think a reform of this type will trigger, and it will bring it to a higher level. This sort of thinking has been going on for quite some time. The increasing vacancy rates is not something that has just occurred yesterday; it's been a gradual trend. People have been living with it. But I think, given the extent of the reforms that are being contemplated now, I think there's going to be a significant trigger for people just sitting down and reassessing what their future is going to be. So that's where I'm coming from.

MR WOODS: Supported resident status: you suggest that fee is reviewed. There is a question of what the type-boundaries, at the moment the \$98,000 asset test, et cetera, supported residents, whether that creates a group who're immediately above that, in the 100 to 150 thousand, is that part of your thinking behind the review of the supported resident status or is it where they fit within the new paradigm of looking at people's requirement to make co-contributions for care, given that, at an asset level, doesn't cut in until 313-odd thousand, so it's quite a way above? What is your thinking and what are you urging us to look at?

MR MERZIADES (CHA): One of your terms of reference was to balance affordability to community and affordability to the individual. At the same time, we've been arguing that the standard of accommodation for a supported resident should be higher, and obviously there is a cost associated with that. It seems to me that if you're looking at the total picture, you ought to be looking also at what the current criteria for supported resident status. I'm not necessarily suggesting that there will be opportunities there to change it in a sensible way, but it's certainly something that needs to be looked at. For example, protected resident status, from an equity point of view, are the current arrangements appropriate across the board? You get protected residents in terms of spouses, you get protected residents in terms of dependent children, and obviously you take those sorts of things into account. But I think that area needs to be explored and also to be link in with the issues you raised about those other cut-offs which apply, because there are issues of affordability and equity which need to be considered.

MR WOODS: But do you have a view on what results that review should produce? Where is your endgame? I can see where you are at the start, I just don't know where you are at the end.

MR MERSIADES (CHA): We're leaving that endgame to you, but it seems to me that is an area that has to be looked at.

MR WOODS: It only needs to be looked at if you think there is something fundamentally wrong with what's there. You don't just inquire into something because it happens to be there, you inquire into it because somebody raises an issue of whether it's still appropriate or not.

MR MERSIADES (CHA): The example I gave was of the protected resident, where in that situation the total cost to the entity or to the group becomes less than in other situations. Now, is that equitable? Bear in mind that you are introducing or proposing the equity release scheme as well, as a way of accessing funding. I'm just trying to look at the total package to see - - -

MR WOODS: I understand the point, I was just hoping that you could illuminate it with some of your thinking as to what the future should look like.

MR FITZGERALD: I might just say, there is an issue about people that are currently not regarded as supported residents, but that next group above that; those of modest means. People have various names for that group, whether they're assisted residents, and we are looking at that up to the final report, because there do seem to be some genuine issues around that group and we just need to consider what our approach will be there. We are certainly looking at that issue.

MR WOODS: Can I just move on to a small one, that's that you raised the point that by taking out the construct of extra services and all people are eligible for their care that they've been assessed as having an entitlement to, and then additional services that they may wish to purchase as a transaction between them and the provider of those additional services. You make the point about being able to distinguish easily between what constitutes their entitlement and what constitutes the additional service. Again, do you have, through your experience in the extra service regime, any views in terms of operationalising this? The only caveat I would put on how we would then respond is that we are soon going to exhaust our level of competence if we go too far down the level of creating standard operating procedures and the like, and we're not going to go there, because that's what providers, regulators, and others do, not what the commission does. But if there is some simple notion that we could refer to, in principle at least, that would be helpful?

MR MERSIADES (CHA): I guess the precedent would be the current specified

care and services, which attempt to make it clear to a resident what their entitlement would be in terms of the services and then activities they are expected to receive. I would see that being revisited and being used as a basis for giving some guidance to both providers and residents as to what they can expect to receive through their own individual payments. Bearing in mind, this is on the living-expenses side, not on the care side.

MR GRAY (CHA): Also the current list of hotel-type services that can be expected under extra service is an indicator of the types of things that a resident could purchase, over and above what they'd be entitled to under the basis care subsidy.

MR WOODS: One last thing from me for a bit is: given the extensive geographic distribution of your facilities, how would you set up a set of principles that we could refer to in defining what constitutes a region? Clearly, if it is too large, then there is the danger of creating in one part of the region some ghettos of a certain nature and in other parts of the region a different standard. Do you have a set or could you contemplate drawing up a set of principles that would help guide us in how regions could be defined? Again, we're not going to go to the point of putting lines on maps because a level of detail that's - - -

MR MERSIADES (CHA): Is this from the point of view of, for example, how the gateway agency might operate or the supported residents - - -

MR WOODS: The gateway, the supported resident quotas.

MR MERSIADES (CHA): My experience is that for every discrete function, you could come up with a justification for a discrete set of regions. I think you have to really work on the 80:20 rule and the most important thing is to get complementarity with related activities as much as possible. I think that's far more important than trying to devise your own system. So I'd be guided by what happens with Medicare Locals and LHNs and those sorts of things to get as much commonality as possible as the objective.

MR LAVERTY (CHA): Mike, you made reference to the geographic reach of where our services are. You're familiar with the geographic reach of our hospital services as well. In our case, many of the aged care services that we are speaking about today are in fact part of hospital networks owned by or governed by the hospital networks. It occurs to us, if we take the illustration of Rockhampton in central Queensland, that there is a local hospital network that is evolving around an existing set of established relationships built out of Rockhampton. These relationships have been in place between the base hospital, between the Mercy Hospital and Mercy aged care organisations for some 30 years and around them, a new piece of bureaucracy is now being constructed and it's one illustration where we say a boundary is being built on what is sensible.

So whilst that makes it difficult to articulate a set of national principles that's going to take that Rockhampton illustration and bring it to life, because the establishment of local hospital networks is meant to have an interface with the way in which aged care is to work, it would seem obvious to us that as those boundaries are being established, we should be cognisant of them and we would argue further that as a provider of both health care and aged care services that's going to relate to those, we loathe having another layer of confusing boundaries established, not just for the operators but for the consumers as well. So if there is a reference point, the start of what a Medicare Local is and what a local hospital network is would surely lend itself - but I'm telling you something that I suspect is obvious.

MS MACRI: Just the second dot point, the last one where you talk about the capital grants program, and continue to support the development of multi-service and community based services, do you see the capital grant program beyond that or just restricted to that? What are your thoughts around that particular area?

MR MERZIADES (CHA): Reading the draft report, we felt that you hadn't really developed that. I mean, you commented about these issues but you didn't take it through to sort of say, "This is what we think should happen." What we've tried to do is to say while moving to market based accommodation payments and rentals work in most parts of the country, there will be other parts where it won't, and we're saying in those areas, there's needs to be a specific recognition that there will be an ongoing need for some sort of capital program. The obvious case is the MPS; it's a very successful model and we go one step further - - -

MR WOODS: Are you referring to the Tasmanian or the New South Wales variety of that model?

MR MERZIADES (CHA): I'm not sure there's a big difference, other than - - -

MR WOODS: The New South Wales one, to simplify it, is a Health Department, driven downwards, with associated aged care facilities, whereas the Tasmanian is a community and aged care facility with health supplementing it.

MR LAVERTY (CHA): Thank you for affirming our view that we support the Tasmanian model.

MR MERZIADES (CHA): I was thinking that you were heading that way, but subject to the Commonwealth providing the capital as well, so they can drive the development of them as well. In that way, there can be that separation from the Health Departments. So I think there's a specific life for that model of care in rural areas and I think it just needs to be given life. Of course there's the indigenous services and one can contemplate there may be other community based organisations

where it really is the only option available for providing aged care services in certain areas and we think a capital program would be appropriate in those circumstances because those sort of organisations, putting aside the MPSs, even with market based accommodation payments, they're not going to be able to raise capital.

MR FITZGERALD: Can I just deal with a couple of things: you made comments in relation to independence and wellness in your submission which we would applaud. One of the issues we raised this morning with Rod, and we've raised it several times, is what do you think the entitlements should look like that the consumer takes from the gateway - in residential care, just put that aside for the moment - but in terms of community care, and it's directly related to this. When we were in Perth on Friday, Silver Chain were encouraging us very strongly to a view that most people should go through an enablement process, a period of time where there's a detailed assessment and their view is that this particular type of enablement service reduces the level of support required for people long term and so on and so forth. So I just want to get a sense of when Mike Woods goes through the gateway and he comes out with his entitlement, what should that entitlement look like? It's been called a building block approach in terms of the assessment of need and financial packaging but what is it from a provider's point of view? What should it look like?

Specifically, when you talk about enablement teams, in a sense, the government won't care what you put together, it will care that it identifies correctly the service to be provided. How you as a provider choose to actually put that together is not going to be all that concerning. But, for example, one of the services may well be an entitlement to enablement service or to restorative services or to whatever term, however you want to describe that. So I just want to get a sense from you of: have you given any thought as to what this entitlement should look like?

MR MERSIADES (CHA): I think this is probably one of the more difficult areas in the whole exercise. To be quite honest, I don't have the solution. I think there's still a lot more thinking to be done around that. But I think I come at it from a similar point of view as Silver Chain, because as you were saying in your draft report, there's the issue as to what extent consumer preference should be tempered by other considerations. I think the reality is that there needs to be a process in there which points the service delivery towards achieving an outcome where greater independent is the result. I think we owe that to the overall cost of the system as well. If we want to open the system up to be more responsive and to be entitlement driven, then we need to be mindful about the costs and the benefits we give out. Part of the benefit is that with that greater responsiveness, you're getting a mix of services which gives the community a lower cost but also gives a better outcome for the individual.

So it's a question of changing that culture about how service delivery,

particularly at the HACC level, is delivered. Now, some organisations have already adopted that culture; others, because the system doesn't really promote it, they're accused of client capture and once people are on a particular service, they're on it for a long, long time. So we need to change that mentality, and I think part of that, to get the basic level, is having an assessment approach which sort of looks at each individual and says, "In your situation, the best combination of services are this, this and this and then we'll review it again after three months and see if we can wean you off this one and get you into a better situation." You need to have that system in there in some way which is done in a cost-effective way.

MR GRAY (CHA): But I would think also that an enablement service shouldn't require a co-contribution, otherwise people will probably not bother to buy it.

MR FITZGERALD: I'm not completely sure that you've articulated why. We're trying to get a co-contribution arrangement that is consistent across all services that are provided, irrespective of the nature of those services between 5 and 25 per cent, or in the case of hardship, zero. Why would enablement services - which actually have services components in it, would actually have, you know, some personal care and all those sorts of things - - -

MR GRAY (CHA): Well, that - sorry, I was thinking of enablement as actually enabling that person to avoid the need for certain types of care services. So I was taking the front end of the restorative wellbeing approach where what you're trying to do is encourage the person to actually avoid the need for services and becoming service dependent.

MR FITZGERALD: But would these be what we would call social support services that almost - you access without even having to go through the gateway, so that you've got a range of preventative health and wellbeing support. Just to explain that a little bit better it's clear that in the draft we didn't fully articulate this range of services that sits outside of the formal aged care. They include things like advocacy, they include things like information. They also include social support and preventative health programs. We need to articulate in the final report exactly how we think they should operate.

MR GRAY (CHA): Yes.

MR FITZGERALD: For those you can have direct access, but you can also be referred by the gateway. The enablement services that's all the trend we're talking about are those that would actually come through the assessment process, but they might actually have a combination of more detailed assessment, service delivery, as you say, for a period of time, which then leads to either less or more specific service delivery.

MR WOODS: So they could have physio and OT and a couple of other things for a seven to 12 week period to see if that corrects the particular situation facing somebody and then reassess and then see what their longer-term needs might be. Silver Chain's view, or Gill Lewin in particular, says, you know, you put almost everybody through that first, and to see what results that can produce before you then identify what is a more stable set of next services. So we would see those as fitting into the co-contribution, because they're an active provision of service as distinct from social support and information.

MR LAVERTY (CHA): Well, if it would be useful we will go back to our network and have this discussion over the next fortnight and write to you saying, "Here's what we think entitlement should be."

MR WOODS: Yes, there are two questions. One is, you know, are entitlements sort of broadly-banded ie. one hour, three hours, five hours and what happens within those is variable and for the price points, which also raises - the transitional issue is whether we need an additional price point between CACP and EACH, which you can separately address. But also this concept of an enablement process at the front end that most people would go through to better analyse what is their situation, what corrective support can go in immediately and to see if that then extends their full level of independence for another year, two years, whatever.

MS MACRI: I think we probably need some clarity around the terminology too, because there has been confusion around what "care coordination" is, what "case management" is and obviously again some confusion around what does "enablement" really - so probably for us too some clarification and good articulation so that when we're talking about these parts of the service we're clear in terms of where they fit in the gateway and the ongoing scheme. So some thoughts around that.

MR FITZGERALD: I should just point out that appendix B as you, I think, are aware but some people aren't is simply a consultant's view of the world.

MR WOODS: Yes.

MR FITZGERALD: It's not our view of the world - - -

MR WOODS: No.

MS MACRI: No.

MR FITZGERALD: - - - although we agree with the general direction of much of what's in it. I think you've picked that up, but some people have taken appendix B as the commission's position. Are we're doing is putting it there for further discussion.

MR WOODS: Well, now that we've given you some homework as well as us, I think we can call it quits and thank you for today's part of your contribution and look forward to your ongoing engagement.

MR FITZGERALD: Thank you very much.

MR LAVERTY (CHA): Thank you.

MR FITZGERALD: Could we have the next participant, which is Maree Bernoth. If you could, for the record, give your name and whether you represent any organisation.

DR BERNOTH: My name is Dr Maree Bernoth, and I'm an academic at Charles Sturt University in Wagga.

MR FITZGERALD: Great. Okay, you've given us a paper, and so thanks very much for that. If you would like to give some opening comments and then we'll have a bit of a chat.

DR BERNOTH: Are you all right if I read?

MR FITZGERALD: Yes.

DR BERNOTH: You're okay with that?

MS MACRI: Yes.

DR BERNOTH: Okay. The comments that I want to share with you today are based on the interim report that the commission has produced and the extent to which the recommendations in the draft report match with the outcomes of research that I have conducted both alone and with colleagues, especially the last two projects over the last six or eight months. I have been involved in aged care research since about 1995 and I have a masters and PhD qualifications focused on research in residential aged care. Currently - well, I've said I'm doing the two research projects. The focus of my response is predominantly around quality of care in residential aged care and the commissioners' comments about research. So I'm taking a very different paradigm to the last three gentlemen.

MR FITZGERALD: No, that's good.

MS MACRI: That's fine.

DR BERNOTH: Firstly, in the draft report the supply of aged care services is not matched to the level of demand or geographical incidence of that demand. Certainly in the research we're doing looking at older people who have had to move away from their communities to access aged care and aged care services we're finding that this is so. There's a social and financial and emotional toll to pay for having to move away. But the interesting thing we did find is that it's not just people moving from small towns to large towns to access aged care, it's also people moving from large towns to small towns, because the sorts of services that they want aren't there. One particular couple had to move from a large town because the residential aged care providers in

that town would not allow them to cohabit. They wanted to be together. They wanted to have the same room and they wanted a double bed. All of the aged care providers in the town claimed OH and S issues, so the couple who had been married for 60 years couldn't be together. So they had to move to a town that was 77 kilometres from where their family was so they could find that sort of service.

The other issue in the draft report is you say - you're talking about the single gateway to the aged care system. Universally the nearly 50 people we've talked to over the last few months all say what a maze aged care is and how difficult they find it. Even really articulate and computer-literate people have found it difficult to find how they get help for their parents when they're needing care. So everyone is quite excited about this single gateway.

MS MACRI: Trust me, people even in the industry find it difficult to navigate the current system.

DR BERNOTH: That's right, so that's very welcome. However, the divergences that I have from your findings is around the quality of care, this issue of treating older Australians receiving care and support with dignity and respect. We have talked to nearly 50 people now and the issue of quality care comes up all the time. We have lots of examples where quality care is not provided.

You make some recommendations in the draft report relating to improving care and you talk about palliative care and access to a multidisciplinary team, but those require referrals. The people giving the care and assessing care are care workers, semi-skilled or unskilled people who may or may not be able to identify when the need is for those sorts of services to be accessed. I have a number of cases I can share with you to illustrate those points.

The other thing that I wanted to talk to you about was the issue of research in aged care and the issue of researching in residential aged care. When Prof Nay published her PhD in the mid 90s she was banned from residential aged care facilities on the mid north coast because her findings were adverse to those wanted by the industry. I found the same situation when I was doing my PhD and I have been subjected threats of violence, verbal abuse, constructive dismissal. I've had contracts terminated and we sold our home and moved to another town because of the professional bullying that I was undergoing because I was revealing the outcomes of that PhD research. Subsequently it's then difficult to get back into residential aged care to do other research, however I have found a wonderful place on the mid north coast that will allow me back in.

The other issue with research is participating in the Australian Research Council grants, in linkage grants. It requires a co-contribution from a partner and that amount can be \$30,000 or more over three years. Residential aged care

providers often find that sort of money difficult to dedicate to research, although this particular facility that has agreed to come as a partner in the linkage ARC grant has found that money. It does detract from wanting to do, or making research financial viable when you're looking at residential aged care.

The other issue with researching residential aged care is that most facilities don't have an ethics committee and the agreeance of whether to participate in research or not is at the willingness or unwillingness of the proprietor or the manager of that facility. So we're then restricted in the places that we may have access to. I currently have a student wanting to look at the quality of oral care in an aged care facility but she was refused access to a facility to do that, and she was just going to do a simple questionnaire. So they're my particular focus for today.

MS MACRI: We'll come back to some of those. Another one that you've been fairly strong about is in regards to accreditation and I'm just wondering if you want to just elaborate as well on that, because looking through your - you mention it on numerous occasions and it's something obviously you have some concerns around.

MS BERNOTH: That's right. That came out of my PhD research. What I found was that accreditors go into a facility, the facility knows what the accreditors are looking for. The facility, through their representative bodies, are supported in going through the accreditation process, so they know the paperwork that has to be put in place and they're aware of what's going to happen. We have experiences where aged care facilities have put out the good linen, have put out the good crockery, ensure the right sort of staff are on duty that day when the accreditors come. I found that when I was doing my research. I was working in a facility where staff were reporting to me poor care but they had just gone through accreditation and they had received full accreditation.

There was an incidence in the mid 90s where an aged care facility had been given full accreditation and after a public outcry the accreditors went back in and reassessed the facility. On the second occasion the staff there told me that the accreditors came in at 6 o'clock in the morning and worked with the staff; they were there with them when they were doing their care. Subsequently the facility was found to be in breach of 25 of the 44 standards. I also am aware that people doing the accreditation don't necessarily have the clinical skills to assess clinical care. So an accreditor can be looking at something that's happening and not aware of the significance of that.

MS MACRI: In your research did you, in terms of looking at accreditation, do any sort of comparative research around the ACHS model and the outcomes of that, and the accreditation in aged care and the outcomes in that, I mean, in terms of looking at what an accreditation system should actually look like and what the outcomes of that should be?

MS BERNOTH: No, I didn't because that wasn't the focus of my research. My research initially started as instigating education programs to encourage aged care workers to work safely. That's how it started.

MS MACRI: Okay. So there was an evolution, or a revolution.

MS BERNOTH: Oh, revolution. So it didn't, but the basic premise is the same. It's part of the neo-liberalist approach where we're into auditing and accreditation and filling in the squares but not necessarily looking at the actuality. So we can have folders, we can present systems, we can say we're doing the best care, but when you go and look, when you're actually in the bedrooms, when you're in the toilets, when you're watching people being fed or not fed, it's very different. One facility I was in, who had also passed accreditation, I went with two AINs. The staff knew I was coming and I was coming to help them with their manual handling practice, because that's what I was into. Grounded, I was a grounded nurse and I was moved elsewhere by the research.

I went with these two nurses to watch them get an older lady out of bed and I was going to give them suggestions as to how to do it well. So I asked them to show me what they usually did. So, walked into the woman's room. She was facing the wall, curled up. One got her knees, one got her head. They turned her onto her back. They pulled her continence pad down, they put the clean continence pad on and her trousers. They swung her around and sat her up. At this stage she started to wake up. They took her top off, they put a clean one on. They stood her up in a frame and started to pull up her pants. I said, "Are you going to wash her? Are you going to tell her what you're doing?" They just ignored me.

They sat her in the chair and she started to kick them. They took her out of the room and I said, "Aren't you going to wash her?" They took her across the corridor, they turned on the cold tap, they took paper towel from the paper towel dispenser, they wet the paper towel. They wiped it across her face, wiped it on her head. They took her up to the main dining room. They gave her a glass of water after putting a table in front of her. She picked up the water and she threw it at them. They turned around and said to her, "Cantankerous old bitch." When the manager walked through everyone was sitting nicely in the lounge room. They were all sitting with their tables, with their - but how did they get there? What was the experience of them getting from the bed to the lounge room?

MR FITZGERALD: Just taking that point, I mean, we have heard criticisms of the accreditation system, there's no question that people are concerned about it. When you look at the range of opportunities for the accreditation system to work, both in terms of formal processes and then spot checks and unannounced visits and so on, people are saying they should look at the outcomes, but I actually don't know of any

system that does do that. How do you actually get a system to look at the outcomes? The question here is that we know that some systems, some services work very well. There's a culture and they're within the culture. So the accreditation is getting blamed, and maybe there are substantial faults in it, but it doesn't seem to me that I've heard any suggestions about accreditation which would dramatically improve accreditation. So unless I'm wrong it's actually somewhere else we've got to put the energy and the effort.

MS BERNOTH: Yes, yes.

MR FITZGERALD: So what is it?

MS BERNOTH: I would contend that the aged care industry is over regulated. We've got too many watchdogs and we've got too much energy put into subverting the watchdogs. Let's get the care right. I'm suggesting that instead of having these bureaucracies that we start to look at the provision of good clinical care, that we have clinical mentors in the facilities where they would be employed - well, they need to be there where people are doing the work so the money that can be saved by taking away some of the regulatory authorities be invested in good clinicians who are there on the floor with those aged care workers.

We have aged care workers providing care to the most fragile people in our society. In your report you say that aged care doesn't take much skill as far as washing and feeding. But it does. These people have complex, multiple, chronic conditions. They have atypical presentations of pathophysiology. They are dealing with polypharmacy and we have issues like dementia, delirium and depression that are really difficult to differentiate. So if we're going to give good care, instead of having watchdogs come in and checking, let's actually give it. We need to support the careworkers while they do their work. The careworkers can provide the care, but there has to be a clinician there with them. That's currently supposed to be done by registered nurses. However, the registered nurse is very distant from where the care is being given. Even the endorsed enrolled nurses, they're giving the medications, they're not there.

MR FITZGERALD: Can I ask you this question - and it's almost heresy in these hearings, I know - but there is this sort of view that we have been getting that registered nurses and enrolled nurses are the answer and it's the careworkers that are the problems and yet we know from absolute certainty that registered nurses and enrolled nurses are as good or as bad as other professions; there are very good operators, there are very operators. So there does seem to be a bit of a strange thing happening that if only we had more nurses. You're not suggesting this, you're suggesting a much wider package, life becomes better, but in fact that doesn't seem to be borne out in truth and just putting more clinically trained staff in in and of itself may not in fact address a lot of the issues you have talked about.

DR BERNOTH: That's right, you're quite right. We certainly need registered nurses there. But I'm talking about skilled clinicians. Those skilled clinicians were supposed to evolve with the certificate III and then the certificate IV. However, we have denigrated those certificates. The quality of education being provided to our AINs is a package that you fill in. Who fills it in? And they submit it for marking. I'm teaching second-year registered nurses, students, they have to come to lectures and tutorials, then they do clinical skills. We then have to go out and watch them perform those clinical skills. We have to watch them and determine whether or not they're competent. The AINs don't get that or, if we do have a competency tick list, the competencies are given to another AIN, their best mate, whoever they're working with on the day, and they tick it off.

When the New South Wales Nurses Association brought in that certificate III in the mid-90s it was meant to develop those skills but because of the denigration, because of the money-making focus of some education providers that is not happening. So perhaps we need to relook at systems that are already in place and ensure that they are doing exactly what they're supposed to. The Australian Qualifications Framework was supposed to oversee RTOs. I think they're failing. Again, it's this monitoring. We're monitoring. We're looking at paperwork, we're looking at folders. Let's look at the actuality. When the Australian qualification accreditors go out, are they sitting in the classrooms? Are they watching? Are they really seeing how assessments are - no. They look at the folders, "Show me your tick sheets," and they're already done. But what's behind that tick sheet? Instead of focusing on the tick sheet let's focus on, "Did it really happen? Who did it?"

So then we put in trainers and assessors, certificate IV trainers and assessors, and they were they ones who were supposed to be doing the assessment but they're not. Again, we've got the AINs assessing AINs and then the certificate IV person signs off on that. But they may or may not have seen that happen. We need to make sure that the AIN course starts to develop some of the skills or the strategies of the EN course. I'm not saying make them ENs. I'm saying we need to ensure that those courses have that theoretical and clinical component and then the assessment process to follow it up. We also need mentors in facilities to ensure that that is followed through because what happens now is care is not dictated by a care plan. Care, in some instances, is dictated by the biggest bully on the shift and they way that they want care done.

MR FITZGERALD: Just talk to me about your idea of clinical mentors. Exactly what do you mean by that?

DR BERNOTH: A clinical mentor in my mind might be someone who has gone through a substantive certificate III, certificate IV course and maybe even some of the certificate IV and trainer and assessor where those course are real courses. When

the certificate III first came there was a prescription as to how many hours people had to do. I think it was 150 hours they had to do. That's gone. It's now when you develop competence. So my clinical mentor would be a person who has gone through a number hours with skills assessment and then skills in basic education and communication, people who can relate to people on an adult to adult way.

MR FITZGERALD: Sorry, are they simply monitoring the students doing the cert IIIs or are you saying into the residential aged care facility you have clinical monitoring?

DR BERNOTH: Yes, you have clinical support people who will support the AINs as they do their work. So when they see someone develop Bell's palsy the AINs don't dismiss it as just a progression of the dementia but understand that this is Bell's palsy, that maybe we should refer this person on, they have had some adverse event.

MS MACRI: I must say right around Australia this is a problem that's been raised consistently around the certificate III, certificate IV aged care workers and those that come out of TAFE come out very well prepared and then there are others advertising, "Be a nurse in seven days." Certainly this whole area of competencies around the cert III, cert IV has been a problem right across Australia. The other one that I just have very quickly - you talk about staff ratios quite a bit through your report. There has been a lot of comments around staff ratios.

DR BERNOTH: Just from what people have been telling me, especially lately, it seems to be deteriorating as we go on. There are insufficient carers. I have talked to a number of people who have gone and been with their relative from 10 o'clock in the morning until 4 or 5 o'clock in the afternoon and they have not seen staff. If you are thinking about the afternoon shift when we have 20 people who need to be fed and there are two or three staff what is happening is that any resident who can feed themselves is left alone, unattended in the dining room and because they're unattended, they fall. Now, this lady fell, there was no-one around to look after her. So she was left in this state and she has had numbers of falls. There are insufficient staff.

The report in the paper over the weekend of the lady who was left on the toilet overnight. There is not sufficient staff to deal with these frail older people and their complex needs. One lady went in to see her mum, she found her mum on the toilet. The mum said she had been there for a long time. The woman buzzed and buzzed and buzzed for nurses or carers. No-one came. That was a frequent story that we heard, buzzers that weren't answered. The daughter went walking and found a carer in the hallway. The carer came to help but the carer stood her mother up, and because her mother had cancer in her bones and osteoporosis she fell and the carer went with her, sustaining more injuries and subsequently more pain.

Another woman told me just recently she'd been in to see her dad. He stank. He hadn't had a shower for a couple of days. She got him out of bed herself - - -

MS MACRI: Yes, but rather than give us these graphic examples, I mean, your thoughts around - is it staff ratios, skill mix - - -

DR BERNOTH: They're issues, they are big issues. We have insufficient carers there to deliver the care. There aren't enough to do showering, there aren't enough to do the toileting, and certainly the issue of social interaction that seems to be done by the activity officer and not by the carers.

MR FITZGERALD: Research - I'm conscious of the time, but with research, what do you think we need to be saying more about research? We recognise the importance of research and the absence of a coherent research agenda in this area, and even a clearing house by which research or evaluations are in fact shared with the rest of the industry or sector. I just want to get your comments about the approach to research that the government should be taking.

DR BERNOTH: Maybe that clearing house could also include an ethics committee so that smaller aged care facilities that don't have an ethics committee could refer to that place to have any applications for research referred to it. Then if the proprietor of that facility has any concerns about the progress of the research again, they can refer back to that committee. I'd also ask that the Productivity Commission consider some way of funding residential aged care research that there be some money available that aged care facilities could access so that they can participate in linkage grants and that best practice in residential aged care is not solely based on quality assurance projects, that it does have a substantive research base.

The other thing with research is that it promotes inquiry. I've seen the benefits that it has in residential aged care facilities, the excitement it generates, the ownership that the aged care workers have in it. So I would ask again if research is being done in residential aged care there be a requirement of the researchers to include staff in the process and maybe even some acknowledgment. We could also use that for the promotion of nurse practitioners and the upskilling of aged care workers, whatever form they are, into a mode of research, and maybe develop their research skills. So when the researchers leave they have got someone there with those skills who may then be able to link with tertiary sector academics.

MR FITZGERALD: Is there an informal network at the moment whereby researchers and academics involved in aged care come together?

DR BERNOTH: No.

MR FITZGERALD: There's nothing at all?

DR BERNOTH: No. The sad thing is that I've had to hide my research, that my PhD is quarantined because of the potential impact it could have on the informants, and often that's the case.

MR FITZGERALD: All right. We're out of time. Thanks very much for the case studies that you've given us, in the first submission in particular. We really appreciate those. Then to try and take those examples and turn them into a public policy is the challenge, and I think you appreciate that. So thanks again.

DR BERNOTH: Thank you for your time. Thank you for listening.

MR FITZGERALD: We'll resume in about 25 minutes, just about 11 o'clock, thank you.

MR FITZGERALD: Okay, for the record could you give your name and the organisation you represent?

MS SPARROW (ACSA): I'm Pat Sparrow from Aged and Community Services Australia.

MR FITZGERALD: Good. Thanks for the submissions. If you want to give your opening comments, that would be great.

MS SPARROW (ACSA): Sure do. Firstly, just by saying ACSA has really welcomed the landmark report that the Productivity Commission has released. As you would know from our submissions we're overall in support of the reform and the framework that you've laid out. We think the report touches on most of the areas that it does need to, for us. We do acknowledge that there's probably further detail and financial modelling that's needed, and we're looking forward to seeing that in the final report. I'm also aware that you've heard from a number of my state colleagues. I'm going to try not to touch on all of the aspects that they have, which they've talked about from their own state perspective, but there are a few key points that I thought I would like to draw out.

Firstly, regarding the overall aims and principles that underpin what you have recommended - and obviously the reason we all exist is because we're here to support older Australians, so we're comfortable and support those overall aims. But we do think there's an additional aim that should be in there a bit more explicitly. We think it's in there implicitly, but explicitly we think we should be talking about ensuring sustainability of services. The reason we think that's important is because that's how we will make sure that older people can access what they need, when they need it and wherever they live and get good quality care.

I'm just going to go through some of the areas in the report and draw out some of the key points for us around funding. Clearly, I've already said we're looking forward to seeing some more financial modelling in the final report. We think the cost of accommodation is a really important concept and we need to tease it out a little bit more. ACSA would be suggesting that the areas that should be in - these are broad areas, not sort of finite detail - but should include things such as land, construction and financing. We would be very interested in terms of seeing the periodic payment and the lump sum conversion. We think there is not enough detail at this point around that and are waiting to see what you see.

I guess overall with the funding we think that there's a lot of different funding types that you talk about happening with capital and with care funding, being some block funding and building blocks and case-mix payments. We do think it's important that however that pans out that there's a simplicity in the way that can be

managed for providers and understood by consumer groups. We also think that it needs to be put together in a way that's very flexible for providers to be able to meet the needs of the people that they are looking after.

The costs of care study we support one hundred per cent but would argue that from the beginning that should be done by an independent body rather than through the department. We are looking for more guidance from you on the trading of places for supported residents to make sure that people aren't disadvantaged through that process.

In terms of the gateway we are very supportive of the concept of the gateway, but we do think we need to make sure that the resourcing is adequate. We think with the inclusion of the Home and Community Care program that's going to increase the demand on the gateway significantly to what say ACATs do now. We want to make sure that the gateway doesn't become a bottleneck in the system. We think the size of the regions will be very important for the gateway. They need to be a size where people can actually access them. I know you talk in the report about telephone and Internet, but we do think there needs to be an ability to have face-to-face, and also that maybe the staff of the gateway might actually go out to see people who can't come into the gateway. We have to have sensible regions. It might be around communities of interest too, particularly in rural and remote areas that we need to look at.

Also in terms of the gateway we do think that there is a strong role for providers in terms of reassessment, that not all reassessments would go back to the gateway. That picks up on their role on a day to day basis of providing case management and care coordination for people and knowing what people might need and working with the consumer to meet those needs. We do think again - I guess it's a point around the funding that it needs to be flexible, so when we've got an assessment and it says that people need X, Y, Z the provider or the individual person need to be able to work out - the providers need to be able to work out if that's exactly what is needed or whether some changes are needed, either straight after the assessment or as needs change on the way through.

I wanted to draw out some points around rural, regional and remote. The key point, and I think the report does make that well, is that obviously there are areas where the market can't provide. We think that is the case in many regional, rural and remote areas. We are much more interested in a collaboration rather than competition approach in those areas. We think collaborative service models not exactly like the MPS but similar to an MPS actually work quite well, but we would like to see the focus move away just from health services. We would argue that block funding is needed in most cases, given all of the additional costs.

I know there is some talk about viability supplements. If viability supplements

do form part of the final recommendations we would be recommending that we move away from use of the ARIA to work out what people would actually get under a viability supplement. The ARIA throws up some odd areas, Darwin, I think, being one where there are additional costs but it doesn't score anything under the ARIA. There are other areas like that where it just doesn't really make sense. We would also say for regional services that there are some additional restructuring costs and in the transition we need to be looking at how we support regional providers to restructure.

One point on workforce to draw out - and I know that many of my colleagues have covered that, particularly people from the west - but one point we did want to draw out is around workforce planning. We think that much more work needs to be done around workforce planning. Health Workforce Australia has got a project at the moment looking at medical and clinical staff. That's good, but it needs to be broadened. Nurses are only 30 per cent of the aged care workforce. We want workforce planning that covers the other 70 per cent as well.

On regulation we're very strongly supportive of your principles there around independence, transparency, consistency and proportionality. I think with regulation there are a lot of other processes in train at the moment, and we don't need to go into those issues. But I did want to touch on community care quality monitoring and the recommendation around perhaps the agency doing that and bringing it in with residential care. I understand why we would want to do that, but there are some concerns around how that might translate, whether or not we would see an imposition of the way residential accreditation works on community care, which we would say is not appropriate, that community care is different. I think the most extreme example is the spot checks, and there has been talk in the past about introducing spot checks to community care, which clearly is a nonsense and can't happen.

So to manage that risk, we would say that if that is going to happen there needs to be a special advisory body that brings in community care expertise, in the lead-up and a whole cycle of quality reporting, to make sure that that's bedded down and done in a way that's appropriate for community care. In conclusion really, again just stressing that we really support the reform. We are looking for some more detail in the final report. We do think a partnership approach is going to be important moving forward.

We note that you've recommended an implementation task force which is predominantly central agencies. We would argue that needs to be expanded to include key stakeholders, particularly provider groups and consumer groups, to bring the real on-the-ground experience and needs of people into that discussions, to make sure that the really good policy intent and beautiful policy actually works really well on the ground. Clearly, the last thing to say is it's just really important that we get some action. So we're looking forward to the final report and seeking that picked up

and implemented as a package.

MR WOODS: Thank you very much, and thank you for your extensive and ongoing contributions to the inquiry. This is one of a number of contributions that you have made and it's helpful, in that you specify very clearly some areas where you do want us to look further. Using a summary list to trigger some questions, your very first point was ensuring future sustainability of aged care services. What are your views therefore on our proposals regarding co-contribution, things like the range of co-contributions from between 5 per cent to 25 per cent, recognising that in some cases it will start at zero for particular hardship issues; the lifetime stop-loss proposal; the inclusion of all assets in the assessment of the total wealth of a person. Are these, in your view, the right directions to take if we want long-term financial sustainability?

MS SPARROW (ACSA): I think they absolutely are. I think the report is quite clear in terms of the personal and public responsibility for paying for aged care. Just given the sheer numbers of what we're going to see, I think there's no other way that we can ensure the sustainability.

MR WOODS: Do we have the balance reasonably right in your view, or is there some areas in there where you would ask us to look again or to refine our thinking?

MS SPARROW (ACSA): I think broadly they're right.

MR WOODS: Okay. A couple of issues you raise on the question of regional delivery or regional levels: the socio-economic profiles in particular regions for sorting out what would be the quota for supported residents; construction costs, et cetera being set at regional levels. Do you have or would you be able to give us at a later date your views on what sort of principles we should draw on in defining what these regions might constitute?

MS SPARROW (ACSA): Certainly one of the concepts that we do have is around communities of interest, particularly in rural and regional areas, that sometimes there will be a town or an area that's in one planning region but actually the person gets all of their services from the neighbouring region. So looking at how those sort of principles work, in defining regions. But maybe that is something that we could come back to you on, in terms of some of those principles.

MR FITZGERALD: One of the former presenters this morning, Catholic Health Australia, I think urged us to try to align it as closely as possible to some of the new health regions that are being established, if that is appropriate. Obviously we then would share the view that there is a great connection between health and aged care. Nevertheless, some of those boundaries, some of those regions, may not be appropriate for this. So, as Mike said, some guidance around this from your point of

view would be helpful.

MS SPARROW (ACSA): Because Medicare Locals will be different to local health area networks. I mean, you'd have to have a look what made the most sense, in terms of some of the issues we were talking about with the gateway people being able to access. So, yes, we could look at that and see what we thought would work best.

MR WOODS: Just on that question of Medicare Locals and Local Health Networks, we're obviously very cognisant of the reforms that are being proposed and developed in those areas. To the extent that a mutually beneficial alignment of those with our reforms can be developed, that is good. But we at this stage aren't proposing to hold the reforms in aged care hostage to the possible or, presumably, probable successful realisation of those.

MS SPARROW (ACSA): No. They have to make sense so that providers too aren't straddling two and three and four different regions.

MR FITZGERALD: Related to that, not in terms of the boundaries for the regions so much but this rural and remote service provision - thank you very much, firstly, for attachment 1 to your latest submission, which is a good analysis of those issues - it's an area where the commission probably doesn't want to be too prescriptive, but how do we establish a set of principles in order for the government to define which services fit within these special categories, whether it's block funded or viability funding. Clearly it's not all regional communities and centres, and you're not suggesting that.

MS SPARROW (ACSA): No.

MR FITZGERALD: So I was just wondering whether you've given any great thought as to how you clarify what services should be treated with more flexible funding arrangements, be they block funding or some other sort of funding formula. It has been very helpful and you've given us a number of examples, but we are still lacking clarity I suppose to say, you know, "Really this is a boundary issue. These sorts of services are the ones that we really think - - -"

MS SPARROW (ACSA): It's probably clearest in terms of the remote services, and, you know, a lot of the indigenous services in the remote areas. But I think it is trickier around the regional one, and perhaps that another one we can come back to you on in a little bit more detail.

MR FITZGERALD: I think that links to your support, as everybody has been of the multi-purpose services, given that there are different models; you know, people have different views about that, and you have particular views, for when that is

appropriate and when it is not appropriate; again there's no magic, but for a community of 3000, 2000 or 5000 - I'm not sure if there were benchmarks - just some sort of clarity would be helpful I think, from our point of view.

MS SPARROW (ACSA): Sure.

MR FITZGERALD: The second thing, just going back to your sustainability of supply. I'm sure that you are obviously not intending that we have a policy that sustains individual providers, rather it's a system of service. Is that correct?

MS SPARROW (ACSA): Yes.

MR FITZGERALD: So your association acknowledges that, going forward, some current providers won't exist.

MS SPARROW (ACSA): ACSA acknowledges that the system needs to have a mix of providers who are providing the services that are required. So, from a systems approach, yes.

MR FITZGERALD: When we have got smaller facilities - and we raised this this morning with some of the presenters - where they effectively were low care facilities and then they have now got some high care residents in them, but they're of a size that really, going forward, is probably not sustainable, some of those will actually suffer higher vacancy rates, going forward. Your association's view in relation to the treatment of those facilities, as they transition potentially out?

MS SPARROW (ACSA): I think the key though is making sure that services are available locally. I know that there might be some issues around sizes, but that's where the focus should be, that the service is available at a local level.

MR WOODS: Where the debate arose this morning in particular was small services though that operate in a larger market environment. So, you know, they may have been a small hostel in the old days providing low care in a larger metropolitan region, but now with ageing in place et cetera they will get to a point where they can't be of sufficient size to sustain the full high intense and acuity needs of the residents, with full RN coverage, et cetera. Does your membership have views on whether there should be some transitioning strategies, not necessarily involving government but within the sector? Is there discussion?

MS SPARROW (ACSA): We have looked at that more from a rural, regional and remote perspective, around transitioning, around other sorts of arrangements and supports that can be put in place to keep good, smaller, local services on the ground.

MR WOODS: That's where you need the presence and that's either by supplements

or block funding or something because you need something there.

MS SPARROW (ACSA): And they also might get services and support from a bigger service, so I suppose we've looked at it more in terms of the rural and regional sorts of areas. There's been some work done in Tasmania particularly which I'm sure Darren Mathewson would have presented to you on. Those sorts of principles we've looked at in terms of the smaller services.

MR WOODS: Okay. That was quite useful in terms of how some of the larger organisations could sort of buddy with or mentor and provide back-office sort of related support to the smaller services without taking them over, so it's sort of community run.

MS SPARROW (ACSA): That's really important. The community identity and community investment is really important.

MR WOODS: Yes. That was very helpful. It's just that within metropolitan or large markets, and they need not only be metropolitan but can be large provincial centres et cetera, again under this model, some of the current facilities might either reinvent themselves as providers of community services with a small facility hub or move into different spaces within the environment but there's more flexibility for them to adjust either to the circumstances of the region or to merge with other entities.

MS SPARROW (ACSA): True. Can I just say that sometimes in metropolitan areas, that level of community investment and community involvement in a small service is much the same as a rural area and we shouldn't see those lost. We do think there needs to be transition support and restructuring support for a whole range of services who will be now looking at what the future will be for their service and making sure that the people that they service continue to get good quality services.

MR WOODS: Transition or restructuring support, given that this is a growing industry - I mean, it's clearly of a different nature to industries which have outlived the structural relevance in the global marketplace and aged care is not in that category - it will be growing, albeit in different proportions and rates over time of community and of low-intensity residential care and higher intensity residential care. So mindful of not spending taxpayer funds with little cost-effectiveness, where would you target any structural adjustment and what would be your rationale for it?

MS SPARROW (ACSA): I guess we've looked at - and when the ACFI was introduced, there was some business advisory service support put in and a service like that could work well here - and you may well target smaller services or rural

services that you see to be at risk. I think we did propose with the ACFI that there be like an assessment framework about the services where there were issues. I think what we have to keep in mind - and yes, they are different from some of those other industries - but it is around ensuring a continuity of supply for consumers and that's why we need to take the transition and make sure that services stay on the ground.

MR FITZGERALD: I want to go to a couple of other specific issues if I can which we haven't dealt with this morning. One of those is in relation to disability. On page 14, you've indicated you have examined the Productivity Commission's report into disability, care and support, and the current draft proposals that people with disability would be able to elect at pension age as to which system they wished to be in. Could you just explore a little bit further your views about how we as a commission should be treating ageing people with disabilities.

MS SPARROW (ACSA): I guess our overall construct is the ageing in place construct and that people should be able to age in place. We see that there's a need for blended funding, that if you're a person with a disability who is getting older, just because you turn 65 doesn't mean you don't still have a range of disability-related care needs. Overall, the funding, if you look at residential disability services, is \$10,000 a year more than what comes in to support a person with disability in aged care, so we do think that there are needs related to the disability and then there may be additional needs related to aged care and that's where the notion of the blended funding model comes in.

I guess what's in the other PC report is that notion that people would, at 65, elect that they would move out of the disability sector for services and into an aged care service and get aged care service funding and pay the co-contributions, and I guess we don't see that as workable on the basis that their disability needs aren't necessarily going to be funded. I think the example we used in there was quadriplegia, that they will still have all the needs and the costs associated with that disability, as well as some additional costs then related to ageing.

MR FITZGERALD: In a sense, it's their election. If they believe that the disability system best suits their needs, they stay with the disability system; if they make a judgment that the aged care system can best suit their needs, they can make that election, irrespective of where the money is coming from, which is a separate issue.

MS SPARROW (ACSA): Sure. I guess one of the issues though is around the expertise in both of those sectors to support those needs and that's where that notion of blended funding and working together to meet those needs becomes really important.

MR FITZGERALD: The issue is specifically around people with early onset

dementia and particularly younger early onset dementia. You haven't specifically canvassed - - -

MS SPARROW (ACSA): No, I haven't.

MR FITZGERALD: - - - and you may not have a view about it, but I'm just wondering whether you do have in fact any views about the way we deal with dementia.

MS SPARROW (ACSA): Other than to say that we do think that dementia probably needs to be brought out more in the final report and we're quite supportive of a number of aspects of Alzheimer's Australia's submission; haven't thought specifically around younger onset, no.

MR FITZGERALD: Okay. There's a couple of other specifics, but Sue might have something.

MS MACRI: I was interested in your recommendation 11, around the creation of a cultural pool. I was just wondering if you could elaborate a little bit on your thinking around that.

MS SPARROW (ACSA): I suppose the thinking is that it's quite hard to fund those increased costs for culturally appropriate care individually, and so the pool being able to be sort of drawn down on really across a range of services. That's really the thinking behind it, that it's very difficult to fund. If there was a pool that could be drawn down on, that would assist with that.

MS MACRI: I suppose it's around really trying to identify what those specific differences are that would require some additional resourcing.

MS SPARROW (ACSA): Yes, and it's not just around language and translation services.

MS MACRI: No.

MS SPARROW (ACSA): We have some work on that. I can send you something that we've done on that that goes into that in a little bit more detail if that would be helpful.

MS MACRI: Yes, it would be.

MR WOODS: You do have amongst your membership a number of ethnic-specific service deliverers.

MS SPARROW (ACSA): Yes.

MR WOODS: What feedback are you getting from them in terms of both the opportunities that these reforms present to them in being able to expand their services in a variety of ways and through a variety of regions according to where their sort of expected patronage lives and whether there are any downsides that they see from our reforms?

MS SPARROW (ACSA): I'll have to be honest and say that most of the commentary that's come from those providers has been around the specific section in the report dealing with cultural diversity. So maybe that's something we should test, but most of the comment that we got on the report were around cultural diversity and the concern that there was too much focus on language services.

MR WOODS: We've experienced the same in talking to some, not all, of the CALD providers, that once you create a chapter with that title, that's where they go, but there are 13 other chapters and in a lot of those are things that provide them with very specific opportunities. Where there is a group from that culture in another area but they don't have packages at the moment, that will no longer be a barrier. They will be able to deliver services there if they have got the workforce and the management capacity and if that community actually wanted their services of course. But we're finding difficulty with some of the providers having that conversation about what the rest of the report provides for.

MS SPARROW (ACSA): I guess I'm reinforcing that even from our perspective, that's not come up as something they have either focused on that or talked more broadly, but maybe that's something that we can explore a little more.

MR WOODS: If you could have that conversation back with your membership and - - -

MS SPARROW (ACSA): About the other 13 chapters.

MR WOODS: Yes, and get their views on opportunities, as well as any downsides that are inadvertently in there, that would affect them.

MS SPARROW (ACSA): Sure.

MR WOODS: Some providers, to be fair, have done that in terms of their responses to us but not everyone.

MS SPARROW (ACSA): Sure. But certainly that's a role we can, as the peak body, take.

MR WOODS: Yes. That would be good. You refer to the issue of accommodation payments and the potential for more periodic payments and providing a sustainable revenue stream. Do you have a view of, or are your providers giving you a view on whether they think there will be a significant or marginal move by the client base to periodic charges and, if so, are there any characteristics of those people away from bonds?

MS SPARROW (ACSA): I think there are mixed views and I guess that's where people are looking for a little more in terms of some of the modelling and the detail to really assess that. So there is some concern that people will elect periodic payments and that will have an impact on the capital; it's not clear. I guess it's what we're still working through. We had some conversations yesterday about how much of that is transition and how much of that will be an ongoing issue. We're looking around that area at the moment, so it might be something we can give you more information on later. It is something on which there are mixed views presently.

MR WOODS: If I can test your views one step further on that. If we are proposing that for non-supported residents, providers set their own periodic charge - taking into account a whole range of things: the cost of supply, the local market, and all the rest of it - and provided that they publish what that is, do you have a view on whether in fact we do need to be prescriptive of the nexus between that and what the bond that they set, provided, again, that it's a published bond?

MS SPARROW (ACSA): I think the publishing is the important point and I think there does need to be some flexibility. I'm pleased to hear talk about the impact of the market on how those are set. I think if we're looking at not tying those too closely, that would be useful.

MR WOODS: In recommendation 8 of yours, you refer to providing flexibility to modify service mix and intensity and, if I can borrow one of my colleague's questions, if you could describe for us what you think would be the right shape, size, nature, character of an entitlement that somebody comes away from the gateway with. What does it look like?

MS SPARROW (ACSA): I suppose this recommendation came out of not wanting to see it too prescriptive, if we look at things like output based funding models which lock people into X number of hours and then you can't vary that. So really the recommendation came out of trying to provide some flexibility, and sometimes the assessment is not a hundred per cent accurate in terms of what people need; sometimes when a person has been using a service for a little bit of time they actually discover that what they want is something a little bit different. So I guess the intent was to say that there needs to be an ability for providers to have some tolerance limits or some ways of modifying that immediately without going back to have to have a re-assessment. That's really the driver of that recommendation.

MS MACRI: Would you see there being an initial assessment and then a follow-up?

MS SPARROW (ACSA): Yes, I think that becomes - - -

MS MACRI: So three months, six months and then settle in.

MS SPARROW (ACSA): I'm not sure about the frequency, but the need to do some re-assessment and for that to be, perhaps, driven a little bit by the provider who is working with the client and, obviously, the client's needs. We do see that as a really important component. We're really just saying, we appreciate there has to be an assessment that gives an overall shape and, ultimately, a funding amount that goes with that person, but then there needs to be the flexibility to shape that based on the experience. As the person's needs change or as they discover that there's something else that would actually be more useful, that we are able to make that change relatively quickly. If it means up and down, that can happen as well.

MR WOODS: There are a whole bundle of issues in there: there are questions of whether the initial assessment, particularly, quite often, if it's coming out of an acute-care episode and therefore they're not re-established in their home and whether they can be; whether there's a need for a sub-acute or transition-care period; there are issues of what restorative or enablement programs could go in at the front end to help people get back to a more independent state, to the extent they are able, before you then plan longer-term care programs; how flexible the programs are; should we specify bandwidths, so that there are only three bands of care and, within that, it depends on their circumstances. So there's a whole body of work. Are there providers within your membership or is their work that you yourselves have done collectively that can help us get to grips with more of the detail of that?

MS SPARROW (ACSA): I'm just trying to think. Some of things you've talked about, we've looked at things like sub-acute and restorative; we've got some work around that. I'm sure there are. That's another thing we can look at and come back to you on. I think that's really important, all of those issues that you are raising. To say that assessments in acute hospitals very rarely gives the result that we need for people to be cared for in residential or back in their own homes, so I certainly agree there is a body of work to be done. I might have to think about what we have already done or what we can do to support you through that process.

MR WOODS: We have some material from some individual providers, but if there is some collective wisdom that exists, that would greatly help us. Again, it's not an intention to reach too great a level of detail, because we would exhaust our competence fairly quickly as we head down but, with the exception of our associate commissioner of course, Robert and I fade out quickly.

MS SPARROW (ACSA): There are a number of things that we've done over time. Something I'm really thinking about is, what are the more recent things we could give you that would be useful. Let me trawl through what we've done and come back to you with anything that I think would help with those issues.

MR FITZGERALD: Can I move to quality issues, and it's got to do with workforce. If you've read any of the transcripts over the last nine or ten days of public hearing - we've got a few more to go - you will see a recurring theme and from a range of participants - some unions, some independents, some researchers, and so on - but the quality of care being provided in aged care is less than what people believe is appropriate. There's been this recurring theme that the accreditation system is not doing its job, either in one sense or another, because the outcomes are variable.

We've heard - as we'll hear in these hearings - believe that the unions believe the way forward for that is perhaps greater engagement of registered nurses, enrolled nurses, client to staff ratios, and other approaches. I was wondering how you, as an association that has a very large portion of the provider market as your members, respond to these recurring themes, that the quality in the aged care system is poor and, in particular, it's poor because the accreditation system doesn't work and that the staffing mix and ratios are in fact going backwards not forwards. So how do you deal with that?

MS SPARROW (ACSA): Firstly, we would say that we think the quality is good; we provide good quality care, our staff provide good quality care. I don't think that services are necessarily going to be improved by ratios. I think the Productivity Commission got it right in terms of ratios and licensing not being the way to address those things. I think in terms of accreditation - - -

MR FITZGERALD: Sorry, before you do accreditation, what is your response then? If ratios are not the right way forward, if we continuously hear that the staffing levels are inadequate to meet the needs, what is your response to that?

MS SPARROW (ACSA): I think we do need to look around staffing and skills mix, but not tying it into any form of ratio. Because people's needs change over time, we have a range of different things we need to address. I think we do need to look at the skills mix.

MR FITZGERALD: Yes, we do have to look at the skills mix, but what is the way to do it; what is your response? Let's assume for a moment that, at least in part, what we're hearing in the public hearings is accurate: that there is some quality variation at least across the system, and that in some instances there are problems with staff mix and staff numbers. What is the practical way forward for us? If we don't want

to go ratios - and the commission has so far resisted that - what are the concrete measures, do you think, we need to build?

MS SPARROW (ACSA): As I said, I know I'm not answering your question specifically enough, and maybe that's something we can come back to you on as well, but it is around the skills mix, is really what I can say to you today and that's something that we can perhaps come back to you on more fully.

MR FITZGERALD: I don't want to push you to an answer today but is there a mechanism by which this issue could be dealt with, because it seems central to our consideration. Clearly one of the issues, and no doubt Michael or Sue would have raised it, is around the training of cert IIIs. This has been constant every single hearing multiple times. So we see that as important, improving the quality of the person actually coming out of the cert III or cert IV. Is there a mechanism by which this staff mix issue can be dealt with? You might think about the mechanism rather than the answer. I think saying that there shouldn't be ratios is maybe an appropriate response but it's an incomplete response; there's something else missing.

MS SPARROW (ACSA): Yes, I accept that and agree with you around some training issues and the particular issues around RTOs and how people actually come out work ready, but probably all I can do today is say that, you know, there's not an obvious mechanism that I can think of to say to you today but that's something that I'm happy to take away and think about and come back to you on.

MR FITZGERALD: I appreciate that. Sorry, I interrupted when you were about to move to accreditation.

MS SPARROW (ACSA): Can't remember what I was going to say now.

MS MACRI: I'll follow on with that. Just in coming back to your comment around accreditation and community care, and I mean we've had raised a number of times that - in fact one provider we visited had ACHS accreditation, had Retirement Village Association accreditation, had the Aged Care Standards and Accreditation Agency and in community care, so for one organisation four separate accreditation bodies coming into the organisation. I certainly can see how we could tie in the retirement village, aged care, community care. The other, the ACHS, we'll leave out there.

Just in relation to community care and your reservations about it coming in under the agency and then becoming a model that's better tuned to the residential aged care accreditation, would you not see, though, that perhaps an evolving accreditation system as it currently sits for community care could be incorporated in as part of the accreditation process so that when an organisation is being surveyed or audited that the standards for residential aged care sit there but there's a whole lot

around that standard one, around management and all of that, that could be done at the same time and then the community care standards be incorporated in? I mean, there must be ways that there can be greater unity.

MS SPARROW (ACSA): Yes. I think that's true and I think that we do say that. I guess our concern has been to make sure that if that does happen that it doesn't just become a translation of residential care because it's very different, providing care at home where it might be only for an hour a week or an hour a fortnight and you don't control the environment in the way that it's controlled in residential care. So we're not necessarily saying it can't happen but just that any integration needs to take account of the fact that the two services are quite different. Yes, there may be some things, perhaps some management things, that are common across both but in terms of actual service on the ground it's quite different and needs to be looked at and assessed differently.

MR WOODS: Can I just extend the conversation about the training of the workforce, and as you point out 70 per cent aren't RNs or ENs, they're personal care workers and the like, plus support staff obviously. The quality, the work readiness of the graduates from the RTOs in the evidence coming to us is that they are quite variable.

MS SPARROW (ACSA): Definitely.

MR WOODS: In fact some providers have suggested that they have their own sort of private list of RTOs from whom they are more confident of accepting graduates than others. If that is the association's view as well, to what extent is industry involved in ensuring that the curriculum set by the Industry Skill Council is the right curriculum, and then where do you see the failings in the system that permit RTOs, or some RTOs to not as fully equip their students with work readiness as others?

MS SPARROW (ACSA): I would certainly agree that it's variable. The way that we're involved, I guess, is through consultation with the Industry Skills Council. We try to work quite closely with them but I guess we're one of a number of voices. We probably do - I think we need to look at how that works much better. I'm sorry, I've forgotten the second part of your question.

MR WOODS: With the individual RTOs, is there any system failure that permits RTOs, some RTOs to keep producing less work ready students?

MS SPARROW (ACSA): You would have to think there was. I don't know the details of the RTOs but, as I said, the quality is very variable and that does need to be looked at.

MR FITZGERALD: A related issue: one of the issues that you canvassed again

quite extensively in one of the attachments has been this issue of overseas workers. You make the point that in WA they have a multicultural workforce complement as high as 90 per cent of their total staff in the aged care area, which is very substantial. On the other hand, one of the problems that we've heard from consumers and their carers is the high number of personal care workers in particular that haven't got English proficiency.

So, in one sense, if we need labour, to allow migration into Australia either on a temporary or more permanent basis makes eminent sense, but it then conjures up the other problem about English proficiency and what have you. So I was just wondering whether your association has been able to work out a way by which you can achieve both, by increasing the workforce but also ensuring that they're not only work ready but also able to communicate effectively? Do these recommendations sit in isolation or does there need to be a package that goes around this area?

MS SPARROW (ACSA): We have done some work around particularly where services have brought in workers from overseas, how do you actually ensure the success of the workers, and it's also to do with working with the staff that are already existing in the organisation and the new staff coming in and the fit and preparing both to work together. So we have done some work around that area, which again I'm happy to send you some more details on.

MR FITZGERALD: The other one just in that same section of your attachment is about management and leadership, and we've heard a bit about this so we welcome your consideration of this. You've said here that you consider the development of a leadership and management quality framework and a leadership and management program sounds eminently sensible. Do you have any idea how that actually would operate?

MS SPARROW (ACSA): Not in any great detail. That's an area that we're still continuing to look at. We think it's extremely important and is an area that needs further development.

MR FITZGERALD: Is it likely, do you think, that that would happen more through professional development, or do you see that - and again you may not have a view about this - as being a formalised academic qualification or course delivered through - - -

MS SPARROW (ACSA): Not so much on whether it would be an academically delivered one. We do think, though, that while we would want to link in with broader things there are some specific things around aged care that need to be picked up in leadership and management training. We've looked at a number of sorts of different types of things around that.

MR WOODS: One of the sort of rule of thumb indicators of management quality in facilities operated by a large number of your members is their reliance on agency staff. It's just an inaccurate but simple rule of thumb indicator. We go into some and we ask about agency staff and they sort of, you know, bemoan the very high cost and how dependent they are on them. Then we go and talk to the GPs and they say, "When we come to visit the facility the agency staff, quite reasonably, don't know the patients in any depth, don't have an understanding of their history and profile and whether the current behaviour is reflective of a trend or is abnormal," and all of those issues.

We go into other facilities and talk about agency staff and they will say, "Oh, well, yes, we did actually need one a couple of months ago but that was an unusual event. We have a very stable pool of staff and we have a group on the fringe who we can call on but who have a long-term association with the facility." Their greatest problem is that, with all the various professional development activities, the staff move; the personal care workers get a cert IV in medication management and then go into the EN stream and then get lost to the facility but have ended up in the broader health field. Why is there such diversity and what steps does the association take to promote knowledge and understanding of good management in the various facilities, because this is an industry where there is a lot of innovation, there are some outstanding examples of very good operators, but there doesn't seem to be a significant dispersion of knowledge across the sector. So (a) why is that and (b) what does your association do in that space?

MS SPARROW (ACSA): Sure. There are sort of variations. I don't know that it's clear why the variations exist in terms of the use of agency staff, from what things contribute or not contribute. I don't think it's particularly clear - - -

MR WOODS: No, that's purely an indicator of a whole range of other issues.

MS SPARROW (ACSA): Yes. We've certainly tried to look at workforce issues, retention and recruitment. There's some interesting stuff from the United States around recruitment and retention specialists in aged care that we've been looking at and I guess the role that we play in trying to promulgate that sort of information might be through our conference or it might be through other resources and papers that we provide to try and give providers information about how they can manage that. ACSA in Western Australia have done a book recently around staff cover, so there are resources and things that we put out as a federation to try and support providers with those sorts of issues.

MR WOODS: But there seem to be some slow adopters.

MS SPARROW (ACSA): There's a range, and there's probably some very fast adopters as well, Mike.

MR WOODS: Yes, indeed there is a range.

MR FITZGERALD: The issue about affordable housing for ageing Australians, this broad agenda, so we're not talking about residential aged care, we're talking about general accommodation, you've made quite substantial comments about that issue there. Again, it's a bit like the question before: what do you think is the best way to operationalise this? You say here:

The Australian government should work with ILU - independent living unit - providers to determine how the supportable housing stock can be preserved.

You go on that there needs to be a recognition. Again, just trying to operationalise this a little bit further, have you got a particular way by which you think the government needs to undertake these challenges, these tasks. I think we refer to a recommendation or a proposal - I think it's a recommendation - that there be a national housing affordability strategy developed. But again, given this is such a serious issue, and you've identified some very substantial shortages in that stock going forward, I don't disagree with the recommendations, just whether have you thought further about how that actually might happen.

MS SPARROW (ACSA): We do the strategy as being important and I guess we've also recommended perhaps a targeted NRAS round. That would be one specific way of doing that and that's probably the main one that we've recommended, as well as in a paper that we've done with COTA - I don't know if you're familiar with the paper that we've done around this area, maybe that's one we should send to you as well - and I guess we did look very carefully at the NRAS and how you use the NRAS to do that, as well as recognising aged care providers of independent living units as community housing providers as well. I can send you that paper.

MR WOODS: Yes, it could be in the three feet of papers that we've had from COTA already but we'll have a look.

MS SPARROW (ACSA): We'll send you another one just in case.

MR WOODS: Thank you. One minor one on the implementation task force: we know you use the word "include" key consumer and provider stakeholders. Given that the task force will be recommending and overseeing specific implementation activities on behalf of government, I could envisage a two-part structure, that there be close work with an advisory panel, but some of the implementation would be the direct responsibility of departments who are on the task force; the word "include" might have to be defined - - -

MS SPARROW (ACSA): A two-part structure is better than a no-part structure.

MR WOODS: Absolutely. No, we fully understand the need for, as a minimum, a two-part structure. You can't restructure an industry without involving the industry.

MS SPARROW (ACSA): I guess though too, we say "advisory" or "consultative" - I guess that's why we should the word "partnership". We do think it needs to be a little more than advisory or consultative, where we can have a conversation and provide recommendations which nothing happens with. That's really what we want to avoid in this process.

MR WOODS: And of course I define "industry" more broadly because I start with those who are receiving the care and working to those who are providing the care.

MS SPARROW (ACSA): Absolutely.

MR WOODS: I think that concludes the particular things that we wanted to raise with you, but are there any concluding points that you want to raise or points that you want to highlight that we haven't covered?

MS SPARROW (ACSA): I think really in the overview that I did that and as I said, I ended on the implementation task force, so I've come full circle, but also just to say that we are looking forward to the final report, addressing those issues. I will come back to you on some of the areas that I perhaps haven't been able to answer fully today and looking forward to some action.

MR WOODS: Thank you very much.

MR FITZGERALD: Thanks very much.

MR FITZGERALD: Michael, if you could give your name and the organisation and position you hold within that organisation that you represent.

MR WOODHEAD (ADACAS): My name is Michael Woodhead. I am the chief executive officer of ADACAS which is the ACT Disability, Aged and Carer Advocacy Service.

MR FITZGERALD: Good. Thank you very much for attending. We've had some representation from different advocacy services around Australia, but yours seem more comprehensive in coverage and nature, but we welcome your opening comments.

MR WOODHEAD (ADACAS): Thank you for the opportunity to address the commission. ADACAS has been providing advocacy for people with a disability, people with a mental illness and frail older people in residential aged care or in the community for more than 20 years. ADACAS receives funding from five government programs across the Commonwealth, ACT and New South Wales governments. In relation to residential aged care, ADACAS has developed a program of regular visits to all aged care homes in the ACT. This has enabled us to build a substantial profile within homes and advocates have developed excellent rapport and trust with many residents and their families, as well as good working relationships with many managers and staff. In addition, it enables us to connect with the most vulnerable residents, those in high-level care without access to a phone or who have little or not contact with their families. We have the capability of making contact with virtually every single person in residential aged care in the ACT.

We believe that the ADACAS advocacy model is the ideal model for what we believe to be amongst the most vulnerable group of people in Australia. It is more unfortunate that in the large states in particular, most people in high-level care never have contact with an ACAT advocate. ADACAS has also developed and presented major position papers on significant issues including retribution in aged care, younger people in nursing homes, including developing a set of higher-level principles for the deinstitutionalisation of that group of people, and on other issues such as mental health.

We believe that institutions are not the ideal living environment and can indeed be harmful to people in them. We have a significant role in assisting people who wish to leave institutions to move into their own homes. ADACAS contributed to the NACAP or the National Aged Care Advocacy Program submission to the commission in July 2011. We would like to supplement that submission with comments on the draft report. We are aware that a number of other advocacy agencies have provided feedback on the draft report and we will not dwell too much

on some of the issues raised by them.

ADACAS welcomes the draft report and generally supports many of the recommendations. However, we would like to make comment on a number of issues. The draft report refers to advocacy agencies as advocacy services. We note that many NACAP advocacy agencies also refer to themselves as services. The ADACAS name includes the word "service" but that is historical, and ADACAS advocacy principles state clearly that advocacy is not a service.

We also do not generally provide advocacy for carers even though that's in our name. The repeated use of the term "service" undermines the need for advocacy to be independent of service delivery to people with a disability or people who are ageing and is confusing both for them and to the clarity of that separation and independence. Advocacy is distinct from human service delivery, such as services that provide accommodation, accommodation support or community access.

Advocates advocate against or to service providers. The strong relationship between the advocate and the client is unique because of the advice, defence and protection that advocacy offers. The consensus of opinion amongst disability advocacy agencies in Australia and overseas, and with some aged care advocacy agencies, is that advocacy is not a service. Many agencies clearly articulate this as a basic principle of advocacy. An example is the principles of advocacy by the combined advocacy groups of Queensland. Alternative terms include agency, office, protectorate or body.

The focus on the person: ADACAS strongly supports the focus on individual persons and their rights. This is enunciated in the draft report in the following:

The recommendation for increased flexibility and support services, the stress on meeting individual needs for services to be person centred; the emphasis on restorative care and rehabilitation; the right of people to make life choices, including choices with a higher level of risk; the right of people to maintain their connectedness to others while in receipt of care, whether at home or in a facility; the right of people to exert influence over the environment.

ADACAS strongly supports the recommendation to separate the policy role of government from the regulatory activities. The current regime is flawed because of the lack of independence of some regulatory activities. This includes the lack of independence of the complaints handling process, and an embedded culture in government of risk aversion.

Some issues which we would like clarified: ADACAS is of the view that some clarification is needed in respect to some fundamental aspects of the proposed

reforms; these include restorative care. ADACAS welcomes the emphasis on restorative care and that the person would receive a flexible range of care and support services that meet their individual needs and that emphasise, where possible, restorative care and rehabilitation. However, we are concerned about the term "where possible". Clarification is needed on who determines "where possible", and how this is defined. This could easily be used to exclude as well as include.

Feasible and appropriate: ADACAS welcomes the ability of the person to choose whether to have care at home or in a facility and choose their approved provider. However, we are concerned by the term "where feasible and appropriate". Again, clarification is needed about who decides what is feasible and appropriate, and how "feasible and appropriate" is decided.

Portability of funding: ADACAS welcomes the proposed funding system which may lead to greater control by older people. However, clear portability of funding tied to the individual would deliver better outcomes and accountability for people.

To reinforce a transfer of choice and control to older people they would be responsible for paying their co-contribution for purchased services directly to the provider. For administrative deficiency, older people purchasing services will also sign over to the provider their service subsidy from the government.

It is unclear whether signing over their service subsidy from the government to the provider would deliver clear portability of funding tied to the individual.

The assessment process: the assessment process and indeed the report needs to be underpinned by a statement of philosophy. Is the assessment process and the resulting service provision about providing opportunity for a person to thrive or merely survive. An example: residents in aged care facilities and those people in receipt of Commonwealth aged care packages continue to be required to adjust their lives and routines to fit the form of the service provider offers. They are expected to be passive recipients and are not expected to direct or control the shape of their lives.

A generalised impression received on entering residential aged care facilities is that there is not often a great deal going on that generally enhances a resident's quality of life. Facilities often give priority to efficient functioning over the quality of life and wellbeing of residents. The lived experience of residents simply does not rise to the potential inherent in charter of residents' rights and responsibilities or the aged care standards, despite the accreditation process.

Assessments of older people are usually negative assessments in that they focus on what a person cannot do - their deficits. This varies from assessments

generally received by people with a disability and some older people living in the community. These assessments are holistic and focus on the characteristics of the person and include what a person can do and who the natural supports are; for instance, family, friends, neighbours, their church, their club et cetera. The assessments also focus on what can be done to help a person be an included member of the community, to thrive, not just survive. Theoretically this allows service provision to supplement the existing natural supports.

I'd like to just talk a little bit about the current complaints system and the implications of that towards any change. That's the CIS - the complaints investigation scheme, I think it's called. The most likely complainants to the CIS are family carers and care recipients who have ready access to a phone. It follows that the most vulnerable consumers - people in high-level care without access to a phone - do not access the CIS. The CIS is not accessible or relevant to this large group of people receiving services under the Aged Care Program. This is especially significant in the larger states.

It is not obvious that the CIS identifies whether or not the family carer has permission of the care recipient to make the complaint to the CIS. Given the care recipient is the most vulnerable person, we suggest that any proposed complaints scheme spells out what steps are taken to ensure that the care recipient is aware of the complaint and steps are taken, where appropriate, to protect the person from possible retribution and that any new scheme would be accessible to the most vulnerable people.

ADACAS and other advocacy agencies have identified that fear of retribution and experienced retribution are seriously inhibiting factors for carers and care recipients who wish to complain about a service. This has been recognised by the Commissioner for Complaints in the Senate, the Community Affairs Committee inquiry into quality inequity in aged care in 2005. We refer to the ADACAS submission to that inquiry. Any proposed change in service provision of regulatory oversight needs to develop strategies to maximise the opportunities for care recipients and family carers to complain about service providers in a manner that minimises the fear of retribution. It is ADACAS's view that one demonstrated strategy is an adequately funded advocacy program that enables advocates to regularly visit all aged care facilities - that's all.

Younger people in aged care: the draft report has failed to address the issue about the more than 6000 younger people with disabilities living in aged care facilities. We recognise that the Productivity Commission has undertaken an inquiry into disability care and support, and we recognise that the Productivity Commission caring for ageing Australians report will make recommendations on the most appropriate funding, assessment and service delivery arrangements for people with disabilities who are ageing, and older persons who incur a disability. However,

ADACAS is of the view that the draft report - or the final report - should address this significantly disadvantaged group of people.

It is ADACAS's view that there needs to be a more supports in place to stop additional younger people being placed in aged care facilities. ADACAS believes that younger people with a disability should be living in accommodation of their individual choice in the community with adequate portable funding for supports in place.

A role for independent advocacy but for whom? The only mention of advocacy in the proposed building block approach - figure 8.2, page 256 of the report - is in relation to carers. The HACC program does provide funds to carers' associations to provide advocacy for carers for older people. The NACAP, funded by the Aged Care Program, has individual and a systemic advocacy role for consumers of the Aged Care Program which is primarily aimed at residents in aged care facilities or in receipt of the community based funding packages.

Some of these agencies also receive HACC funding to provide advocacy for older people living in the community and their carers. The draft report does not define "consumer" - and this is the same with the department as well; it also does not define it. There is an ongoing discussion within NACAP and between NACAP and the Department of Health about who consumers of the Aged Care Program are. The department generally regards both carers and residents as consumers of the Aged Care Program and of the NACAP. However, this presents difficulties for some advocacy programs who understand that advocacy cannot be provided to an older person and their carers because there is an inherent conflict of interest.

ADACAS's advocacy principles provide for advocacy to be provided to the most vulnerable person in any given situation, which is invariably the older person. However, the ADACAS advocacy process recognises the important role carers have in the lives of older people and the agency has a commitment to maintaining and strengthening these connections where possible. ADACAS advocacy is entirely client directed, and so the degree of involvement that a carer may have in a specific advocacy matter is determined by the older person. In some cases there may be none. In other cases external bodies such as guardianship tribunals may have to be involved.

Recommendation 8.2 is welcome. However, given the lack of clarity about who the aged care consumers are it is unclear whether the Productivity Commission intends for the NACAP to be included in this recommendation or whether it intends resources to be given for care advocacy only. Finally, the NACAP is significantly under-funded for its current role. The implementation of these reforms will place additional strain on the program. It has a vital role in providing an independent source of information to older people and supporting them to make informed choices

about their rights and care options. It could also have a role in assisting aged care consumers to understand these reforms and how they would impact on services and how these reforms will affect them.

Most states and territories have multiple individual disability advocacy agencies. We understand that funding for disability advocacy agencies is approximately 18 times that for aged care advocacy. While we believe that the current NACAP advocacy agencies have the experience and expertise and should be adequately funded in the future, we are of the view that in the large states in particular, consideration should be given to funding either multiple offices of the existing agencies or multiple agencies. This would maximise the number of aged care homes and services that can be visited by advocates on a regular basis.

MR FITZGERALD: Good, thank you very much. We'll come back and clarify a number of those issues that you've raised in a moment. Sue, would you like to start off?

MS MACRI: Just if I can jump to around the complaints investigation scheme and where you talk about - in the second dot point, that permission from the care recipient is not always given or the care recipient is not being consulted around the complaint. I just wonder what your thoughts are around the handling of that situation where there's a high proportion of the residents suffering from dementia and don't have the capacity to give that information or that consent, and if you've given some thoughts around that particular area?

MR WOODHEAD (ADACAS): The comments related to the point that the department has informed us that it is - while they make attempts to ensure that the person who is receiving care is aware of it they cannot always be sure. That was the point I was making. Certainly where it is shown that the person lacks capacity then obviously the family carer is the prime person, and we often are working in that scenario. However, ADACAS advocates would always go and talk to the individual first before - so if a carer rings us, we would go out and see the person who is receiving care. Very often because of the nature of our visits - that we visit all the homes on a regular basis - we often come across a person who has dementia. I also point out that just because a person has dementia doesn't mean they don't have - we find that the vast majority cases the issues raised have some legitimacy.

MS MACRI: Just in terms of the visiting of residential aged care facilities, I mean that's just done, I understand, on an ongoing basis. You talked about those relationships. I think that's one of the things going forward that is very important, that relationship between advocacy services and the aged care industry. Is that common across most advocacy services or is this something you've particularly initiated in the ACT?

MR WOODHEAD (ADACAS): We're at a significant advantage in the ACT in that there's a small number of homes. I think it's 26 or something like that. While we are under-funded, we only get 50 hours a week, we have been able to visit all homes. The last year we have been severely hampered by illness and lack of staff, but going back several years, you know, up to 120, 130 regular visits to those homes in any one year, plus probably another 100 to 150 visits to visit individual clients. My understanding is in Tasmania and the Northern Territory there are a significant number of the homes visited. But certainly in the larger states where you have seven or eight advocates - New South Wales and Victoria they're up to something like 900 homes, it's impossible.

MS MACRI: Yes.

MR WOODHEAD (ADACAS): So the most vulnerable people are not getting any access to advocacy from the agencies.

MR FITZGERALD: In the disability area, as you well know, there are formal advocacy - sorry, there are organisations that are funded to provide individual and systemic advocacy. But in addition to that there are community visitor schemes in most states and territories, I'm not sure about the ACT. Those community visitors visit residential disability services. They also - different teams visit juvenile justice centres, children's services and so on. So I was just wondering whether or not the approach here is to - how do we deal with these issues that you've raised? You've raised the issue about the inability often of people to make complaints, the issue of retribution and so on. We understand all of that. They are real and they exist in both disability services and in aged care services and in mental health services as well.

So do we need to look at a model whereby we not only increase the level of support for advocacy but we need something else that's taking place at the same time where there is regular non-threatening visitation into these services, or is there another way forward, because you're absolutely right, it's hard for people to complain if they're in a residential service. We understand that. Retribution, whilst we would think it would only happen in rare occasions it certainly does happen. So is simply increasing support for advocates and advocacy sufficient?

MR WOODHEAD (ADACAS): Absolutely not. I've been visiting institutional living situations for some 16, 17 years, including - in a previous role to ADACAS, the last five years - immigration detention centres right across Australia in an inspection role. I compare immigration detention centres to aged care. People in immigration detention centres have people in every single day from a whole range of agencies from the department to the ombudsman to charities to churches. So there's an incredible degree of oversight there, including the official agencies like human rights and Red Cross.

Residential aged care is completely different. You do not have that range of people there. Some homes have a few, some have quite a few coming in, but many don't have any at all, really, other than the agency and the occasional visit by some others. I would welcome anything that has people going in, because it's observed things that are really important, otherwise it really comes down to aged care workers to raise issues, and they become the only ones, with their inherent conflict of interest. Certainly our experience is that there have been people who have been threatened with loss of shifts or even lost jobs because they raised issues. So anything such as an official visitor or something like, we'd most welcome. I haven't thought through that model but anything - - -

MR FITZGERALD: No, no. It just seems to me that some of these issues have to be dealt with in a number of different ways. Just in relation to the independent advocacy, we do agree that there needs to be an increase in funding and support for advocacy. In relation to other members of the National Aged Care Advocacy Program, we've had a number of them present in different states and territories already. Is it your view that increased funding for that program, and therefore the current recipients of that funding - which I understand are about one in each state and territory, there's about eight of them.

MR WOODHEAD (ADACAS): Yes.

MR FITZGERALD: I think the funding is in the order of about 2.5, 2.6 million. Is that the most appropriate way to go forward in terms of increasing advocacy support?

MR WOODHEAD (ADACAS): I would say, conditionally, yes, that it is, because they have that experience and knowledge and expertise. But if we look at the disability sector, we see that there is a large number, which makes disability advocacy agencies much more accessible. It also means that they can visit people, whereas particularly in the bigger states most of the work is done on the phone, which is inappropriate. Certainly in my work, extensive work in human services and in government, you use the phone to make appointments, particularly with people with disability or people who are aged and at home. That's the only reason you should be using the phone; you should be going out and seeing them face to face. We need to develop some sort of system where that is available to all recipients under the aged care programs.

MS MACRI: I'm not sure if it follows on, but just in relation to younger people in aged care facilities, again, it is a huge issue and it is a dilemma, and you talk about a moratorium. Again, we'd be interested in some thoughts around this. The issue is, again, when you get out to rural, regional areas where people want to have their family member residing close to them, so they can visit, give care, give support, and often the residential aged care facility is the only alternative. Have you given some

other sort of thought around some of the alternatives for young people who require care?

MR WOODHEAD (ADACAS): You only need one example of it succeeding to show it can be done. ADACAS helped a woman from residential aged care, who had been there for 23 years, move into her own home in the community, with supports. It wasn't hard. The biggest barrier was family, but we worked; it took 18 months. Since then we've moved other people out into the community. There are people who are quadriplegic and on respirators living in the community; if they can do it, anyone can do it.

We developed a set of high-level principles which look at what are the requirements of having a good life. It talks through a number of the main issues you have to meet in order to get that person to live in the community, in a positive way so that they don't just survive. There are a number of ways of doing it and there are a number of jurisdictions, particularly in the United States, where it has happened. I think it's Delaware or New Hampshire in Wisconsin, where they actually talk about 2000 people out of residential aged care. Portable funding is one way, of actually taking the bucket of money - and it's certainly the case in some jurisdictions in the United States where people are able to take the bucket of money that is given to residential aged care and take it home and use that to buy services.

There is another way, which we've touched on, which is actually cost neutral, which is that, at each funding round for residential aged care, the younger person in aged care takes home that money that they were getting from the Commonwealth to live in aged care. That bed just remains empty until the next funding round and then it's picked up again, so it's actually cost neutral. Then the states and territories may take over that funding, and certainly that has happened in the past.

MR FITZGERALD: There have been quite a large number of younger people taken from aged care facilities into the disability system, so they haven't been moved at the rate that anybody would think is desirable, but you are right; there's a lot of examples. Hundreds, in fact, have been moved out over the last five years, but you've still got this very substantial group of people that are still there; that's absolutely true.

The dilemma for the aged care report is that, in a sense - and I hear your suggestion about actually taking money across - is that until the disability system starts to rev up substantially, there is a problem, actually, in that transfer. But we take the point. But at the moment, if the disability system doesn't really improve substantially, it is actually very difficult. Not impossible, because we're doing it, but it's difficult.

MR WOODHEAD (ADACAS): I think it's the will; that is the only problem. It is

the will to do it. It is the lack of thinking about a full range of options. People think - and they have it in an ACT: they move people out of aged care into a group home. That's just going from one institution to another. Your only compatibility is your disability and it just makes it another institution. People, you and I and everyone else, make choices about who we live with and just because a person has a disability doesn't mean they only have a choice of another person in a wheelchair. I really do think that really it's a will issue: people need to have the will to do it and they will do it.

MR FITZGERALD: Just in relation to a couple of your other comments about the words, just a couple if I can pick them up: no, we haven't defined "consumer", but should we? Why I say that is, the consumer, for most people in aged care, it is very clear that it's the person who is ageing; no question. But then you actually do get to the point that you even acknowledge in your own services, where the person is not able to make decisions - and with dementia, that is an example - but much more than that, so in a sense the consumer actually is the person who's ageing but it is also done in conjunction with their carer. So I wonder whether or not trying to define it is actually helpful at all. It's helpful for a particular purpose, but in the end I'm not sure that it does actually help.

MR WOODHEAD (ADACAS): I think you may be right when you look holistically. With advocacy agencies, if a carer comes with a complaint, the person being cared for may not agree with it, so there's conflict of interest. So for us it is important that it's defined.

MR FITZGERALD: I agree. For different areas of activity and for different purposes, you do need clarity. I'm a lawyer by background, but overall my view is you don't define things if you can avoid it, because it doesn't help; it actually hinders. Everybody creates boxes and this is a problem. So if we can not define it, it might be helpful. But I do appreciate, for your area of activity, your issue. For your area of activity there are significant issues.

Just one other comment. We do use the word where possible and practical and part of that is because we're moving from a rationed system to an entitlement based system, which is a radical change. But one of the issues that we actually have to be very candid about is that in not all circumstances can people's wishes be actually achieved. We've seen that in rural and remote areas, but it's actually true about living at home. Whilst everybody would wish to live at home, unless there is a full-time carer, that is not a safe option. So at some point the assessor will say that the safe option is in fact provision of care in an alternative accommodation setting.

There are actual constraints, even in an entitlement based system. What we didn't want to do was to pretend that, "Just because I want it, I can get it." Even if it seems reasonable, it's just actually not possible to achieve it, so we just wanted to be

honest and say sometimes it's just not possible. There's nothing hidden, other than to say that. Frankly, if we look across the whole of Australia, you would readily understand that is in fact the case; that there are just some places it is not possible. But also, I think, in relation to caring for people at home, it's also not safe, and that is another significant issue that has to be addressed. So that's why we use those terms.

But you were right to raise them and, if you were sinister of mind, you could think that these could be ways to ration the system further, but I don't think that's why we put them in; I can tell you we didn't put them in for that purpose. But it is difficult. Other comments?

MS MACRI: No, I haven't.

MR FITZGERALD: Just your other comment about service. I hear your comment about it not being a service, but I'm not quite sure that helps us to actually define what you are. I can talk about advocacy, as you do, but at the end of the day advocacy is provided, generally, by a service provider, so I'm not sure whether we get very far. I should just indicate to you that I have been an advocate myself, so I understand this issue, but I'm not quite sure that I understand how we can actually word the document to accommodate your need.

MR WOODHEAD (ADACAS): I think that there is movement; the fact that nearly all disability advocacy agencies do not call themselves a service and actually articulate that. Certainly one or two of the aged care advocacy agencies are there. I think it really is about stopping confusion, to ensure that people understand exactly that we are not a service provider. We often get calls saying, "Can you do this and can you do that," because we have service in our name. Certainly one of my things as CEO is to get that name changed, maybe calling ourselves ADACAS and just make it a word.

MR FITZGERALD: I'm happy for you to do that, I'm just still not sure if we do it in the draft report. I think I understand where you're coming from, but I'm not quite sure if I can come up with a solution to it. Are there any other points you'd like to make, Sue, or questions?

MS MACRI: No.

MR FITZGERALD: You're all right?

MR WOODHEAD (ADACAS): I'm finished, thank you.

MR FITZGERALD: Could I just make one other comment and this is an important one. It's in relation to the disability report as well. We are trying, wherever possible, to make sure the systems converge. But what is not possible: it

is not possible to have a joint disability and aged care system. We've looked at it and, as desirable as it might seem, it's impossible to actually design one. So we are recognising that there will be two systems, but there are points where they absolutely have to converge and we are very conscious of those.

One of those is around carers, one of those is around people with disabilities who are ageing and how we deal with that. One of those that's emerging is in fact the provision of assistive and adaptive technologies, and aids and equipment. So there are a number of areas where the systems absolutely have to converge, but we have to be absolutely frank: we cannot get the two systems to merge into one system. It is just not possible. Having recognised that can't happen, we are then trying to make sure that the interface issues are dealt with in the way you've described. I know people would like one system, but we just can't make it work. Somebody else might be able to, but we can't at this stage.

MR WOODHEAD (ADACAS): My only two comments on that is: one is older people who use aged care programs, of one sort or the other, are just people, older people with a disability, so nothing changes. The second thing is that I'm not particularly uncomfortable with separate systems, because there's a danger of a slippery slope; you go from one service, presumably, and with the accepted outcome that you're going to be in residential aged care, which I do not think is the correct path.

MR FITZGERALD: No, and we don't want that to occur unless it's in the best interests of the person themselves. All right, thank you very much for that. We'll now break for lunch and resume in about an hours time; about 1.30. Thank you very much

(Luncheon adjournment)

MR FITZGERALD: If you could just give your names and the position and organisation you represent for the record and then we'll go to an opening statement.

MR O'NEILL (NSA): Michael O'Neill. I'm the chief executive of National Seniors Australia.

MR MATWIJIW (NSA): I'm Peter Matwijiw, general manager of policy and research at National Seniors Australia.

DR CURRAN (NSA): Dr Liz Curran, director of policy, National Seniors Australia.

MR FITZGERALD: Good. Over to you. Thanks very much for your contributions and your active engagement in this project.

MR O'NEILL (NSA): We have a few opening reflections and are then happy to proceed from there. Firstly, an apology for the late submission of our material. It was delayed somewhat by forums we ran in Melbourne and Perth and being able to consolidate those, as well as some work that we've engaged Henry Ergas to do on an aspect of the report and we'll deal with that shortly.

Can we say overall that we find the reform framework proposed in the draft report to be commendable. We accept there will be always some debate at the fringes, both here and also in terms of the government response, so that's a general overview. We do wish to emphasise the issue of the enshrinement of quality of care as a key goal which we think was perhaps not emphasised as much in the initial draft report as we would prefer to see. So quality of care being enshrined is important. We think that links to the staffing issue which we'll deal with in more detail shortly, and similarly, links to a broader shift towards demand-driven and consumer forces within aged care. It needs at all times to come back however to that issue of quality of care being enshrined. I'll touch briefly on consumer protection as part of that as well.

So four or five general points to touch on: in our submission we've proposed the appointment of a dedicated and independent aged care ombudsman to report to the parliament and his recommendations be made public. In coming to this view, it's something we've tested at the two forums we ran in Victoria and Western Australia and there's strong support for that. In coming to that view, I guess we were particularly focused on the importance of having confidence within the aged care system from a consumer perspective and it was evident amongst our own membership, which is extensive, and also those who attended the forums who are both members and non-members, that confidence was a key issue and we think the concept of an aged care ombudsman may well provide the confidence that's

necessary.

We note in that regard that the financial services industry has an ombudsman, dedicated, as does the telecommunications industry and we would argue that certainly aged care would benefit from such an appointment. We're happy to detail that more fully. We've also proposed that the idea of an aged care ombudsman be supported by a community visitors program consistent with what's already in place in Victoria, in the model used by the Office of the Public Advocate there which I think provides a good foundation. So that's the first significant one we would touch on.

In terms of the family home, we note the commission's proposal on the family home. We broadly support the concept of the family home being included in a means test. We would say, however, that there is significant resistance from older Australians to the concept. Certainly that came through in some survey work that we've completed, as well as the views expressed at the forums that we undertook, so there's significant resistance there. We have proposed in that regard that the value of the family home to be included should only be above a threshold value, instead of the highest-priced capital city median home value, and we're happy to expand on that in some detail as necessary, or my colleague is.

In terms of workforce issues, we particularly think that the issue of adequate remuneration, attraction and retention is absolutely critical. We're on the record elsewhere as having indicated there can be no reform about aged care without reform of wages and salaries for nursing staff in particular but other staff as well. We think that without that being achieved, reform longer term is not possible. We understand the limits on use of the term "ratio" in staffing and we're not proposing ratios as a concept. I do need to share with you the very strong view from our own survey work and the forums we conducted, the concerns of older Australians about there being adequate staff without going to ratios.

The pensioner bond scheme we think has merit but we believe that it would be important to link that to the long-term Treasury bond rate. This would give consumers a relatively risk-free rate of return on their investment and I think provide the kind of confidence that is important within the system.

The emphasis in the report on greater competition and market forces driving standards and hence quality in the aged care area, we would certainly be - and we've sought in our submission greater empirical evidence to support that view. Over and above that we certainly recognise there is a role for competition and market forces, but that needs to be accompanied by significant consumer protection. The ombudsman is an example of that, but so also are the need for regulation to support the position of older Australians who are particularly vulnerable at this time. We highlight in our submission the issue of prudential supervision of bonds and some concerns we have there based on work done by the Australian National Audit Office

in the last 18 months or two years.

Final issue just to briefly flag is a continuing concern about CALD - minority groups generally but CALD and Aboriginal and Torres Strait Islander folk and the capacity of the aged care system over the next 20 or 30 years to support those groups. I think in our forums and survey work the position of CALD folk from a CALD background has been particularly highlighted. We have a range of examples we can provide.

MR FITZGERALD: Good, thanks very much, Michael. Sue?

MS MACRI: No, I'm right.

MR FITZGERALD: Well, let's just deal with a couple of those issues. The ombudsman, you're right, a number of schemes have ombudsmen. In fact, a number of governments have ombudsmen for a whole range of different purposes. An ombudsman, in a sense, is a complaints handling and investigations body which makes recommendations and findings. I wonder how different that is from what we're proposing where we'd have a commissioner for complaints and reviews that sits within the regulator which would have the same - identical powers to an ombudsman. So I wonder whether or not it's more an issue of the term or is there something more substantial there?

MR O'NEILL (NSA): I think it's more substantial. I think it's about perceptions. The concept of an ombudsman is widely recognised within the community. The independence that they have I think provides the foundation for the confidence that was a clear issue for us in our discussions with folk, that people are seeking - they are seeking to have a confidence in the system. They don't have that confidence at the moment.

MR FITZGERALD: Sure.

MR O'NEILL (NSA): The idea of an independent ombudsman reporting direct to government, not through an agency, transparent in the way they operate - all those historical things that have given ombudsmen a sound name, shall I say. I think that's the attraction that people have around that compared to what's proposed with your complaints commissioner.

MR FITZGERALD: I mean one of the aims we were trying to do is to ensure that it all dovetails together, that is, that you've got the regulation and compliance enforcement, the quality control and the complaint handling in some way that whilst the complaint handling would sit as a independent statutory division within the regulator with its own statutorily appointed commissioner, there would be some synergies within this new basket that we're creating within the regulator. But I do

understand why people like something separate. I'm just not sure - I'm not opposing it but I'm not sure that the outcome is any different. Unless the functions are different the outcome is probably going to be the same.

MR O'NEILL (NSA): Probably pretty similar, but I think the achievement of that issue of confidence in the system - from a consumer perspective I think is the really core thing. Without putting words in your mouth the overview that - the shift in the system will be very much driven towards the consumer having a greater role, greater responsibilities in terms of their decision-making and so forth; enhancement of their position. There is, at the moment, an absence of confidence.

MR FITZGERALD: Sure.

MR O'NEILL (NSA): I think that will be reinforced. I think the idea of the ombudsman can respond to that in a way that people will be comfortable and familiar with.

MR FITZGERALD: The community visitor program I've raised a couple of times. You'd be aware that I was community and disability services commissioner in New South Wales, which also ran the community visitor program for disability and children's residential services. So I know lots about community visitor program, and they're attractive. The question, I think, in the aged care area is the resources that would be attached to that scheme - what gives you confidence that resourcing a community visitor scheme on a national basis is the most appropriate way of using those resources vis-a-vis trying to improve other aspects of it? Now, I know they're not either/or but the question in my mind at the moment is not that I think a community visitor scheme wouldn't have merit, it's whether or not given the resources it takes that's where we'd want to put some of that financial - additional finances. So just a question.

MS MACRI: Robert, there has been a Commonwealth community visitor scheme in residential aged care.

MR FITZGERALD: Previously?

MS MACRI: Yes, and I think to some degree it's still operating in some places, but probably - you know, some facilities and organisations in smaller communities have managed to keep it going - - -

MR O'NEILL (NSA): More informally?

MS MACRI: Well, still with some Commonwealth funding.

MR O'NEILL (NSA): Okay, yes. I guess we would see it as being part of a

response. It delivers a different kind of response but again, the kind of thing that would dovetail neatly with the ombudsman kind of role. I think it's the kind of thing that reinforces that confidence aspect that I keep coming back to. Over time the resource element, I wonder how significant the resources required will be compared to the operation of a substantial public sector group. As you said, it shouldn't be either/or.

MR FITZGERALD: No.

MR O'NEILL (NSA): I think that opportunity is there. Can I say, a little bit off the cuff, my colleagues will probably squirm as I say this, but I think there's - it's also an opportunity to recognise and provide for a continuing role for older Australians in that kind of role, so valuing the capacity of people as they continue to age. This provides actually quite a niche opportunity to harness some of that skill, that knowledge, that wisdom that people have built up over time, but also provides the opportunity for people who have some connectivity to the issues, both now and also into the future, to be harnessed as well.

MR MATWIJIW (NSA): There is a substantial difference with the existing scheme within the department, as we see it, in the sense that the lessons we can see from what happens in Victoria is that it's a stronger body and it's clearly independent.

MS MACRI: Is it funded under the state government or is it part of that Commonwealth scheme that I was talking about?

DR CURRAN (NSA): It's not. It's governor in council appointments.

MS MACRI: Right.

DR CURRAN (NSA): A lot of it is done on a voluntary basis. But where the resource intensity comes in is they have a really effective training modules, they have protocols with not-for-profit and full-profit providers. It's a highly sophisticated system and it reports to Office of the Public Advocate, a statutory officer. So it's very different to the current model, as Peter has indicate, that operates which reports to the Department of Health and Ageing.

The other thing is, highlighting Michael's point, it is a way of involving people who are in the community and again, reinforcing that confidence, because the people are seen to be like them, but more independent than them. One of the case studies in our submission was about - in relation to a person who was too scared to complain because her mother was still in the aged care facility. But through the community visitors program she was able to get the issues noted, reported. They were reported to the OPA and then the OPA - because no action was taken the OPA was then able to actually put it in its annual report.

The other thing we're suggesting, which is slightly different again, is that the aged care ombudsman would be able to initiate investigations of its own volition informed by the direct observations that have been made and verified by the community visitor staff.

MR FITZGERALD: Yes, and those design features are very important if you have a community visitor program. The least effective community visitor programs are those that are run through departments, for the obvious reason, although I have to say there are a number of those. Some of them, I'm sure, are alright, but overall they're not the right model. Sue? I've got a number of other questions on some of the issues you've raised but - - -

MS MACRI: No, look, you keep going at the moment.

MR FITZGERALD: I'll keep going?

MS MACRI: Yes.

MR FITZGERALD: The family home. I'm very intrigued and pleased that you're supportive, to an extent, of having the family home considered for the purpose of means testing. That's a substantial move and I'm sure that many of your members have very strong views about this issue. But you've come up with a compromise proposal so, as you said, could you just talk us through a little bit what that proposal is in relation to what actually gets included and what doesn't?

MR MATWIJIW (NSA): From talking to our members and other people, home ownership has long been thought of as providing protection against poverty in old age and there's very strong emotional attachments to the house. The other thing that was concerning us is this great variability in house prices across the country. We looked at the figures for the December 2010 quarter where median home prices, including units, in the eight Australian capital cities, range from \$330,000 in Hobart to \$515,000 in Sydney.

Under the means test proposal, as we understand it, in the draft report only a couple with a median priced home in Hobart and less than \$59,000 in other assets would qualify for the lowest rate of care contributions. A single person wouldn't be able to qualify for the lowest rate at all, as the Age Pension non-home-owner asset limit is \$313,000. We recognise that a number of Australians have, arguably, over-invested in the family home, because of the treatment it gets under the tax system.

For that reason, we don't oppose it outright, but we are suggesting some sort of threshold consideration to take into account the variation in the prices, as I have said,

and the value of that asset; and also recognising that a home is not just a capitalisation for people, it's a security blanket, it's something that you pass on to members of your family, other people and so on. The underlying principle is that people should be able to pay for what they can afford to pay is not disputed by us at all, but we are saying that you should take the value of the asset - which is sort of equal - given the various price differences.

MR FITZGERALD: All we have done at the moment is taken effectively the means test that applies to non-home assets and then said that the family home would be included in that, to avoid a new set of tests. But putting that aside, taking your example, the highest median price for a house is in Sydney, which is, you say, \$515,000, if you set that as the threshold, what does that actually mean? Does that mean that your house doesn't get taken into account if it's less than that figure at all? Is that what we say?

MR MATWIJIW (NSA): That's what we're proposing, the figure above what the threshold is.

MR FITZGERALD: So if I took a house in Sydney worth \$800,000, the \$285,000 above that is the figure that gets taken into account. Is that right?

MR MATWIJIW (NSA): That's the way we have presented it.

MR FITZGERALD: So it becomes just a straight threshold.

MR MATWIJIW (NSA): Yes.

MR FITZGERALD: Okay. In terms of the house for the means test purpose, you have mentioned there are a couple of issues around single people versus couples, and what have you. I was just wondering if you done any analysis of the effect of our proposal on various groups? Have you done any cameos, case studies, at this stage? We are doing some in-house, I might say, at the moment; so we are looking at that.

MR MATWIJIW (NSA): We have not done our own cameos. We have actually partnered with the Australian Independent Retirees and requested that information from the Productivity Commission, and I think we have provided you with seven or eight cameo that we thought that we might be able to get some enlightened figures on.

MR FITZGERALD: Okay, so we're not going to wait for you to come up with them - - -

MR MATWIJIW (NSA): No.

MR FITZGERALD: We'll do them. All right. Well, we will do them. Are there any other concerns about the family home beyond that. Look, can I just make the comment that our view was simple, but important. We did recognise the accommodation element - you know, people meet the accommodation right through their lives, and so, going into old age, we think the same. The means testing was an issue that, rather than trying to change the age pension through this inquiry - which would not be appropriate - it was in fact, as you rightfully say, to try to acknowledge the wealth and the equity in the family home, but to do so in a way that was fair and affordable. So we welcome that suggestion. Have you got any other comments or views about the implementation of this proposal? I note in some of your media comments you have indicated that these proposals should be pushed off for a very long period of time.

MR O'NEILL (NSA): A transition time, I think is what we called it.

MR FITZGERALD: Yes, but your transition time means that I'll be dead. That didn't seem very attractive. So have you had a thought about your transition time?

MR O'NEILL (NSA): My transition time is also about, with respect, people being given the opportunity to plan for their future, in a way that governments and advisers generally encourage them to do. So if they make decisions they make their plans around a set of rules. I think they're entitled to rely on that set of rules without substantial changes occurring, and that gets even more pronounced the older you might become. With the increasing longevity issue, I don't know where the line may well be drawn. Very clearly, if you've got someone in their late 70s they might have another 10 years left, but also at that point in their life substantial changes to their financial arrangements do impose a significant demand upon them and significant stress upon them.

MR FITZGERALD: But my point is you haven't actually got a fixed view about the timing.

MR O'NEILL (NSA): I think it's longer than you've proposed.

MR FITZGERALD: I gathered that. That's fine.

MR O'NEILL (NSA): Just before we go off the house thing, could I just add one other thing. We flagged in our initial submission the fact the house is one way of dealing with the issue, but we'd also add some work done by Access last year on an insurance model and also a bond, a pensioner aged care bond arrangement, a bit similar to super. We're having some additional work done at the moment by Henry Ergas from Deloittes and someone from the ANU around the issue of aged care insurance. That work is in progress at the moment. We expect to have it to the commission within the next fortnight or so. We have flagged that with your staff.

We think that is important in terms of there being a range of choices there. It may well not work, but until we get some work done on it - we think it's useful that it be done, as a principle.

MR FITZGERALD: We appreciate that. Our view in relation to the funding of the system is not fixed, but what we have done is in the draft just put forward a proposal. We think it's reasonably appropriate. In the shorter term it's probably the best of the options available. We're certainly happy to look at the alternatives, particularly for the longer term, absolutely. So we're open to that.

MS MACRI: This links a little bit into your community visitors scheme and I guess the ombudsman and that whole accountability area. Just in relation to accreditation, you say that the report focuses on accreditation complaints and regulation as being the thing that drives quality care, and you don't deem that that's sufficient. What are your thoughts around what is going to make it more sufficient, or how do you see accreditation and the quality? Because you bring up quality care quite a bit, even in your opening statement. So just your thoughts around that, how you think it can be better enhanced. There has been some dialogue around consumer involvement, which comes back to your community visitor scheme. Just your point of view.

MR O'NEILL (NSA): In terms of our reference to quality of care - that was one of the things that stood out in our conversations with the membership, in surveys and in forums, that their very strong emphasis was on quality of care being delivered. The view they had taken from the summaries of the material that we provided them was that there was a much greater emphasis on those other regulatory aspects, shall I say, without sufficient attention to quality of care.

In terms of how that is best achieved, I think we make reference to prescribing that within the legislation as being an area that needs to be committed to via legislation. It would be supported clearly by things like an enhanced consumer protection role, in a way that's not there at the moment. I think it does go to staffing issues. In my opening remarks I alluded to not ratios but certainly inadequate levels of staffing being core to that as well. It would then clearly be supported by things like the accreditation process, and others.

DR CURRAN (NSA): If I could just supplement Michael's comments, even the material produced by the Department of Health and Ageing concedes that the jury is still out on some of the models of accreditation that are used and whether that's an effective way. The current system does rely heavily on self-reporting and that I think has a lot of its own problems with it, and so the idea of a community visitor scheme would complement that source of information.

The Productivity Commission's suggestions around making information more

publicly available and transparent, we agree, and we think is a welcome thing, but I think the key things that we'd say is that accreditation - a lot of the models look at the minimum standard of care and I guess what we're trying to say throughout our whole submission is we actually think that that reflects a drive to the bottom, if you like, and what we'd like to see is some of the standards lifted.

There was an article in the Seniors Weekly recently about, for example, the requirements around reporting of an incident which basically said that a pretty horrific circumstance that occurred in a residential care facility didn't require to be reported, and so there are some gaps in how the reporting happens and the standards that people are expected to be measured against. So I guess what we're saying is that needs to be examined in a quality of care context and also we've actually also included reference in our submission to the idea of human rights and dignity of the person. That's often not reflected in some of the care standards and we've actually, as Michael has foreshadowed, asked that some of those concepts be enshrined in the act so that it actually requires those who operationalise these things to comply with the act. So we just think there's a lot that could be done to enhance these standards.

MS MACRI: How do you see that then playing out into the community and have your membership talked around some of the issues around care in the community plus elder abuse of older people? I mean, has that come up and how would you see that in relation to fitting into an accreditation scheme or quality of care?

MR O'NEILL (NSA): Certainly in terms of community care and the likes of the HACC program, the consistent message is certainly around the need for further enhancement of the way that's delivered. It's inconsistent delivery across the country. I think the key message has also been around it's over-regulated nature and that very much links then to the quality of care that people are happy to access in their own home. Certainly that preference for people ageing in their own home, as you're aware, are reinforced by being able to access HACC programs that are responsive to their needs.

MR FITZGERALD: Just a couple of things - I know we're over time but we started just a little bit late - the pensioner bond scheme, the only issue there you've raised in your opening comments was about the appropriate rate of return, the bond rate and what have you. Beyond that, the scheme itself, obviously the detail has to still be worked through, but you're relatively relaxed about that proposal. It at least gives people an option as to what they want to be able to do. In relation to the equity release scheme which is of a different nature - and again, the detail will be very important in that scheme because it's not the scheme that's being operated by the private market so it will be of a different character - have you got any overarching view about the equity release scheme?

MR O'NEILL (NSA): We have reservations about equity release schemes and

that's reflective of the views of the over-50s community. We think the industry has a role in some situations for some people, subject to a significant level of advice and understanding about the product which is not there at the moment. We've used the term that it's an "immature industry" at the moment.

MR FITZGERALD: Yes.

MR O'NEILL (NSA): Whether the government's involvement in that will necessarily provide for that maturity, we need to wait and see the detail.

MR FITZGERALD: It may well be the government actually runs it, rather than uses the market, but that's up to them in a sense. Certainly it's not the same product that's on the market at the moment.

MR O'NEILL (NSA): That assumes government would deliver maturity as well.

MR FITZGERALD: Yes, well, you may comment on that. Are there any final comments that you wish to make? Thank you very much. Thanks for the submissions and your ongoing interest. We look forward to receiving that extra work by your organisation and Henry Ergas. Good, thank you.

MR FITZGERALD: Yes.

MS SKLADZIEN (AA): Ellen Skladzien from Alzheimer's Australia.

MR FITZGERALD: Ellen, thanks very much. We've had lots of association with your state bodies and your Australian body, so we're very grateful for that and for the many submissions we have received, so over to you for your opening comment.

MS SKLADZIEN (AA): First of all, I'd just like to thank the commission for letting me present today and also for all of your involvement with us and your willingness to meet with our consumer networks, as well as our CEO and myself. I also want to give you apologies from Glen Rees, our CEO; he is travelling overseas and is very disappointed that he won't be able to be here today.

We've provided you with a fairly comprehensive submission and I'll just touch on the main areas that we talked about in our submission. When putting our submission together, we consulted with our state and territory organisations, as well as our consumer networks. So while not all our views are aligned completely, we do try and consult with the various groups in our organisation. Overall, as an organisation, we are quite pleased with the report. We are excited about some of the reforms and thought that they really matched with a lot of things that we have been calling for as a consumer organisation and that many other consumer organisations have been calling for for a long time.

As far as our main points of difference were concerned, there are areas that we feel need to be expanded in the final report, rather than fundamental issues or problems with the reforms. We have six main areas that we touched on in our submission. First of all, we talked about the fact that we feel that dementia has been a little bit underdone in the report. I know that you spoke at the Melbourne hearings with Alzheimer's Victoria about this to some extent. While we're very much aware that many of the reforms will actually benefit people with dementia, we still feel that there are areas that need to be addressed in terms of dementia care and we need to build on the work of the dementia initiative and that it should be a core part of the reforms. So it's not just a matter of adding in the word "dementia" in a few pages, but it's actually adding in a thoughtful central aspect to the reforms of dementia care.

Our second area of concern was the funding model. There's two aspects of this. First of all, we're very interested and think that one of the things that will be important in the reforms is getting the funding model right and while we were fairly pleased with the funding model proposed in the appendices, we're keen to see what will appear in the final report and we think it's really important that the extra costs associated with dementia care are adequately costed and not just in terms of the immediate dementia care that's provided to a person with dementia but also the

consideration of how dementia impacts on the management of other chronic conditions like diabetes or other chronic health conditions.

Along the lines of funding, we also, as you're aware, have been thinking about a need for a more flexible entitlement system. We understand that the commission is focusing on trying to improve consumer choice and we applaud that, but we're not sure that you go far enough. We feel that consumer-directed care has to go further than just saying you can choose amongst approved providers and in some cases it actually makes sense to give people the option of getting care from family members or from friends or from neighbours. We're quite disappointed actually in the difference in the flexibility that was suggested in the disability inquiry compared to what was suggested in the aged care inquiry, so that's something that we'd like to explore further with you as well. We're unsure as to why it's okay for there to be flexibility in disability in terms of employing family members and friends but once you turn 65, that somehow this is no longer an option.

MS MACRI: You're really talking there about the cashing out.

MS SKLADZIEN (AA): That's right. Thirdly, the area that we addressed was barriers between mental health, disability and aged care. We think that people need to have streamlined access to services. I know we've had a lot of discussion already today about younger onset dementia and people who are straddling the line between disability and aged care, and there's a similar problem in terms of people who require mental health services in older age. Our particular concern is people with behavioural and psychological symptoms of dementia but there's also people with chronic mental health problems and we really hope that the commission will give a bit more thought in the final report to how these different systems interact and how we can make sure that people have access to the care that they need.

I guess there's two issues with regard to both disability and mental health and that is who funds the care and where do you get the care from. With regard to the question of where do people with younger onset dementia get care from - this is something that has been raised a couple of times - we feel that people should have access to the care they need that's the best care for them regardless of age, so the decision about whether they get care from a geriatrician or from a disability specialist shouldn't be based on their age but should be based on the care that they need.

We also raised some concerns in our submission about the gateway. Some of those I think have been addressed, looking at the report from some of the other hearings, but the main concerns we have are around making sure that people still have access to services that they might be looking for before they get an assessment, so the kinds of counselling and support that our Alzheimer's organisations provide.

Fifth, respite: we've had a number of conversations with the commission about

how important we view respite and how it is not only a support for carers but also very important for the care recipient or the person with dementia. From discussions with our consumer groups, we really feel that respite is one of the areas where cashing out or extending the proof of providers, whatever terminology you want to use, probably makes a lot of sense. A lot of times, respite is best provided by someone from your community or someone who knows you, and people do this on an informal basis to some extent but it reaches a point where people don't feel comfortable relying on others' goodwill and if they were able to compensate people for their assistance in some way, this would enable them to use the services that they already are trying to do in small ways. We really feel that respite is an area where flexibility and choice hold the key to good support and to keep people at home for longer.

Our last point was with regard to prevention. We know that there's a growing link between brain health and physical health and while the commission has suggested in the draft report that this is an area that should be further looked into in terms of research and that there's a need for more evidence, we feel that there's enough evidence right now that dementia prevention should be on the preventative health agenda. We'd be looking for the commission to make a slightly stronger recommendation about inclusion of ageing in the new national preventative health agency.

Also I just want to quickly mention that we feel that there's a need to recognise respect and value the range of social and cultural diversity of older Australians. As people age, they get more and more different, not more of the same. So what we've tried to do in our submissions and our thinking about this is to try and incorporate our thoughts about diversity within the relevant areas of the report, instead of - you know, originally had sort of a special group section of our submission but after further reflection, we really think that diversity should be something that we're thinking about in every aspect of aged care.

My last point is that consumers want action. They don't want to wait years before they see a real change in the aged care system. At the same time, we're aware that implementing such huge reforms takes a lot of time and a change in culture. Our thinking right now is that the area of care that would have the most impact and that we might be able to see immediate or relatively immediate change is community care. We think that there should be a freeing up of community care packages and also a consideration of some kind of mid-level package to bridge the gap between CACPs and EACH.

So I suppose there's three main things that have come out of our consultations. We feel that there's a real need for choice, not just lip service to consumer-directed care. We need reforms that build on existing work and services, things like the dementia initiative and aren't reinventing things that are already working, and there's

a need for quality of care for individuals with dementia, regardless of whether they're younger, whether they need psychogeriatric care as well.

MR FITZGERALD: Thanks very much. As we've indicated in the previous hearings, one of the reasons we didn't mention dementia more than 56 times I think is because we actually thought it was part of the core business, but we absolutely do acknowledge that we will give a greater emphasis to dementia, not simply adding the word "dementia" in, but actually seriously in it. From our point of view, certainly the commission's point of view, it was because we see that dementia is in fact at the actual core of this system that we're designing.

Can I just go to a couple of issues and Sue no doubt will: we will be very much clearer in the final report that apart from the formal aged care services that you access through the gateway, there will be and are a number of services that exist in terms of information, advice and advocacy, in terms of social support and inclusion programs, including care and support that sit outside of the gateway which can be and will be able to be accessed directly all through the gateway, a choice. Similarly, on the other side, there are the health, mental health, disability services that also we need to more clearly understand and articulate how they interface with the aged care service, so we're grateful for your organisation drawing this to our attention, as many others have.

But if I can just deal with one issue to start with and then we'll go through a number of others; it's this issue about flexibility and in particular in relation to respite. We seek your advice about this. You're absolutely right. The inquiry into disability support takes a much more liberal view in relation to the way in which these entitlements should be able to be handled by the person with the disability, and "cashing out" is the shorthand term for that.

When we look at the aged care system, it is of a different magnitude. About 3.6 million people per year by 2050 will access aged care compared to a much smaller, but nevertheless large group of people with disabilities, so it's of a different nature and magnitude. The second thing is we're actually struggling to work out how to do it. Let's just take respite. If one were to assume that the entitlement would allow you to engage a neighbour or a friend or a distant non-resident relative, how does that actually work in practice? The difficulty we have here is that if there is an incident, which there will be - somebody falls, somebody is injured, there's issues around insurance, there's issues around whether or not you have to look at the fit and proper person issues - should that friend, neighbour, distant relative be in some way registered by an organisation?

I must say that whilst the concept is not a challenge, operationalising it is a significant challenge. So if you can just give us some help in this, because at the moment, the aspiration and operationalising of it seem to be not connected, from our

point of view at this stage.

MS SKLADZIEN (AA): Sure. I think Mike has several times said that the aim of the commission is to provide sort of a guideline and framework, and some of these nitty-gritty details need to be worked out by people who perhaps have more experience in this particular area. So I'm not going to pretend that I am an expert at how cashing out should happen and I think there's a lot of international models that we can look to in terms of the exact nature of it.

I know that in child care, there's a somewhat similar model, in that people can get some of the child care rebate if they employ a family member or friend to provide child care services. In that case, those providers must be registered and they must show that they have had a police check and a first aid course, and then it depends on the state and territory in terms of any other requirements. I think that's perhaps a reasonable approach and we can always learn from other sectors.

Another option would be to have it work through a service provider. A lot of consumers don't want the responsibility of employing someone. They don't want to be liable if something happens. So that would be another option. Again, I'm not going to be prescriptive about it. I think that there are ways around a lot of concerns and I know that with choice comes risk and I think that some consumers will decide, "I don't want to do it. I want nothing to do with employing my friends or family." But for other consumers it will make sense, particularly for those from multicultural backgrounds who perhaps struggle to find someone who can provide care who actually speaks the language of the person with dementia, which adds a whole other level of complexity; for people who live in remote areas and for instance just want some respite to go to church for an hour, they'd have to take the person with dementia, perhaps a far distance away, and back, and it's so much trouble to arrange that kind of service.

The other thing is that a lot of people decide not to use respite because they find that the person with dementia comes back more agitated, more confused and in more distress. The same person may get left with family members and/or get left with neighbours on a regular basis, but the caregiver is feeling increased guilt about doing that because they don't have the funds to provide any kind of compensation. So I think while we do have to be worried about risks and we need to think about protection just like the disability sector does with the same concerns. We also have to be aware of giving people the option to take risks in some cases.

MS MACRI: It goes without saying that the current respite system is so grossly inflexible and difficult to access. Freeing it up and having a greater capacity for flexibility and access will make a big difference.

MS SKLADZIEN (AA): I know that the government is doing trials around

consumer-directed respite, and I have spoken with a few providers who are administering those packages and their experiences, at least anecdotally, have been that they are actually really disappointed, because they go into one of these consumer-directed respite packages thinking, "I can actually decide who is going to give me services and what I'm going to do with the \$4200," but what they find out in the end is that actually they just have to continue getting services through approved providers. They have a little bit more direction in terms of when they can access services, but people are actually looking for more when it comes to consumer direction than just accessing care through approved providers.

MR FITZGERALD: The second thing is about the gateway, but this is just a clarification, and you're right, we have had discussions, it's very clear that in the final report we have to articulate that, as I indicated, there's a whole range of support services to consumers that are provided by organisations such as yourself, but a whole range of other providers, which will continue to be funded and supported on a block funding basis to enable people to be able to be supported in accessing the gateway, and we need to make that clear.

So this issue about a networking, there will be multiple entry points, to use your expression, except for one thing, you actually do have to get to the gateway. How we get to the gateway and how we assist people through that is the issue. Certainly organisations such as Alzheimer's Australia and your member organisations that provide those supports, and more than those supports actually, counselling and what have you, we see as a vital part of the system. We just need to articulate exactly how that might operate.

MS SKLADZIEN (AA): I think there was a bit of misunderstanding to some extent about the gateway.

MR FITZGERALD: It's us, not you that created that.

MS SKLADZIEN (AA): Could I just make a quick comment on that? We still have a little bit of concern about one solitary system of a gateway. In the sense that particularly for people who aren't comfortable accessing formal services and currently are reluctant to access formal services, we are a little bit worried that the gateway model might limit the access even further for those groups. You don't have to comment at the moment, but I think that's something that needs to be considered further - - -

MS MACRI: We have had comments around that, especially around homeless, ATSI, some CALD, and certainly again we're having a look at that at the moment.

MR FITZGERALD: There may be some novel ways of achieving that. If I can make one comment - and I don't want to compare the gateway to the Centrelink,

except to say that if you wish to have an entitlement from government at some point you have to access Centrelink. Despite the fact that many indigenous people don't want to access Centrelink and what have you, we have to have ways by which that is achieved. In a different way but similar in notion, the gateway becomes a very important point of access to formal aged care services, once we define those. Other questions?

MS MACRI: Just on your comment around not being age-related - and this comes back to the younger onset dementia, about where to get the best care and I guess where they best fit within the system. One view is saying, "Yes, it's a disease and it's medical and it sits with aged care," others are saying, "It sits with disability," so there's a whole debate.

MS SKLADZIEN (AA): We were actually quite pleased with the commission's line on this issue, although there's a tiny little bit in the report, but actually it's in line with our thinking that individuals who have been accessing disability services who then go on to develop dementia may be best served by continuing to access services through disability, just because they're comfortable with the system, people know them. It doesn't make sense to all of a sudden shift to a new system.

Someone who develops younger onset dementia and has never interacted with either system may be best suited to get services through the aged care system where they can see dementia specialists. At the same time, I don't think it makes sense to make a demarcation that if you've accessed the disability services you're no longer allowed to access aged care, even if that would be able to provide the best care. So we really are thinking about it in terms of a continuum and that if people need access to a dementia specialist shouldn't be turned away because they're under 65.

MR FITZGERALD: We certainly agree with that. We're just trying to work out how the systems can work to accommodate that more seamless approach, and choice is just a tad challenging. Can I just raise a question, and it is in relation to early onset dementia. In page 17 of one of your submissions, and I think it's the most current one, marked 2001, you have this descriptor which says, "Care for individuals with severe BPSD," and presume BPSD is behavioural and psychological symptoms of dementia. Then you go on to talk about the need for accessing psychogeriatric care and what have you. Is this simply in relation to early onset, or is BPSD in relation all people with dementia.

MS SKLADZIEN (AA): That's in relation to all people with dementia. It is estimated that about 10 per cent of people experience severe behavioural and psychological symptoms with dementia. This is particularly challenging when those people are also very mobile and able to get around. The thinking is that the majority of people, even if they're experiencing some behavioural and psychological symptoms can be accommodated within mainstream aged care. For the 10 per cent

who really have severe symptoms and who are mobile and able to get around, there probably might be a place for some very specialised care for those people.

MR FITZGERALD: You're also linking that not only to care but also - at the bottom of that page - for ACFI, the funding instrument for residential aged care, to more accurately cover that cost.

MS SKLADZIEN: Sure. So the thinking right now from psychogeriatricians is that ACFI just doesn't cover that level of intensity of behavioural symptoms, and we need a funding model. Especially in a market based system, we need a funding model that does accurately capture the cost of caring for someone. For many people it's a short-lived period. So people might move into having more severe behaviours, and then might have some kind of management that will help reduce those behaviours, or they might become less mobile as the disease progresses. So for a lot of people it's not 10 years in acute intensive care, but there is going to be some period during the disease that they need that kind of care.

MR FITZGERALD: Any other queries?

MS MACRI: No.

MR FITZGERALD: We're just out of time. Just one last comment - because you're the only one who has mentioned it so far in your submission - is that you believe that the Australian Institute of Health and Welfare should be the clearing house for data, and, I presume, research and evaluations eventually. I'm sure they're putting in a submission as well, but we'll indicate that they think that too.

MS SKLADZIEN (AA): I suppose we were just surprised at the fact that they weren't mentioned in the draft report, given their role currently in data analysis.

MR FITZGERALD: Yes, look, it wasn't completely unintentional. One of things we are looking at is that the regulator will in fact be receiving the vast majority of the information, the data, and so in a sense it's in the ideal position to be able to recalibrate that data in a way that can be publicly released. But nevertheless we will look at that issue. Certainly it wasn't a slight on the AIHW, it was just this fact, that there is a repository of data already there with the regulator and whether that would be available.

The second thing comes up about how do we disseminate research and evaluations both in the aged and disability sectors and I think we'll look at that a little bit more fully in the final report. We're out of time. Thank you very much for that. That's terrific.

MS SKLADZIEN (AA): Thank you.

MR FITZGERALD: Disability Advocacy Network Australia. You know the drill; if you can give your name and the organisation and position that you hold in that organisation that you represent.

MS SIMMONS (DANA): My name is Andrea Simmons and I'm from Disability Advocacy Network Australia. I'm the chief executive officer there. I've been active in that role in a paid capacity only since November, which goes some way towards explaining why we don't have a submission before the commission. We didn't have the capacity.

MR FITZGERALD: That's fine. We look forward to hearing your comments.

MS SIMMONS (DANA): At the same time, you would have had a submission from the National Aged Care Advocacy Program and I was heavily involved in assisting with that submission, so I'm aware of the contents of that. You will have also heard from a number of our member organisations, so I apologise if I'm going over some of the information that's been provided but I think that's probably helpful anyway in terms of the things I want to go on to in relation to the system structure.

DANA is a network of 59 disability advocacy organisations across the country. Amongst those 59 organisations are organisations that provide advocacy for people in the aged care sector, because DANA doesn't regard disability as stopping at any particular age, so our membership covers the wide spectrum. DANA was set up, established not very long ago, in 2009 we were incorporated, really to advocate for advocacy because what we recognised was that there's a lack of understanding by governments about the importance of advocacy for people who are vulnerable because of disability or ageing-related disability. That means that my submission today is actually quite narrow. Because of the limited resources we've had, we've only really been able to look at the advocacy issue within the commission's ambit this time round. When we get to the commission's role in relation to disability support and care, we'll be producing a much larger submission.

Really, the point for us is to look at where advocacy sits in the system and what's been happening to it in the past. What we've seen is that people who are very vulnerable, as you know, need advocacy to allow them to engage effectively in terms of the decision-making around their services and their supports. What we've seen largely in the past is a system where people aren't encouraged to do that in any major way; in fact they're encouraged to take what's off the shelf. Clearly, what the commission is suggesting going forward and what people are expecting going forward is a change to that. What we say as well is that in order for people to exercise the decision-making that is now expected of them in a system that offers more choice, they are going to need support to do that. In many cases, the support for older people comes from their family and friends and others and in some cases,

advocacy comes within service providers as well. You would hope that that's the case in a community like ours, that the general community would see that they have a role in terms of advocating for more vulnerable people and their interests.

What we would say however is that there's many circumstances where there's a conflict of interest between the person or the service that is most likely the entity that is available to advocate for someone who might not be able to advocate for themselves and that is where independent advocacy, advocacy that's independent of both the service system and also independent of families, independent of government regulation - not regulation per se but independent of, I suppose, what governments want to see happen - is important.

What we feel from our experience and the experience of our members is that largely, consumers in the aged care area, their voice has been significantly disregarded in all sorts of ways. If you look at, for example, the accreditation processes that we've had in the past, the accreditation agency goes to an aged care facility and talks to people within the facility and families. However, when they come to reflect on how well they did their job as an agency, they survey the body that they've been accrediting; however, they don't in any way look at the responses of consumers within the organisations that they're accrediting or the family members. So they don't check to see whether those groups actually feel that the accreditation has been done in any meaningful way, which leads to a system that absolutely moves towards what service providers actually think is appropriate. That's a small example of how we have a system at the moment that doesn't actually support consumers to be engaged in the quality of their care in any meaningful way. Those sorts of points were made quite clearly in the review of the accreditation agency last year or the year before, I think it was.

MS MACRI: Can I just say I know that was a huge criticism of the accreditation agency in terms of surveying or getting a questionnaire back to the people they had surveyed in terms of satisfaction, so they did put it out to an independent third party. So the agency actually doesn't put that survey out any more. It does go to a third independent party. Does that go any way to - - -

MS SIMMONS (DANA): The survey they put out still doesn't survey the experience of consumers, what it does is survey the experience of the providers. It's useful to have independents involved with that but it's actually only still looking at one-half of, if you like, the equation. So I use that by way of example, because I know that very well, of the way in which our system at the moment doesn't encourage consumers to be involved in things. Advocacy alongside individuals could support consumers in that sort of area, but advocacy alongside individuals also supports obviously consumers actually having a say in how their service is managed, what time meals are available, resident support groups or residents' groups. You might have heard about them, I'm not sure, from other advocacy agencies.

There's a raft of things that at the moment has had a little bit of funding attached to it, in a state, as a project often, which we think should actually be expanded across the entirety of the sector and we think that you would end up, particularly if you are moving to a slightly new way of thinking around delivery of services, what you would end up with is then a system that has the potential to quality improve from the perspective of the consumers in a much more effective way.

What we feel about that too is that you need to look at I suppose the differences in Australia at the moment in terms of the funding of advocacy, so advocacy for people with disabilities up to the age of 65. Although the disability advocacy sector would say that that's extremely poor and not sufficient to do the job in the way that the sector would like it to be done, it's far, far greater than the per head dollar attributable to advocacy for people over the age of 65, even though their level of vulnerability would have to be as high or higher in many cases than the younger cohort. I think part of the reason for that would be a bit historical, to do with people's view of older people as being unable, once they are frail, to contribute, but I would say that there would be many organisations that have sat here before you to say that that's not true, even if it was in the past or thought to be true in the past. So I would say that there's no justification any more in relation to a failure to provide appropriate advocacy support for people in the older age group.

I looked at I think a question that you asked one of the earlier aged care advocacy agencies that came before you: how would you decide how much money to put into the system? I would say a really good starting point would be to look at the per head - and it's not much, but the per head value that's put into the system for people with severe and profound disability as opposed to the aged care area. You could start with bringing the funding level up to that and then you could look to the gaps. I think you also should look at those projects that have happened in a one-off space in particular states that have actually yield great benefits and I think those things should be funded across the country, for example, the Advocacy Tasmania and Dementia Support Advocacy program.

MS MACRI: I was going to ask you if you've got a good example.

MS SIMMONS (DANA): That is probably one of our key examples. Another good example is the South Australian advocacy organisation - whose name escapes me just at the moment - they have done a lot of good work around supporting residents committees and that sort of thing you could see being expanded across the country to considerable value. What I wanted to talk about really then is the system design and I was very relieved, I suppose, to hear you talk about that a little earlier in relation to where you might see advocacy sitting. DANA's view is very strongly the case that advocacy has suffered in the past in being funded by the same area of

government and administered by the same area of government that funds and administers services. What you have seen is the growth of funding to services kind of exponentially over the last 20 years. The aged care advocacy program has virtually stayed static or gone backwards; over some periods of time it has gone backwards in terms of its funding.

MS MACRI: My understanding is - and you may correct me - some of this funding is at a state level and some is at Commonwealth from the various organisations that we have spoken to.

MS SIMMONS (DANA): It depends what you're looking at. So the National Aged Care Advocacy Program is the only program that funds individual advocacy in relation to people in receipt of Commonwealth aged care services - that doesn't include HACC because HACC wasn't regarded as a Commonwealth aged care service - and that funds nine organisations and you've heard the figure around that. So that is a national program. You've got the Home and Community Care Program that funds advocacy irregularly across the country. I know of eight organisations dotted around the country that get funding to do advocacy for the benefit of people who are eligible for HACC services. But there would be none in some states. But for those particular organisations it's a significant bucket of funding in advocacy-organisation terms. It doesn't relate to aged care service funding.

You would also find that the HACC program is used for funding some advocacy that is regarded as generally for people with disability but that can go across the age spectrum and it's very hard to unravel actually how much of that funding - New South Wales is the particular example, it's a bit of a nightmare to try and unravel how much of the funding would actually be allocated to people who are in the aged care sector. I suppose the reality is that there is very little funding across the board and it is predominantly Commonwealth in terms of its focus because the HACC program, as you know, is about to be split and the aged care component goes to the Commonwealth. There has been no discussion about what is going to happen with advocacy in that arena yet and I am hoping to find out tomorrow at HACC conference.

MR FITZGERALD: Are you? When you find out, you can tell us.

MS SIMMONS (DANA): So in thinking about that the view we have taken is that advocacy actually is very poorly served by funded and administered by the same area of government that actually funds and administers services. It's poorly served also because it's in the interests of that area of government to not actually want to be too confronted by the advocacy that's delivered. So the program has had experience of being - having had the system advocacy component of the program removed completely, of the education part of the program being emphasised at the expense of advocacy to the point where some organisations struggle to deliver any sort of

advocacy that's face to face.

MS MACRI: It seems a bit fragmented and again you talk about 59 organisations belonging to - - -

MS SIMMONS (DANA): My peak body, yes.

MS MACRI: This is the first time this has occurred that all those organisations have belonged to one peak body?

MS SIMMONS (DANA): Yes. Advocacy traditionally, if you're talking across the whole spectrum of disability, has been funded variously and organisations have had different responsibilities. So there is self-advocacy, family advocacy, individual systemic, so you get a different flavour and because of the limited funding at different times you have had real encouragement of competition between organisations in a way that has meant that they haven't easily worked together. The establishment of DANA has actually been a significant achievement and I think we're also now finding or I think organisations are finding the benefit of a united voice in particular areas.

MR FITZGERALD: So going forward, given that the commission is favourable towards increasing the resources for advocacy for older Australians, what is the best way for that to be achieved? Just prefacing that, there are two ways: you can scatter the money through a very large number of organisations or you can build capacity in a more limited number of agencies. It seems to me that we would be wise to try to build advocacy before you spread it too widely and in the presentations we have had around the states and territories there does seem to be a view by the advocacy organisations that a part of that national aged care advocacy - and there is eight of them, I think, with the \$2.5 million - that that is where you're first port of call would be to increase resources.

I'm sure there are people that would have a different view to that. But I must say that at this stage if we are going to significantly increase the level of advocacy that might be the best way forward, at least initially. What is your view?

MS SIMMONS (DANA): I represent 59 organisations across the country. I would have to say that the aged care advocacy organisations that are currently delivering advocacy in that area have particular expertise and they all have very, very limited funding from the NACAP; \$2.5 million across that many organisations, it's very, very small. So there is no doubt that they would benefit enormously and government would benefit from some economies of scale in terms of providing appropriate or more appropriate funding for the existing organisations.

Having said that, there are some others in the HACC space that also have

experience of delivering advocacy to older people as well, more in the community. So I think you would be wanting to look across all those existing providers of aged care advocacy in terms of that.

MR FITZGERALD: Do you actually have a profile of that? I have not actually see a profile of the formal advocacy organisations for older Australians and for aged care. So that would be helpful if you have that. The second thing is in terms of a funding formula, you talked about looking at the per capita for people with profound and severe disabilities. In a strange way is the equivalent of that in the aged care system those that are in residential aged care and those that are just below, people with very complex needs in the community? The reason I'm just trying to get a handle on that is because the numbers involved are very different. The numbers of ageing Australians is very, very large relative to the number of people with profound and severe disabilities. They're not insignificant, as you know, they're big numbers both ways. But I was just wondering whether or not the pointy end of this is really for people that are in residential aged care facilities and I know there would be many in the community but - - -

MS SIMMONS (DANA): My sense of that is - and I don't know if it's comparable - the comparability is found in terms of those people who are eligible for Commonwealth aged care services and those who are eligible for the home and community care services. Home and community care have the severe and profound requirement in a core functional area and then, of course, the residential aged care has something similar. So that group, I think, is significantly smaller than the numbers of people that you are talking about and that's the group where you would look first to ensure that they had adequate access to advocacy because they are the group that are most likely to be unable to put forward their views themselves without assistance and very commonly there is a goodly proportion of that group who don't have access to family members because of where they are living, because of their history et cetera.

The other thing that I didn't get around to saying is that DANA is actually putting forward a system design proposal, if you like, in relation to the Disability Care and Support Scheme which I can't put forward now as a fully supported proposal here but to let you know that what we have said is that we believe that advocacy - because it sits solely beside the consumer it isn't a service element in the way that other services are, it needs to be recognised and administered as such. We would propose a statutory advocacy authority to administer advocacy and to really have a focus on what the gaps area across the country, to look to what's required in terms of quality which is very different from your normal service design type things in certain areas.

That is not a proposal I can yet put for the aged care area but it is something that will be and has been put in relation to disability and it is something that is under

consideration.

MR FITZGERALD: Is the equivalent for that the public advocacy, the public advocate in Victoria?

MS SIMMONS (DANA): The Public Advocate's Office is not independent in the sense of being - - -

MR FITZGERALD: No, but if you made it independent, it's that sort of function, the statutory function. So it's not a complaint handler, it's purely an advocate.

MS SIMMONS (DANA): Well, it's not an advocate per se, it's an administrative body for managing advocacy. Really the justification for that is to say, well, we have our other statutory safeguards in statutory authorities, for example, the Human Rights Commission, your public advocate organisations, your disability services commissioners et cetera. Really advocacy, because it sits alongside the consumer really warrants a similar kind of separation from government because governments notoriously struggle with advocacy.

MR FITZGERALD: Having said that, of course, no matter where the money comes from, it's ultimately the government and the government will determine how much it is going to put through either a statutory body or directly to you. So at the end of the day whilst we have tried to make very substantial structural changes in the governance of the aged care system, ultimately, the government and the department is going to be the one that provides the money. The mechanisms by which it does that may be different but the self-evident fact is that they are the gatekeeper for the budget and they are going to be the ones that allocate the money. I don't think we resolve your problem.

MS SIMMONS (DANA): One of the answers to that may well be though is an agreement reached about an appropriate proportion.

MR FITZGERALD: Funding model, yes.

MS SIMMONS (DANA): That is a proportion of the total services funding because if you recognise that services funding relate to per capita need, then you take a proportion of that.

MR FITZGERALD: You're going to put that in your proposal to us or your letter whatever.

MS SIMMONS (DANA): Absolutely.

MR FITZGERALD: I think we are out of time. Thank you very much for that,

that has been terrific. We do look forward to getting your submission. It only has to be short.

MS SIMMONS (DANA): So you would still like a written submission on - - -

MR FITZGERALD: I would love a submission, even if it's just a couple of pages highlighting a couple of those issues you have raised through your presentation. That would be wonderful. It doesn't have to be extensive. Thank you very much, that's terrific.

MS MACRI: Thanks.

MS SIMMONS (DANA): Thank you.

MR FITZGERALD: Our next participant is Challenger Ltd. Welcome. If you could both and individually give your name and the organisation and the position you hold in that organisation that you're representing.

MR COX (CL): David Cox, head of government relations, Challenger Ltd.

MR BOFINGER (CL): Tony Bofinger, chief financial officer life and appointed actuary, Challenger Ltd.

MR FITZGERALD: Thanks very much. We have just received your opening comments. So if you can give us some opening comments and then we can have a discussion.

MR COX (CL): Would you like me to summarise them rather than go through five pages.

MR FITZGERALD: It's up to you. We're just time constrained and if you want to spend the next 10 minutes going through some of the key points, that would be terrific.

MR COX (CL): Our principal business focus is providing income security for retired Australians and the purpose of our submission is to demonstrate that APRA regulated life and general insurers could provide products which would make a substantial contribution by assisting individuals to meet the costs of their aged care. Most important to this is recommendation 13.1 that:

The Department of Health and Ageing make data publicly available in a suitable form that both protects individuals' privacy and has sufficient detail for actuarial analysis to allow the pricing of efficient products to meet the needs of the frail aged.

The commission has published some data in its draft report and Challenger would like to place on record its appreciation to the commission staff who provided us with data on time and residential care desegregated by age which has allowed us to prepare some baseline pricing to demonstrate how this type of information can be used for product development. The product described in our submission would allow an aged care resident to buy a single premium lifetime loan to cover an accommodation bond as an alternative to selling their family home or other assets. With this product the resident would the size of the bond with the aged care provider, as they do now, but would only need to pay a fraction of that to the life office. The specific premium would be set determined by their age and sex. The life office would pay the nursing home provider the full value of the bond, with the residual amount being returned to the life office when the resident dies or leaves the nursing

home.

As with lifetime superannuation annuities, an arrangement for return of part of the premium if the resident remains only a very short time in care would be necessary to overcome the reluctance many people have to purchasing a financial product which would otherwise seem overly expensive if they were to die within a very short time. Without allowing for any return of premium on early exit or transfers between nursing homes, the baseline pricing for a 75-year-old male would be around \$20,000 per \$100,000 of bond; a little higher or lower, depending on the size of the bond. The premiums for women would be slightly higher on account of their longer life expectancy and expected time in care. With respect to the difference in pricing by age and gender, it is worth noting that the insurance industry current has an exemption from the Disability Discrimination Act provided differences are based on data on which it is reasonable to rely. This is another reason why release of the date contemplated by recommendation 13.1 is absolutely critical.

While it might seem superficially attractive to introduce community rating or cross-subsidies, it should be note that where participation is not close to universal, there is a high likelihood of adverse selection which would raise costs to all users, possibly to a point where the cost of insurance for most people would become prohibitive. Why would people want to buy this product? It providers a lower up-front cost for the accommodation bond; it allows retention of the family home or exposure to other assets to continue; it allows transfer of longevity risk in relation to accommodation costs; it provides certainty and it protects intergenerational wealth transfers.

Provision of the data contemplated by recommendation 13.1 would allow the development of a range of other efficiently priced products. These could be risk products, either single or periodic premium, providing a payment or payments triggered by aged care, essentially a limited form of long-term care insurance. Another possibility is deferred lifetime products, non-commutable single premium deferred lifetime annuities with a known real return priced to cover two risks: the risk of needing care, that is, survivorship and the age of needing care, and longevity, the length of time in care. Such products use pooling to make paying accommodation costs and co-payments for care more affordable, reducing the financial burden on individuals, would facilitate implementation of a number of the Productivity Commission's recommendations.

Challenger supports the Productivity Commission's recommendations on pricing, cost recovery and removal of rationing because they will result in a more efficient market. This is essential to expand the provision of care to meet growth in demand for aged accommodation and care. However, Challenger does not support the recommendation in the draft report which would result in the government entering the market as a provider of financial products or services. This is likely to

result in a misallocation of resources. Government provision would be less efficient, stifle innovation of product design and the high risk of mispricing or misuse of the government guarantee is likely to result in private providers not being able to enter the market.

The Productivity Commission has proposed the government establish an equity release scheme. Equity release schemes are more commonly known as reverse mortgages. This is an area where there are established commercial providers. Challenger is not one of them. Reverse mortgages necessarily have low LVRs because no payments are made on them. This makes them unsuitable for accommodation bonds which would normally require most of the equity to be transferred up-front to the aged care provider. There are also a number of inherent incompatibilities between reverse mortgage operations and the Australian political process. The present system where the government and the Reserve Bank sets rates and the government of the day doesn't seem to be working comparatively well and shouldn't be complicated.

Governments would inevitably feel that they face political constraints in adjusting mortgage interest rates when required. Similarly, they would face political difficulties taking a view on the value of individuals' pieces of residential real estate and offering differing amounts of credit to different individuals with large disparities between different states and different regional areas. If one of the reasons for government provision is a concern that reverse mortgages are not universally available, that suggests that the markets, where they are not currently available would be likely to entail the government taking an out-of-market risk on its ability to recover debts.

Even if the government provides a no-negative equity guarantee, it would inevitably need to conduct mortgagee sales to enforce the terms of its credit contracts. At some point this would be likely to prove too politically challenging. The draft report also proposes that the government establish an Australian pension bond scheme which would allow pensioners to place the proceeds from the sale of their home into a government guaranteed account to draw on flexibly for living expenses and aged care. This facility would be exempt from the age pension means test, free from all fees and the capital would be indexed by the CPI.

It should first be noted that life offices already provide capital guaranteed, fixed-term, CPI-index annuities at rates which pay a real rate of return that generally compares favourably relative to bank term deposits and very favourably relative to Commonwealth bonds. A literal reading of the recommendation would suggest the scheme would provide CPI indexation of capital only, not a real rate of return. A product with such pricing would seem destined to fail in the marketplace without a subsidy delivered through the aged care and age pension system. Banks and other ADIs already offer products to pensioners at the prevailing deeming rate. If the

government believes such products should be given concessional means test treatment, then it can do so without also having to provide the financial product or a government guarantee.

If the government decided to become a provider of financial products or services, this could be done either on budget or funded. If it was done on budget or funded. If it was done on budget, the return to retirees would reflect the risk-free rate for issuing new government bonds on that purchase and the purchase price that the pensioner bond would replace. Without a subsidy, which would have to be borne by other taxpayers, this would be lower than the rate a life office would offer the pensioner reflecting the higher-yielding assets the life office would purchase. If the government decided to invest the funds to provide a market-competitive rate, it would have to accept the same market risks as the shareholders of a private provider. The government would also carry the implementation risk of establishing the new product and integrating it with its existing delivery of aged care, as well as the ongoing operational risk.

To provide guaranteed product life offices have to meet requirements of APRA's prudential standards to hold significant amounts of capital against liquidity, market, inflation and operational risks. In the case of retirees purchasing from the government this capital would have to be provided by taxpayers or the costs associated with these risks would become additional budget expenses. There are four possibilities for unfair pricing. The first two result in the retiree receiving a lower than market return and they are the options of no real rate of return, CPI indexation with capital only, or a return which reflects the government risk-free cost of capital. Third, if the government were to fund the return on the bond with more risky assets, if the government funded the bond on the basis that it provided weaker provision than the capital standards APRA applies to a life office, that would be a major departure from the principle of competitive neutrality and, as such, would not be fair pricing relative to private providers.

While the government may be able to borrow at a lower rate than a life office - a proposition I will deal with shortly - it would be necessary for the government to hold a much larger quantum of capital against a portfolio of riskier assets and the cost of that additional capital would have the effect of reducing the extra return to the aged person. Fourth, unfair pricing, which does not recognise, actual capital requirements would eventually result in losses being borne by the Commonwealth budget. That would not be fair to other taxpayers. Near identical issues were raised in the course of the Henry review when it was proposed that the government enter the superannuation annuity market as a provider. That proposal was explicitly rejected by the government.

The proponents of this concept argued the public provision has a number of benefits over private provision. The government has greater capacity to invest assets

in a risky portfolio against long-term liabilities. Government has the least possible default risk. Government has a lower cost of capital. By utilising the existing administrative structures the product would also benefit significantly from economies of scale and scope for cost effective delivery.

Challenger commissioned Access Economics to examine the implications of using the government's triple A credit rating and therefore low cost of capital to provide an advantage in pricing of publicly provided annuity. Their report has been provided to this inquiry. In summary, Access concluded that the government could use its capacity to borrow at the risk-free rate in the short term to benefit buyers with publicly provided annuities, but that would not benefit Australians as a whole and the funding advantage would be eroded over time. The central issue was labelling borrowing as public or private does not change the inherent risk in the transaction but only who bears that risk.

The cost of the marginal transaction is the same regardless of whether done publicly or privately. Over time public provision would either draw directly on the budget or tend to dilute the cost of capital advantage to public sector borrowing as a whole. Debt markets prefer government debt over private borrowing because governments are less likely to default than corporations. Governments enjoy superior credit ratings in part because they have the ability to pass on the cost of debt to taxpayers. The question of economies of scale and relative efficiency of administration is a highly contestable point. Modern life offices and no doubt ADIs already have low costs and their operations are highly scalable.

The other issue we wanted to raise in relation to public provision of these financial services is the government's already considerable exposure to longevity risk and growth in the cost of caring for the ageing. Standards and Poor's has for some years published a series of growing reports which estimates the trajectory of various developed countries' sovereign ratings as a result of the ageing of the population. In this analysis S and P focused on age pensions, health care and long-term care. It found that a no policy change basis many triple A rated sovereigns will hypothetically fall to at least double A by 2020 and then to speculative grade by 2030. According to the S and P report, without significant policy change this is a trajectory of Australian sovereign rating.

Recommendation 6.2 is for the government to provide a stop-loss arrangement at a real value of \$60,000 for an individual's total co-payments. While this would make it less risky to offer insurance to cover an individual's potential costs of care, in the light of the current trajectory of Australia's sovereign rating the Productivity Commission should give further consideration to the appropriateness of government accepting the residual risk when it could be transferred to life offices and general insurers.

In conclusion I would also like to draw the commission's attention to that section of Challenger's submission dealing with the potential for superannuation deferred lifetime annuities to contribute to the cost of paying for aged care. With longevity insurance in its purest form a deferred lifetime annuity would allow a 65-year-old male to use \$10,000 of his retirement balance to buy a deferred lifetime annuity which would not start to pay an income until he reached his age-cohort life expectancy which, for 65-year-old, is about 91 years. The pricing provided by Challenger to Henry review in 2009 showed that deferred lifetime annuity would then pay an amount equal to an annual income in real terms of \$8000 a year. Superannuation annuities can provide significant amounts of guaranteed income late in life when other income streams are likely to have failed and so have the potential to provide funding for an aged person's care without them necessarily having to buy a separate aged care product.

If the impediments to provision of deferred lifetime annuities are removed, which was recommended by the Henry review, a second outcome of implementing recommendation 13.1 on the release of DOHA data would be the ability for life offices to give tools to financial advisers so that they can assist their clients in selecting starting dates for deferred lifetime annuities which incorporate amongst their client circumstances the age range when they are likely to have the need to pay for aged care.

MR FITZGERALD: Thank you very much. Thanks for that submission but also the more substantial submission which we have just recently received and our staff no doubt will be going through that and the access report and other materials and come back to you. Can I just ask a couple of questions. Why do you think the private market in terms of equity release schemes or reverse mortgages represents such a modest part of the market at the moment? It's available and people can access it but the numbers at the moment are indicating that there's not a high take-up. Is this a temporary thing or is this a permanent feature, and if so, what's the problem with the private product?

MR COX (CL): We used to be the largest non-bank mortgage provider in the country until the GFC so we've got some experience with the mortgage market. We were never a reverse mortgage provider although we did look closely at that market. It is a fairly risk area for people to get into. At the moment it's not that well regulated; it may be mispriced. There are limited loan to valuation ratios which are necessary because people aren't making payments on their mortgages and so the amount of money that they can actually draw out in that way is limited. The people who expect to inherit their homes may have negative attitudes towards their parents taking up reverse mortgages. So there are a whole range of reasons which would dissuade people from going into it.

MR FITZGERALD: Can the product that's currently on the market be modified in

a way that could make it more attractive to people? You've indicated that you don't believe the government should be involved in this and we'll obviously look at your arguments in relation to that in quite some detail, as we have previously in relation to considering this issue. Do you think that the product on the market can in fact be made to be more attractive to older Australians?

MR COX (CL): I think it could be better regulated and therefore made safer. I don't think it will necessarily become enormously attractive and I don't think that LVRs will make it a suitable product for covering accommodation bonds either. I know that in aged care since 1984 the reason for bringing in accommodation bonds was so that the equity in people's homes could be used to cover their aged care accommodation costs and the residual returned to them or their estates, and that is a perfectly reasonable principle. It could be done more efficiently, and if accommodation bonds applied across the spectrum of residential aged care it could be done more fairly as well. These things could be priced better and you've made draft recommendations about that and they're all very good. We think the sort of product that we've put in our submission is a reasonably innovative way of giving people a sense of alternative where they've got a bit of extra spare cash, or they could take out a small reverse mortgage to cover the upfront premium.

MR BOFINGER (CL): So the reverse mortgage, I guess there's a couple of differences between that and the product that we're talking about. So first of all the reverse mortgage is a loan secured on a property and it's also generally expected to be taken out earlier in somebody's life, or when they've got a longer life expectancy than is the case in the bond that we're talking about. So what that means is because the person is not paying any interest it accumulates over time. There's a risk around how long the bond will be outstanding and therefore how much interest will accumulate, and then the no-negative equity guarantee around a risk with respect to the house price rises as well.

So what that means to the provider, there is a reasonable amount of risk involved in it both from a longevity point of view and the no-negative equity guarantee. They then need to price for that, which means it's expensive in an interest rate sense. So the interest rate that somebody is effectively paying on the value is materially in excess of what you might pay in a different scenario and that's what drives the very low initial LVRs. To contrast that with the product that we're talking about, the first difference is the expected time that the produce will actually be outstanding and therefore the risk associated with longevity is much smaller in this case, and then there's the security backing the repayment. There's no house price inflation risk; it's effectively a Commonwealth government guarantee. So there's no credit risk as such, it is just a timing risk associated with the time that the person is in care.

MR FITZGERALD: So explain to me what prevents that product being put onto

the market now? Just explain to me what are the barriers for this product being placed on the market at the moment? If I want to take out an insurance policy effectively with the prospect that I may have to enter into a residential aged care facility and pay an accommodation bond, which already exists, what is it that's in the way of the market offering that?

MR COX (CL): Lack of detailed data about the length of time that people remain in aged care and the reasons that they leave aged care or change aged care facilities.

MR FITZGERALD: Well, they don't do much of the latter. We already know how long they're there. Depending on what condition they've got they're either - - -

MS MACRI: We know how most of them leave. There's very few that change.

MR FITZGERALD: I mean, effectively the average stay is about eight months but the issue that's changing that of course is people with dementia where they're staying longer. So it depends on the client mix going forward.

MS MACRI: Not necessarily because it also depends on when they go in. I mean, people are staying in the community a lot longer too.

MR BOFINGER (CL): I think the data that we've received does provide - so we've received sort of the first stage of data and to price the product up properly we would require some further analysis and more detailed data, but it does show probabilities of leaving over time by age and sex, it does show that those probabilities have been reasonably consistent for, I think it's about 10 years' worth of data that we've got. So that is very helpful. Some of the things that would be worthwhile and we've just recently received some further data on is cause of exit, which will impact as well. Ultimately you could get to a point in which people are actually underwritten as to the pricing, and so there's that differential. I think that is a fair way off but it is an ultimate outcome that you could have.

MR COX (CL): The data that we've got is based on all residential care. The thing that we really need to deal with the current market is a split between low care and high care. We assume that the low care resident is likely to have greater longevity than a high care resident, so that would help us to improve the pricing dramatically.

MR FITZGERALD: Except low care is diminishing as a percentage of the overall resident population going forward. So basically you're really saying that what inhibits the market offering this type of product is simply the lack of data which allows you actually to determine the risks associated with that.

MR COX (CL): That's right.

MR FITZGERALD: Given that nobody is actually sure what's going to happen in this area, that does become a slight problem. The reason I say that is, going forward we can make some projections in relation to how many people will access community care but of course that may well change over time and we're already seeing quite a substantial change in that area. So going forward 30, 40, 50 years - your business is to actually predict and deal with risk but it is going to be very different to what it is today.

MR COX (CL): We only have to price risks that we need to understand for the next 10 years. So we only need to understand the margin of risk that we're taking on.

MR BOFINGER (CL): So I think you're right that that is something that we would need to consider and adjust for. There's a number of aspects around it. One is secular changes that are occurring through a variety of factors; the other is simply the make-up of the people who actually choose to purchase the product versus the full population of people to whom it's available. So those are the sorts of things we would need to think about beyond the data but the data certainly gives you a baseline to then start thinking about how do you adjust it for those sorts of aspects.

MR FITZGERALD: The other thing is just in relation to our proposal in relation to the Australian government aged pensioner bond scheme - long names, all of these things at the moment. The one fact that you didn't mention - I'm sure you have in the thing - is the reason to do this is to stop the current distortion in terms of paying excessively high accommodation bonds for the sole reason of retaining the age pension. So the purpose of the bond is to allow you to sell your home to pay a bond or not to pay a bond, it's up to you, but for the balance of that amount to sit in a safe, secure place that allows you still to retain the age pension, even when it makes no sense, but we know Australians like to keep the age pension and they are determined to do so even when financial advisers might say, "You'd be better off not to," but they do. So this is a means to deal with the behaviour that we have in the Australian population.

MR BOFINGER (CL): We don't disagree with the intent, it's just who the provider is, and we've just been through the GFC and no Australian bank has failed and no Australian life office has failed. They're robustly regulated institutions.

MR FITZGERALD: No, we're not casting aspersions on those providers.

MR BOFINGER (CL): It's something that the government doesn't need to do and it's something where we would give a higher rate of return than the government should.

MR FITZGERALD: Thanks for that. It is a detailed submission and you've made a lot of very substantial points. So we'll look at that.

MR BOFINGER (CL): Thank you very much.

MR FITZGERALD: If we can just break now for about 10 minutes and then resume with COTA at 3.30.

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

MR YATES (COTA): Ian Yates, chief executive, COTA Australia.

MS ROOT (COTA): Josephine Root, national policy manager, COTA Australia.

MR WOODS: Thank you both. I think I mentioned to an earlier participant that we have several contributions from COTA for which we are very grateful in terms of initial response to our issues paper and then to our draft report and then a supplementary submission that came in last night that we will be putting on our web site. Please, take us through the various points that you wish to raise today.

MR YATES (COTA): Thank you for spending some time with us again. As you have observed COTA has put a lot of effort into the process of the inquiry, including ongoing consultations at state and territory level, a lot of which we draw both in our second submission and in these comments. The notes we sent through to you last night are essentially of a truncated form and we will clean them up. I should point out that there is a significant - even though it is only one word - error in section 4 on consumer protection in the third to last line where the word "not" is there and it should be "not not". It reverses the whole meaning of the sentence.

MR WOODS: We understand the point.

MR YATES (COTA): So I will touch on these and then with your indulgence we would like to make a few comments about a number of other matters that are no news matters but on which we have a view about some of the things we have been hearing from other stakeholders and indeed perhaps put to you. The issue of the principles for regions which you asked about we have made some suggestions. We don't think they are terribly unique suggestions. We didn't, I notice there - and we're happy to do - specifically address the question of whether regional boundaries should align with the unfortunately Medicare Locals or local hospital networks and since those things are actually not finalised as you yourself have noticed, it's a bit tricky. In some sense you could argue that there was value in an alignment because, as we point out, they and aged care all seem to be part of the whole reform. But then, as I understand it, some of those boundaries are not going to align anyway, so that leaves you having to choose between them.

There is a service logic to some degree, particularly at the higher care end, in aligning with local hospital networks but if that relates at all to the issue of supported residents, for example, I don't think there is any correlation. So we have made some really quite general points and we understand your dilemma in trying to work out what regional boundaries out to apply.

MR WOODS: We certainly won't be planning to map them out on a document but we would like to give some indication of principles to be applied in our final report.

MR YATES (COTA): What we talked about are some generic principles which actually are about following how people live and work and recreate and link to other services.

MR WOODS: Yes.

MR YATES (COTA): Shall we just proceed through?

MR WOODS: Yes, please.

MR YATES (COTA): The carer support centres, I think we made a brief comment and you asked to expand on that, which we have here. We do say in the opening couple of lines we don't necessarily oppose such entities but we then go on to provide you with a goodly, sound number of reasons for not having them. We make the first point that carers, as we have argued before, have to have the same entitlement to services as other service users and the CSCs could become a rationing device if they were block funded and that's shared certainly by some of the carer networks.

We were concerned when we read them again that there might be some potentially for splitting or subdividing the gateway functions. We don't want to see them as another layer and we're not sure whether they oughtn't be provided by bodies like Alzheimer's and Carers and indeed the mainstream service system. I'm not sure why we need to separate them off.

MR WOODS: We might as well debate that one whilst we're at it. There are two separate questions: there is the issue of when an older person approaches the gateway to be assessed for needing services, that has to be done in the context of the environment in which they're living, primarily of course being the capacity and willingness of any carers to continue to support and assist them. In that context then assessments can also be made of the carer's capacity and skills and support needed for them to continue in that role. Fairly self-evident and the gateway would work perfectly for that.

There does exist, though, a cohort of older people who are convinced that they don't need any help, thank you very much; they will rely on their spouse to do their cooking, washing, assistance with showering and every other thing that they need and that it be delivered by them and therefore they don't want to go anywhere near the gateway. They don't need any help; their partner can do it all for them. That partner usually, although it might be another family member or neighbour or friend,

themselves, in trying to achieve all of those outcomes, may find that the burden is substantial and that they need, even if it's the basic help with home maintenance and cleaning or whether it's getting some skills themselves to improve their capacity to care, or other support measures.

Now, either they go directly to the gateway themselves, but not in the context of the older person that they are caring for, or they go to other sources of help. As you point out in this addendum, as have others, Carers Australia, Alzheimer's et cetera already provide some measure of support in these contexts, but there is that need. The question is how do we address it and is this an alternative venue by which the carers in their own right can get some support but in the context of them caring for an older person.

MS ROOT (COTA): I think the carer support centres could be seen as a service provider of that care and support but it's the way that they're portrayed in the report, and even in that discussion I think is that they're somehow separate from the rest of the system. I think carers could go to the gateway for an assessment as a carer and get their entitlement. I think it is this issue of the carers actually having an entitlement that we are concerned about and I know Carers Victoria is concerned about and have put it in their submission to you. They have developed a model, and I think we would probably support this, of having a dual assessment, the way you assess the carer and you assess the family support and ideally you would do it together, but there's no reason why the carer can't come separately.

If the carer support centres are a source of education and training for carers then that's what they are and people could use their entitlement to access that. I take the point that Robert was making, has made several times today, about having some of the counselling and advocacy services sitting outside of the gateway. So maybe the initial contact from a carer could be to one of those services that is outside of the gateway, but I think we've made the point consistently that somehow you need to get information back from those services through to the gateway so that people's co-contributions - particularly if you're going to have a lifetime limit on co-contributions, and keep some sort of record of service usage in one place. So I think the CSCs possibly sit there but I'm not sure what they add to what would be provided by other specific services. They just seem to be adding a layer in that doesn't need to be there.

MR FITZGERALD: Well, yes. Look, I must say that, now having heard from different carer groups and there are variations around the theme, the one thing that is clear that they want a set of carer services and supports for carers that they can access directly. Secondly, they want that to be provided, support for carers of people that are ageing, disabilities, mental health and medical frailty or medical needs. So at the end of the day whether those centres are in fact run by the carers associations or other organisations is less important than saying that so far the advice we're getting is

that they want a place that they can access directly that provides that range of support to that range of carers.

The second issue about the entitlement is it's tricky to say, well, what actually lends itself to an entitlement, and this is the issue. We've raised this with you before. Planned respite looks like it lends itself to an entitlement. I can go to the gateway, identify that I need two hours' worth of respite every fortnight. They can do that, and that's an entitlement. When you start to get into the other areas, including emergency respite, counselling, peer support, training, all those, they are less likely to be suitable for an entitlement in that sense. Yes, they should be able to get the service, that's not what we're talking about, but the actual entitlement for which funding is attached. So I'm struggling to find out what we would put within that entitlement and what we would put within the block funding. I don't think there's a complete answer to it yet and it will evolve, but that's the issue we're grappling with at the moment. So we're not talking about having a right to a service, that's that type; we're talking about the entitlement has money attached to it.

MS ROOT (COTA): I think the issue is about having the right to access education and training. I mean, we do deal with this in the higher education system where we give people - you know, we say, "If you get the grades you get into university," and under the new system that's going to come in that becomes more the case. So I think education and training you could actually- if you did a good carer entitlement you can identify how much education and training somebody might need and you can build that in. Whether it becomes part of the co-contributions is perhaps part of the issue, but given that people pay for education and training in many other spheres in life then I think there are some interesting discussions there.

I think probably emergency respite is a tricky one. I think from our extensive consultations now across six of the state and territory COTAs and public forums on a whole range of issues, what people want is to know that they will be able to access emergency respite and they want greater flexibility in how it is provided. I mean, the definition of emergency, you know, there's different emergencies.

MR FITZGERALD: Well, you call them unplanned or unscheduled.

MS ROOT (COTA): Unplanned or unscheduled. People want to know that they can get it. Yes, you can't predetermine what that is, their needs, and so that possibly comes into a separate - so I think we agree with you on that one.

MR FITZGERALD: Yes, that's fine.

MR WOODS: As you said, there are a tricky set of discussions about whether the co-contributions, particularly for the planned entitlements, do they attach to the carer as part of their lifetime stop loss, or do they attach to the person being cared for

because the service being delivered is in the context of the person being cared for?

MS ROOT (COTA): I think I'll flick that one back to you to answer, Mike.

MR WOODS: Yes, I thought you might.

MR FITZGERALD: There is actually another issue and that is, given that the current public policy in Australia is to treat carers as a group, whether or not you charge co-contributions for carers of people with older Australians but not for carers of people who are living with mental health conditions or living with a disability or have a chronic medical condition, raises another set of issues. So every time we have this discussion we increase the number of issues, which Michael has to resolve. We thank you for raising them.

MR YATES (COTA): I might comment that your draft report and presumably your final report are going to raise a number of issues of public policy consistency in a variety of areas.

MR WOODS: Absolutely.

MR FITZGERALD: I have to say to you, it is an issue that we actually have to deal with at the end of this project and particularly at the end of the disability report's project - we do have to have a coherent system and we are desperately keen to make sure that we do have that. The carers is a subset and a very important one at the moment.

MR YATES (COTA): I guess in summary there are a couple of principles in there that if you have them - we weren't saying it doesn't, but we don't want to see the gateway function compromised and we'll talk about that a bit more in a minute.

MR FITZGERALD: We agree, and we thank you for that point and we'll try to avoid that.

MR YATES (COTA): We shall move on: user contributions. Probably the most significant point we wanted to make here, and it comes from our feedback, is we had a conversation with you about the user contributions at the Melbourne hearing early on in the hearings where we, apart from anything else, clarified issues around cohabitants. We're pleased to see the transcript of that because we've had suggestions that the commission had a different view than we had at that exchange that day. But in terms of what we've said here, one of the conclusions we've come to is that rather than having a 5 per cent to 25 per cent range, the starter of the contribution scale is actually zero, that people in particularly defined kind of positions ought not have to seek access to hardship, and we've given an example of that, whereas a general hardship might apply at any level of contribution, that is

based on the scales you might have this, but there might be reasons in your circumstances - - -

MR FITZGERALD: Mitigating circumstances.

MR YATES (COTA): Mitigating circumstances that would create an issue. So it becomes an exception. We've given clearly a fairly specific and out there example, but there are not insignificant numbers of pensioners in that situation unfortunately. It's one of the issues that the pension review addressed but never resolved.

MR WOODS: All of those who are full pensioners with limited assets in residential care start at zero for their care contribution anyway.

MR YATES (COTA): Correct.

MR WOODS: It's just the language so that you don't have to demonstrate hardship in those cases, that that's an automatic given, that they are zero, but for others - - -

MR YATES (COTA): We were aware from our conversations about that context that that was your view. We think that there are other contexts in which that will also apply.

MR WOODS: We'll have a look at it.

MR YATES (COTA): On the flip side of that, we've also said that it's really, really hard until we get down to looking at the actual figures, but we're not necessarily saying that 25 per cent is an absolute cap. What it is, I don't know, but there was some willingness to say that people who are of substantial means might pay more than that.

MR WOODS: Yes.

MR YATES (COTA): Similarly, the 60,000 figure for the stock loss. Is that high enough for people? There's an interesting discussion. I don't know the full answer to that. We noted with interest the point made by the department in its submission to you, that at the moment people can actually end up paying substantially more than that.

MR WOODS: If you use the current figures of 25 per cent and if the maximum annual cost of care is in the range of \$50,000 to \$60,000, then your annual cost is capped at 12 and a half to 15 thousand anyway, so even if you took the upper limit for the very wealthy up to 35 per cent at a maximum cost of \$60,000 a year for care, you're talking about \$20,000 as an annual cap and they would be at the very high end of wealth, plus the continuous, most intensive level of care.

MR YATES (COTA): We agree you're not talking about large numbers.

MR WOODS: No, and on that basis also for them, we're not talking about significant incursion into their wealth.

MR YATES (COTA): No.

MR WOODS: My point on that one is that an annual limit is self-generating in that sense, that there is an annual limit. We could set the annual limit as being, if the current maximum cost of care is 60,000 and we chose the 35 per cent figure, you could set an annual limit at 20,000, but it would have no relevance other than comfort, because that would be what the formula generated anyway.

MR YATES (COTA): The finally point was to report to you that in our consultations, the issue of inclusion of the family home, as we said to you last time, always gets discussed, but at the moment we have not had a strong reaction back against it, although, as we said at the time, we're not sure whether the assets test level you've chosen is appropriate or not. A lot of feedback to us was about some relationship to median property values, although of course you'd have to be very careful in the way of doing that you don't end up excluding most people from the assets test.

MR WOODS: Absolutely.

MS MACRI: And it could disadvantage some others that are in a high area but their home doesn't come up to the median price, because you've got some homes in some areas worth two and a half million, three million and they throw out the median price for particular areas.

MR WOODS: There's also a question of whether you have a national figure or a state figure and if you have a state figure, what is happening out at Mungindi, north-west of Moree, where your house prices, I would gather, would be under \$100,000 at a good bet, are a lot different from Sydney.

MR YATES (COTA): You could raise a whole lot of other public policy issues if you went down that route, differential pensions.

MR WOODS: Thank you. It's very kind of you to suggest that. But it is a real issue of what figure. We had a rationale for the figure we chose. We are conscious that that figure is subject to annual indexation that may not adequately reflect what is actually happening in property prices, that it's probably tied to CPI, not property indexation. We take on board your view, but we don't have a final resolution of that.

MR YATES (COTA): We don't have a definite position to put and in the end all of this other feedback we get is people just really want to see the figures.

MR WOODS: But I do think we should take your views in their two parts: one is the general principle of including all assets and then the second is what is the minimum threshold.

MR YATES (COTA): To say the obvious, but because it was repeated so often, the really strong feedback is, "Okay. If that's a direction and if the user contributions are more universal and higher, we can wear all that if we get a better system and it is affordable."

MR WOODS: We think we've demonstrated a better system.

MR YATES (COTA): We agree and we want to come to the quality issue, if we could, before we finish today.

MR WOODS: Yes.

MR YATES (COTA): Consumer protection was really just to flag, with the addition of the correction, that really your recommendations turn the system around from people going to providers to obtain things to people having an entitlement and effectively having a contract about services. I think that it's a very good thing that it will bring it much more into the mainstream of consumer protection relationships and we're just flagging that through our consultative arrangements with the ACCC and ASIC. We've started those conversations and both of those have indicated they'll have further explicit discussions about it once the report is out and see what the government response is.

MR WOODS: I noted with some trepidation your reference to "interesting implications". I'm assuming that it's in the Chinese sense of, "May you live in interesting times."

MR YATES (COTA): A bit inevitably there, but I think that firstly for those bodies, aged care has existed somewhere over there and doesn't often come in their - - -

MR WOODS: Sure.

MR YATES (COTA): So the idea that it might come into their scope is of interest to them and the notion that a more, if I might say, market and rights based approach was also intriguing to them. So I think it's generally a positively interesting application and they would have to think about it in a way they haven't so far. The next area is ageing and disability and I think from listening today that we get the

impression that there is a sense in the commission that there needs to be some alignment across the two reports without having a totally integrated system. We put a position in our original submission, which we have had reinforced, that regardless of age, if a person is receiving long-term disability support, that should continue and if there are age-related developments, they should access those. Obviously you wouldn't double-dip.

Workforce matters. We continue to be engaged in discussions which, as the commission will be aware, are ongoing between unions and providers and with the government. We thought we would put down here a few things about our position. We do think that inevitably because of the financial pressures on the industry, that that has an impact on staffing numbers and it's worth just saying that that is a fact without having to have any ratios on it and from our understanding, many providers are spending three-quarters of their income on staffing anyway, so clearly there are significant pressures on their capacity to provide.

We continue to not find great support for fixed staff ratios, but we do want to see a lot more work done on what is an appropriate skills mix for the balance of clients.

MR WOODS: Sorry, on that one, do you have the view that our proposal, that a price recommended by the regulator to government would of itself need to come to a view on what the appropriate skills, hours of delivery of those skills, and associated inputs to price; the particular needs, bands, or levels, or however that entitlement is finally described?

MS ROOT (COTA): It would have to, because if you were going to do a "cost of care" study, you've got to decide what you're going to cost. You've got to have a basket of things that you're going to cost, and that automatically is going to feed in various skill groups and quantities of staff. It has come up across all our consultations that people see the need for more staff and for the staff at all levels to be better remunerated. That's coming from consumers quite strongly and that leads to more government funding; that's the critical issue for quality of care, really, is government expenditure.

MR WOODS: That's a point we do keep making to the workforce representative groups: that this is one avenue and a very significant avenue for achieving that.

MR YATES (COTA): There is a distinction, which we make here, between those segments of the workforce for which there is a direct competitive parity, or reasonable parity, which we have been advised since we started in this journey that a not-insignificant number of providers are already doing, because they found that, if they don't do that, they are into casual and HACC agency staff and so on. So being competitive in the market, particularly for nurses, is important. We don't have any

figures on that, obviously.

But in other contexts there is a lot of emphasis on the other staff in the industry that have generally been very low paid and the mechanism for increasing that is more complex, as the commission itself noted and we keep reiterating. It is a point that we will continue to make to government, in difficult times for government, but it is about the status of the industry as a whole, I think. It is what many both consumers and families will tell us, that as well as having appropriate clinical support it is about having companionship, persistent support.

I might say also, just in passing, that the issue that was raised earlier in the day with regard to language and communication skills is also raised in all of our consultations, and it is not necessarily just straight literacy; the person may be quite literate verbally themselves in English from another context, but it's the capacity to understand what idioms mean and accents mean.

MS MACRI: I think that really goes back to the quality and the calibre of the education that's coming out of the RTOs in relation to that certificate level III and IV at the moment. Again, it comes back to there are courses that are very good and excellent and there are a courses that are a quick fix. If you come from a non-English speaking or a CALD background and then go through a quick fix, you're not going to come out with the language skills around the care or the environment you're working in.

MS ROOT (COTA): Some providers have indicated that their preference is to take entry level people who don't have a certificate and actually do a lot of in-house training before they even go off to do the certificate III, to deal with some of those issues and to suss it out for themselves and make sure people have got the skills they want.

MS MACRI: Yes. It's a double-edged sword a little bit, too, in terms of then looking at the residents you have from the CALD background getting staff that have the language skills to look after them and then the language skills to translate to the broader workplace, so it's not an easy one.

MR WOODS: Can I say I was pleased to see your reference, not only to more clinical skills, but that they be deployed in an efficient and focused way. It's a principle that Robert and I underlined when we did the Health Workforce Report, that what you need is a delivery of care by those who have the appropriate skills, provided in the most efficient manner. It's not just a, "Let's have the best of everything," because the best might not be the most efficient and the best might not be the best in the right context. High-level clinical skills may not be the solution to delivering quality support and other forms of care for a range of the needs of the resident or community-care person in need.

MR YATES (COTA): They're an essential component, but they're not the whole story, yes. The final point in the written material was to just make the point about the reform process and the other components of that. This is a matter we have now raised with the minister, to start a conversation. It's obviously something that the commission can't go too far into, but it has occurred to us that it actually is significant for the future of the industry, and the industry itself will have to start thinking about how it relates to those other structures in the health process, rather than just being an attachment of services.

MR WOODS: Just on that point, just to reinforce, our approach has been to acknowledge and recognise the development of these other initiatives, but not to assume that (a) they're in place, and (b) operating in the most efficient manner during the time of the development of these new policy structures. But should that eventuate, then a further review would see how they best align or amalgamate.

MR YATES (COTA): That may be something that the industry as a whole is able to address. But in our view it needs to start addressing it, otherwise it will start to not be organised in the same way that those other two sectors are, I think.

MR WOODS: Yes. Quality?

MR YATES (COTA): Quality: can I just make a few points about our quality. I know our view is that, by and large, as we said in our original submission, Australia has a fairly high-quality system. There are too many things that don't meet that standard and we could do more, and we would support, for example, the points made by the advocacy services earlier today; that there is an imbalance in their capacity to reach out and be available to people.

But I think we wanted to put two things on issue, one is there is a difference between the quality of the individual service that's being provided, which is frequently of a very high calibre, but the consumers have made the point to us and to providers that have sought to explore this that there is a difference between that and the impact on the quality of life of the very nature of the system itself. It is in that context that we believe that what you've recommended will add to the quality of the system as a whole. It will create greater control and choice and those will drive improvements in quality over time - not overnight, but over time - in tandem with things like a good independent complaint system and good sanctions against people who are rogues.

The standards that we have in the current system can be critiqued. There is a consultation going on about some new ones at the moment. We would just remind people that those standards contain within themselves a commitment to continuous improvement and that needs to be pursued. We have argued before that the whole

system would benefit from greater consumer involvement and we will pursue that in the new regime. But quality is a function of many aspects and people's control over their lives is an important aspect of that. Which leads me to make, if I could, a note that a number - we're not sure how much this has been said to you, but in the discussion about this whole process, there is quite a bit of conversation about whether or not greater choice and control is relevant to a population that can't exercise it.

We would just like to say that, in our experience, and we are talking about the whole gamut of aged support and care, for many years now a really strong message we have had from people from the very early low care or community care services, right up to high care, is that people would like to have more control, and that the control issue is central to their own quality of life. Just because the system and indeed a whole lot of society doesn't enable them to do that at the moment, doesn't mean that shouldn't be our aspiration into the future.

MS MACRI: Absolutely. The other thing is, I think, Ian, around that, even if the individual themselves can't influence that quality, certainly their family can.

MR YATES (COTA): Yes, many people can, and are unable to now. Secondly, just the fact that you have dementia or some other disabling issue, challenge, does not mean that you can't partially do that, with the system. In fact COTA is involved - in a South Australian context - at the moment with a project, being funded by the Office for Ageing, with the Public Advocate, to talk through models of assisted decision-making, shared decision-making, which I think is going to be really quite exciting into the future. So we would just go on the record and reject the fact that necessarily people who have professional and other expertise know better about what people need all the time. They know a lot of things. There needs to be dialogue with a person. By and large, the population in our client group will respond well to this report I think.

MS MACRI: Having been sitting through these in a number of states and territories and just again today sort of thinking about the accreditation system, can I just ask you a question around that quality and accreditation. Accreditation is not going to prevent a catastrophic event. It should prevent systemic problems, but it's not going to prevent that one off catastrophe. Like, there was an example this morning of an unfortunate incident, I think in a nursing home in Sydney. People tend to come out and say, "Well, accreditation is not working, because" - something happens. Accreditation is not going to prevent a one-off catastrophic event, but it should prevent systemic poor performance. There seems to be a bit of conflict between what accreditation can and can't do in terms of the overall quality of care. I just wonder what your comments are around that.

MR YATES (COTA): Obviously we would agree with that observation, as indeed

one would in other contexts, like workplace safety for example where you need to identify whether a workplace accident is a systemic failure - that is, you haven't put things in place - or in fact all that was in place but there was human error, or freak things happened. On the other hand, I'd also say that the quality in relation to those things is the function of a variety of things.

Part of it is the regulatory system, but part of it is the culture, part of it is the training and support, the quality of management systems, which has been addressed by the commission as well, and funding and all those issues. If you're not properly funded and you're stretching, even though you've got the systems in place, that can lead to greater likelihood of those kinds of events. But, yes, you will never eradicate them in any context of human life, basically. Contrary to that is the concern that gets expressed about trying to take all risk out, in terms of the client having no risk to their safety at all, but their quality of life is totally destroyed because everything that happens to them is so controlled.

MS MACRI: Yes, so you become so risk-averse. I would say, Sue, that, having taken the Queensland government state nursing homes through the first accreditation - they were dreadful places before accreditation, before the Aged Care Act - and, although they may not be perfect now, there's certainly a lot better quality of care and there is more consciousness of everybody about providing better quality. So no accreditation system is perfect, but it has moved us a long way. I think we need to be careful that we don't throw away what it has given us just because a few people can pick holes in it. I just say that.

MR FITZGERALD: What is your view about the accreditation function being with the regulator?

MR YATES (COTA): I think you asked us that in Melbourne, and we said we were comfortable with your recommendations.

MR FITZGERALD: That's fine. I just wanted to reaffirm, because we heard alternative views about it today.

MR YATES (COTA): We don't have any difficulty with your recommendations. We understand both the synergies and the separation. I think the final point we wanted to make is that we have observed some kind of what I'd call critique of whether a body like a gateway could ever deliver the things that as promised. We believe that it certainly can, as well as anybody is doing now, and that there is a little bit of special pleading going on for the way things are now, when actually in a lot of cases it doesn't work very well, and some of the people who are making it work are doing so by begging, borrowing or stealing to assemble things, and that's now how you build a system. So reaffirmation strongly on the gateway.

MR WOODS: In that context, we had an interesting demonstration of that point from a very large provider of community and other care in Western Australia. After they demonstrated a particular delivery of service needs, we said, "Well, how do you fund that?" and, upon more detailed investigation, we were told it comprised a collection of bits of funding from various sources, which they then, within rules, put together to create an excellent outcome. So we understand your point. If we could more transparently identify those needs and fund them appropriately we'd have a much cleaner and clearer system.

MR YATES (COTA): Yes, and the kinds of things that the good assessment processes ACATs do produce now would become the norm, whereas frequently it's not and, as we have said before, it is really inconsistent around Australia with some very poor outcomes. Just two minor points. There was reference in earlier presentations today to the COTA-ACSA paper on national housing strategy for older people. That is an attachment to our original submission, as indeed is a paper on the possibility of a social insurance scheme.

MR WOODS: But we notice you're not going to pursue that.

MR YATES (COTA): No. We said last time we wouldn't do that. But that does draw on the sources that we referred to.

MR WOODS: Yes. We have your submission -which we discussed before - in relation to the draft report. So I don't think we need to reiterate those. Anything else?

MR FITZGERALD: No, that's fine. Thank you.

MS MACRI: No.

MR WOODS: Thank you, Ian. Thank you, Josephine.

MR WOODS: Elizabeth Hannan? Hi, Elizabeth. If you could give your name and whether you represent an organisation or not.

MS HANNAN (KW): Elizabeth Hannan. I'm Kangara Waters' councillor, which means I represent Kangara Waters on the IRT Resident Council. I'm also a member of the Retirement Village Residents Association, and so have worked with Pam Graudenz on certain parts of the paper. Some of them I haven't addressed, because she has also put in submissions.

MR WOODS: That's fine. I think you know the drill now. Just give us an overview of your key thoughts, and then we can have a brief discussion.

MS HANNAN (KW): Please feel free to interrupt. I'll read out what I have written, which is a bit of a summary. You have my presentation before you. To me, the thrust of the draft report is ensuring that older Australians receive good quality care, and I think we'd all agree with this. There is a problem of how the increased costs are to be met. Having said this, as you well know, many older persons will not need to access either in-home or residential care but will die as a result of a sudden event either at home or in hospital. As you can see from my written submissions, much of what I have said concentrates on some of the financial implications for persons and their significant others when care is required.

First of all, there's the cost to a person and significant others when receiving in-home care, and I suggest the following: that the family home be not included in determining the fees for in-home care, the rationale being that the person is living at home, they have their accommodation, and if they're living with someone else it also affects them. The second one, which may be regarded as being even more controversial, is that up to two carers receive the equivalent of the age pension free of means test if the person has been assessed as needing high-level care. This, to me, is to acknowledge the huge contribution that informal carers are making and to ensure that they have ongoing income and additional income.

In a past life I used to go and see people who had an allowance - and this is decades ago - called special benefit - caring 4. They were very dependent, because they didn't have any financial income of their own. In those days you had to have a very strict means test to get that allowance, but in addition to that, as I've put in my submission, they needed to have retraining when - usually their mother - died, because they had been caring for a long time. I have great feeling for carers because I think that they do a tremendous amount, and they suffer for it; you know, in hospitals there's this no-lift policy, there's no no-lift policy for a spouse, a daughter, a son, and they can do in their backs, they then need to have treatment for that, and this costs money along the way, as well as meaning that sometimes they can't go back to work that they were doing previously. To me, it's a huge problem.

I do say that carers, depending upon who the carer is, may need to be assessed as being able to care and to giving appropriate care. I am not discounting the great work that I think the carers associations do that I have come across and the respite care associations do, but for this thing I'm just taking a slightly different angle. The next thing is the cost of residential care to the resident and significant others. I would suggest that the federal funding needs to be increased, and I would think that that has been said to you many times. Certainly the continuation of additional funding to providers to cover the cost of concessional residents is necessary, if there is a shortfall in the funding, the federal government to increase its contribution.

Adequate funding need to be increased annually to cover increased staff costs. That hasn't been done in recent years and needs to be done because that has put the providers in a great deal of financial difficulty, because they need to draw on their capital, or other ways, to finance the staff costs. As COTA has just said, we need good staff in order to provide good quality care. You could say, "Oh, well, you do it out of love," but, if you've got a family to support, you need to be able to support your family as well as being employed in aged care. Then there's one special group that I'd like to draw attention to, that the providers be adequately funded to provide palliative care and other specialised care, because, as you well know, the amount of money that is given to providers is much less than the cost to the community of someone being in a hospice.

Then I come to contributions from a person requiring residential care. My particular concern is for a person who has a partner or is leaving someone else to go into residential care - that is a cumbersome way of putting that some people live together, they may not be in a partnership relationship, they may have lived together in a group-house situation, be very good friends, two women, lived together for 30 years, or whatever else - might have only been five years, but, you know, they share the same accommodation and it's mutually convenient for them to do that. The other group - which is of even more concern - is, if there is an adult relative who has been living in the house, what happens if the contribution is going to include certain things.

So what I am suggesting is the value of the family home, including a unit in a retirement village, should not be included in assets if the dependent person - ie the person going into care - has been living with a partner or others. Too, I suggest that the assets of a couple are determined, minus the home, and then the amount be halved so as to treat them as two single people financially, and then the aged pension non-homeowner asset test be applied to the person requiring care. I think there is a tendency for some providers - this is hearsay, and I would certainly not say in this room - to be asking for bonds, according to what they perceive that a person can pay, not according to a rational way, another way, of doing it, which is, "What is the cost of care?"

Regarding bonds, the maximum amount that each provider is asking and how this is determined - which I think you have well and truly put in the report - should be published together with other ways of payment in place of bonds and how these payments are determined. This is very difficult for a lay person to find out. You need to be very aware of how the aged care system works currently and be able to ask very relevant questions of providers. There needs to be clear information on inclusions for accommodation and care available in particular facilities. I liked your idea of a ratings system to help persons in comparing residential facilities. I support the recommendation of persons having a maximum lifetime limit to meet the accommodation and living expenses for care; I consider this equitable.

I gather that the commission is recommending that the extra service fee for services be abolished and that aged people be more up-front as to what they're paying for for so-called extra services. But if that is rejected, I think that any extra services provided needs to be clearly documented and there needs to be monitoring, that the extra services that are desirable are being provided. I just give an example, "Can a person still swallow if provision of gourmet meals or alcohol is included in the cost?" Any questions up to the present?

MS MACRI: No.

MR WOODS: If you'd just keep going, and then we'll come back. That would be great, thanks.

MS HANNAN (KW): Good. Ensuring the quality of care for older Australians. I think the creation of an Aged Care Regulation Commission, as outlined in the draft report, would have much merit and I would like to emphasise the following. The function of this commission should be publicised through the proposed gateway to ensure that the general public and those who are receiving care and their significant others know how to voice complaints. Just apropos of that, it's said people may be able to voice complaints through the advocacy service, but some residents are frightened of being even seen to be supporting an advocate. One might say, "Oh, well, they could ring up?" But some aged people cannot use a phone.

It's very difficult for some people to voice a complaint, and it's sometimes very difficult for their significant others to do so as well. Though significant others often have many more means to do it than a dependent person, that can still be difficult. In my previous life I was a social worker, so I have had contact with a lot of aged care facilities, a lot of people who have been in aged care facilities, and some have been frightened to voice complaints, "What will happen to me?" "What will happen to mum if I do so?" So apropos of that, I have some concern if mandatory reporting of assaults is abolished. I mean, we would not want to have any of our people assaulted in any way. That is one of the worst things that can happen, for someone to be

physically damaged, and, as important, mentally or emotionally damaged, through being in aged care.

Then I get to accreditation. The assessors should make themselves available to residents and their significant others so that they may have input. This, as I have just said, can be difficult for the residents because, "Mary is speaking to someone. I wonder what she's saying. Oh, yes, she did fall out of bed the other day. Is she telling them that?" If that comes out in the report about how to keep people safe in bed, it can have implications for Mary. I'm not saying that people always need to have guardrails or anything else I think mostly people fall when they try to get out. It's not when there are not guardrails, it's if there are guardrails and then they have a significant fall.

I think the use of the equip model as used in hospitals, satisfaction surveys would assist with some consumer input but some residents may not be able to fill in forms or attend focus groups. Now, workforce issues to educate, train, develop and competent staff in community aged care and in residential aged care. I commend the ideas in the draft report to address issues and in association with these ideas I think that there should be formulas. I take the point from COTA that it's not just the number of people, it's the quality of care that's given. But it really concerns me that in some facilities in town there are not registered nurses on when a person is very sick. They are on call instead of someone being there and some of the facilities are quite big and they require more than one registered nurse.

Maybe this is getting a bit too micro a statement to make. Sometimes the registered nurses expertise is not being used. It is being used for accreditation, paper accreditation. I have been surprised that nurses are being expected to update their care plans every three months. I think they should be updated at least every three months but they are doing it on paper. Marvellous care plans but they take forever to write out longhand because the facility hasn't got a typist to type them up and to do and cut and paste thing with computers.

MS MACRI: There are a lot of computerised care plans now.

MS HANNAN (KW): Thank goodness. I think gradually they will become more and more into vogue because a registered nurse is too precious; his or her skills are too precious to be used on pen and paper things like that. Then the other thing about workforce is ways to be found to increase the numbers of doctors and allied health professionals to specialise in geriatrics, gerontology and facilitate means to access these professional. This can be by consultation, it can be by team approaches, it can be by better transport to take people out to appointments, a whole variety of ways to do that.

Then we come to the Australian Seniors Gateway Agency and I certainly

support the establishment of a gateway. I don't say this is the only way to do it, but I wondered whether consideration is being given to expanding the social work services of Centrelink to provide this service. They are very expert at having the technology when people are unemployed as to what to be doing or where there are facilities available, where there has been abuse in the family, you know, on a very local level they are able to tell a person where to go to. It would mean a greater expansion of their services. You may prefer to outsource it to someone else but they may just be able to expand their services to increase the resources there.

I think an independent body such as ACAT should continue to conduct assessments for level of care. I think it's very important it's done by an independent body rather than being done by providers. ACAT resources may need to be enhanced in certain districts in Australia and possibly ACAT assessments may not be needed for some services, eg, respite services. If a person is over 70 and has had an operation and needs to go into respite, we don't want ACAT using all their resources for that. We don't want people having ACAT assessments just in case they may need respite. I gather from some of my colleagues who have worked in ACAT that they spend a lot of time doing things just in case.

Then we come to age-friendly housing and retirement villages. I would again support the ideas and suggestion made by the vice-president of the Retirement Villages Residents Association who is here, by the way, and I would commend the draft report's recommendation 10.5 but I would want the accreditation process to be carried out by an agency independent of providers so that it is seen to be independent and is really independent. More importantly, I would have preferred if the recommendation in the draft report had been to seek that the responsibility for retirement villages be transferred to the Commonwealth government. In the absence of this transfer, I would hope that the Aged Care Regulation Commission and the Australian Seniors Gateway would be able to facilitate the handling of concerns, complaints and gather more information at least to begin with and if the legislation isn't being followed by certain providers that there be increased avenues for sanctions.

Often people, once they have entered a retirement village they do this when they are of advanced frailty or their partner is. They can still live independently but they are not really able to voice concerns, like I can. I mean, I do live in an aged care facility - self-care I mean by that. I'm one of the younger people there and ours is a young village in any case. I would just like it to be on record how much I appreciate the services provided by IRT. Nothing of what I have said is meant to be a reflection upon IRT. I mean, always things can be improved but I regard them as being reputable and ethical.

MS MACRI: I think probably one of the things that it comes back to in terms of retirement villages for the ACT the fact at the moment there is not a legislative

framework for retirement villages as there are in the other states and territories. So that some of the issues that you are raising are unique to the ACT as opposed to perhaps some of the other states and territories where there is good strong advocacy mechanisms for complaints through Departments of Fair Trading and those sorts of issues.

MR FITZGERALD: Thank you for all of that. Your novel proposal - novel in the good sense of the word - in relation to providing greater support for carers of people with complex needs, the government's immediate response is, "Well, we already provide carer pensioner payments to some degree and they have been increasing over a period of time."

MS HANNAN (KW): Sure.

MR FITZGERALD: I must admit that that never comes up. Notwithstanding the considerable cost to government of this scheme it never comes up. So what is it about the current scheme that needs to be improved? You have said there should be two carers provided with age pension equivalent support for a person with complex needs, but by world standards, in a sense, the carer payments and benefits are not insignificant.

MS HANNAN (KW): What I mean is that you can have a 40-year-old who has got a 70-year-old mother. She decides to give up work to care for her aged mother and she's got a house somewhere, she's got assets somewhere, but she's now going to lack an income. Why should she, with the assets test, need to dip into her savings because she is caring for her mother if she doesn't fulfil the means test for the carer's payment. I don't mean carer's allowance because that's free of means test. She or he is providing to the community, providing for her mother, saving the community, I mean by that, providing for the community.

I just thought, "This is little enough that could be provided by the Australian community." It's given to people who are blind. I know that there are various reasons for that in the dim, distant past, but this group is potentially a very needy group. It would have to be restricted to those who are caring for a person with high care needs, because, you know, it could almost be abused.

MR FITZGERALD: These things tend to be, but, yes, it's true. In relation to your issue about residential care and taking Sue's comments about accreditation and what have you previously, what is it, did you think, would be the single most significant thing that could happen in terms of improving the quality of residential care? Of all the things that could happen, what is it that you think is going to make the biggest difference?

MS HANNAN (KW): There are two levels. One is the quality of food. In some of

the facilities, the food isn't very good at all, according to the residents. So that is on a daily basis, especially for the main meals. The other thing really to me is the knowledge of staff. When do they call a doctor or ask for outside assistance and how available is someone there to respond? So there's their medical pharmaceutical care, because the people who are especially in high-level care, they've got very complex medical needs, their metabolism is very different from a younger person and sometimes it just isn't noticed. There are very basic things. People don't think to keep people hydrated in the summer months. People don't think to take older residents outside to be in the sun or give them vitamin D.

We've got a geriatrician in this town who is always going on about vitamin D, so it's increasing the amount of vitamin D. I'm sure that's been taken by people who are residents because it has other implications. There are people in this town who have died of dehydration because personal carers haven't noticed that a person is dehydrated.

MR FITZGERALD: It's about knowledge.

MS HANNAN (KW): Yes, about knowledge.

MR FITZGERALD: Knowledge and education. Thanks for that.

MS HANNAN (KW): And noticing. Lots of personal carers are very proficient and very, very caring. It's to ensure that this happens and to individualise out the care to a particular person.

MR FITZGERALD: Thanks for that. Sue?

MS MACRI: No, I haven't got anything.

MR FITZGERALD: Thank you very much for that. Thanks very much for the breadth of your submission too, we much appreciate that, and from your personal experience. That is terrific. So thank you very much.

MS HANNAN (KW): Thank you.

MR FITZGERALD: If we could have the Royal College of Nursing Australia. If you could give your name and the organisation and the position within that organisation that you represent.

MS CURRY (RCNA): Mrs Maryann Curry and it's the Royal College of Nursing Australia and I'm part of the health and wellness and ageing faculty.

MR FITZGERALD: If you could just give us some opening comments. Thank you very much for the materials. We've heard from various members of your college over the hearings, so thanks very much.

MS CURRY (RCNA): I just want to give my apologies for Laurie Grealish. She's unavoidably detained, so she's not here today. Firstly I'd like to say that the Royal College of Nursing welcomes the Productivity Commission draft report and applauds the work and thinking of the Productivity Commission in this enormous undertaking. RCNA has publicised the need for infrastructure supports, professional development supports and funding mechanisms to enable nurses to deliver a greater level of care in residential facilities and community settings. The RCNA health and wellbeing and ageing faculty committee and members have identified these priorities and seek to see them supported in the final report. There are three key points which we would like to highlight to the commission for consideration and comment.

One of the first ones we'd like to make reference to is professional development. In our submission, we recognise that the commission has reviewed the position of unlicensed care workers in detail, but we also recognise that specifics related to the development of registered nurses is lacking. We appreciate that you've given thought to teaching in nursing homes, but one of the aspects of registered nurse development is considering the need to have a professional development framework in place so that we can build confidence, quality, leadership skills in the registered nurses who are currently sitting within the aged care workforce itself.

Another focus that we have is on the aged care unlicensed care workers. We recognise that there is a great need for regulation or licensing of care workers and a practice framework would greatly support having the ability for care workers to have some sort of a national common practice framework to work from. The third area that we wanted to focus on was around the building block approach and the figure that you portray, figure 3 I think it's referenced as, and it uses language such as "specialised care" and the college is suggesting that the term "clinical care" would better represent that third category of care, suggesting that those areas are really specialist components of clinical care, as opposed to specialist care within that framework.

In that figure it also references "residential care" in the reference of both at

home care and residential aged care and we probably would like to see some sort of differentiation there just in terms of the language, whether the commission is referencing residential care or care in the home, as opposed to care in residential facilities.

MR FITZGERALD: Thank you very much. Could I just ask a question. It's my ignorance perhaps. When you talk about the unlicensed care workforce and you talk about the development of a professional development framework or some other term, what was the term you used?

MS CURRY (RCNA): "Endorsed practice framework".

MR FITZGERALD: An endorsed practice framework. Can you just explain to me briefly what that would look like or the elements of it?

MS CURRY (RCNA): Currently there are a number of RTOs delivering certificate IV in aged care nursing or a component of and they are delivering it in various ways so that you can move from state to state and see that certificate IV, or even from RTO to RTO, being delivered in a multitude of ways. What we're recommending is that a framework is put in place where all of those RTOs are actually working to the same practice framework so that we get some sort of continuity across RTOs, let alone across states.

MS MACRI: There's been some problems around that with the enrolled nurse and endorsed enrolled nurse too where Queensland has had a diploma and New South Wales has just had it at the cert IV level. So there have been some issues around that. The RTOs, it goes beyond the cert IV. It seems to us the bigger issue seems to be around the cert III and the variability of RTOs and the end product coming out. Just everywhere the same issue has come up, so we're pretty much across that.

While we're on what we're calling the unlicensed worker, and in terms of that endorsed practice framework certainly the College of Nursing has presented and has had a similar conversation with us through the hearings, one of the things that we have asked both the RCNA and the College, being the two bodies that - putting aside the ANF which is professional but plus union, where the two colleges are not - we have been looking for a little bit of guidance around what that framework would start to look like. Now, we're starting to get it now around some codes of ethics and some of those sorts of things but has the RCNA given any more consideration to just what that framework would look like?

MS CURRY (RCNA): Not at this stage, no. I think at this point we're really saying that we recognise there needs to be a strong framework, a unilateral framework. I'm aware that the College of Nursing is suggesting a licensing of care workers as opposed to - - -

MS MACRI: They have again come through the language of expertise and skills and a framework then of endorsing where they're at with their level but have not at this point in time endorsed a full licensing.

MS CURRY (RCNA): Yes. As I said, I think it's the beginning of the discussions around saying we need to recognise that, and perhaps that's something that the commission would recognise, that this is a beginning point, rather than up until this point our unlicensed care workers have not been considered, certainly from both colleges' perspectives, and we're saying it's at this point now that we really need to move forward and suggest a universal approach.

MS MACRI: Just in terms of your first one on professional development, and again I guess the unlicensed workers come into that whole RTO and starting to get a proper framework around the curriculum, the content, the length of the course and the workability of the person when they have completed the course - just around the RN development, and this is not defending our draft report, one of the things I guess we were cognisant of was the fact that the RCNA has been responsible for administering many of the Department of Health and Ageing scholarships around registered nurses, clinical care, all of those sorts of things.

One of the things that started to come through to us and we did talk about was around the management skills because there seems to a lot of registered nurses that are promoted through the system from being an RN on the floor, clinically sound, doing a great job, and then might become deputy and then director of nursing but there's absolutely no pathway in terms of developing the appropriate management skills. So where does the RCNA fit on that side as well as the registered nursing, the development? I mean, you've got your clinical skills but seem to have a cohort of nurses out there that are thrown into management positions without the skills to transition into that role.

MS CURRY (RCNA): That's where we mention like a training guarantee levy. We can provide the courses but it's very much about the approved providers recognising the need to support the registered nurses through management and leadership training. Yes, the college can provide the educational support but it really is around supporting and encouraging approved providers to be able to support their own staff through that management and leadership training. You're absolutely correct in that registered nurses are promoted up through the ranks. Whether it's because the skills are recognised or whether it's a management shortage, it's often you don't know which one comes first. They do rise through the ranks and they are often then either leaving because they can't cope with the pressure, they're not equipped for it, and often we're then getting providers saying, "Well, you know, we promoted them through and yet they've left the organisation. We don't know why." So it's about, I suppose, getting the approved providers to recognise they also have a

responsibility and they play a part in the promotion of management and leadership education.

MS MACRI: So when you talk about that RN development, are you talking about that management, leadership as well as clinical?

MS CURRY (RCNA): As well as clinical but primarily it's around management and leadership. As we've said, we have such proportion of unlicensed care workers and they are delivering - they are being given tasked, delegated nursing care, and yet we're asking registered nurses to lead unlicensed care workers in this role without equipping them with leadership skills and knowledge. As I said, we can provide the courses, and there are courses out there, however the providers need to recognise and accept that they also have a responsibility on them to provide those registered nurses with that support.

MS MACRI: Can I suggest to you, then, it would be really good to get - because everything that we read is not talking about that specifically - just even another page from you around that in that workforce the RN, the leadership, the management and some of the issues around that. When we read the submission to date it's around RN education and development but it's not specifically around where you see the gaps and how those gaps need to be filled. It would be helpful for us.

MS CURRY (RCNA): Yes.

MR FITZGERALD: Just in relation to a couple of recommendations, you've said that funding incentives should be provided to establish increased number of specialised advanced practice nurse practitioner positions and funding be made available to establish nurse practitioner services to manage the health care needs of aged care populations. As you know, if we're talking about residential aged care we're talking about the ACFI in effect, being the main instrument by which care is funded at the present time by the government. Whether there's a co-contribution or otherwise is another issue. So these funding incentives that we're talking about, is it simply making sure that the ACFI is in fact appropriate and appropriately funded, or are you talking about separate incentives or initiatives that would be required to actually get providers to use nurse practitioners and advanced practice nurses?

MS CURRY (RCNA): I think with the current ACFI model there is scope for the recognition of the acuity, obviously, of residents and that funding is meeting the needs of the current workforce. In order to develop and promote nurse practitioners there needs to be some other sort of subsidy for them, simply because, if we want to look at developing nurse practitioners within the aged care sector, we're then again going back to the whole wage-parity issue. Trying to promote those practitioners within the aged care sector we would need funding other than currently what's

coming through the ACFI model.

MS MACRI: Can I just ask you, in terms of that: this has just come to me in the last couple of weeks through these hearings, and in the report we talk about nurse practitioners. We know they are far and few, and hard to get endorsed; it's a very rigorous process. One of the things, it seems to me that there's a gap between what we talk about, our RN, and then the nurse practitioner. We start to look at the model, that we're talking about greater acuity, some specialisation in - and I'll talk about clinical care and specialisation in a minute.

We probably need to start having a look at where clinical nurse specialists and clinical nurse consultants start to fill some of those roles; of where we might be in the future, having people bring care in for specific residents. Because, again, it's very hard for a facility to carry a nurse practitioner or often even a clinical nurse specialist or consultant around; wound care, ileostomy care, it doesn't matter what it is. So it's about having that care coming in and out. What are your thoughts around the gap that we currently have?

MS CURRY (RCNA): I'm not confident that we recognise the extent of the gap that's there. We're saying having nurse practitioners is a positive move, but definitely having a mid-tier practitioner, a specialist nurse, is something that, again, whether you're providers within residential care facilities or whether it's in the community setting, they can certainly meet a lot of the specialist care needs of residents. Again, we're coming back to funding and saying, "How do we fund these positions within the industry?" I'm not sure of how we do that in the current funding model.

MR FITZGERALD: Let's assume we've got a reasonable-sized aged care provider, is there guidance as to when the engagement of a nurse consultant or a nurse practitioner becomes desirable? What triggers the desire to appoint any of these more advanced nursing positions?

MS MACRI: It would be resident care.

MS CURRY (RCNA): Yes, it's true. I think there are practitioners that are being put in place by providers, those who have got a number of remote facilities where they find that having that nurse practitioner or that specialist nurse be available to a number of facilities, that is the driver for putting in a position such as that. Having a nurse practitioner position within a metropolitan city where there's a cluster of homes, there's no real driver for it, because they have access to services. The drivers are coming from the rural and remote areas where you just don't have access.

MS MACRI: But the drivers for a clinical nurse specialist in wound care or diabetes - yes.

MS CURRY (RCNA): Just in the access, and there are organisations and providers that will access those specialist nurses for a period of time., but whether an AP could then start to build capacity within their own organisation to have those specialists - - -

MR FITZGERALD: If you can't afford to employ a nurse practitioner full-time, where do they sit?

MS MACRI: It's not even an affordability issue. It's about whether you need those skills?

MR FITZGERALD: Whether you need it or whether you've identified that you need those skills.

MS CURRY (RCNA): It's (1) identifying whether there is a real driver for that specialist skill, and the other then is how you fund it.

MR FITZGERALD: One of the things we've been floating in the last few days of public hearing, particularly in Adelaide and Perth, was the notion of these multidisciplinary health aged care teams, which I think have real merit. There is a very limited number of those around at the moment. It seems to me that many of these specialist services or practitioners would well sit within those more mobile flexible, multidisciplinary aged care teams. Is that your thinking as well? We haven't seen that development, but now that we're starting to have these Medicare Locals and all these others things, the notion of team based health practice, surely the day has come, we would think.

MS CURRY (RCNA): I think certainly, again, in WA or rural and remote areas, that has merit. Whether that would be successful in a metropolitan setting, I don't know.

MR FITZGERALD: Why wouldn't it be successful in a metropolitan setting? What is it about metro that is precluding this sort of team based approaches?

MS CURRY (RCNA): The reason for team based approaches in the remote setting is access to services. If you've got a team who can provide a number of services within one setting or within one team, then you've got that access to that service. Within the metro setting you've got a number of services within that area health service, whether it's across town, whether there's a daughter who picks her mother up and takes her across town for a specialist appointment; you've got far more flexibility and far more choice. Having a specialist team within a metro area, I wouldn't see there'd be such a driver for that as opposed to there being a real driver for it out in the rural and remote setting; the further out of the city you get, the more you need it. For

example, even looking at somewhere like, if I can use the central coast of New South Wales. It's not rural or remote by any means, but there is a real need for health services, so it's depending on the population, depending on the clinical service availability in that area, that's the driver for those teams as opposed to anything else.

MS MACRI: Just asking you again, in your submission - and the latest one we received on 21 March. Here you say:

It is unfortunate that the title of this program reflects terminology and concepts more relevant to the 20th century.

I assume you're talking about the teaching nursing home there? That surprises me a little bit, because I read a lot around this area and there are some esteemed academics still talking about teaching nursing homes. Then you don't give us an alternative of what you think they should be called. I'm taking you to task on this one.

MS CURRY (RCNA): Certainly sitting around the nursing roundtable with DoHA a few months ago, we also had this conversation and there was great debate around the table: are they nursing homes, are they aged care facilities; if they're not nursing homes, what are they? The view of RCNA is that "nursing home" tends to be an outdated terminology, yet I acknowledge and accept that we actually haven't come up with an alternative. Your comment certainly reflects the comments around the nursing roundtable, in that we too couldn't come up with an alternative even though there was robust discussion around, is it a nursing home, is it a care home, is it an aged care facility, what is it. We also couldn't come up with an alternative, so I think we've put that in to note it is an aged term, if you like; it's an old term. What the term should be, we leave it up to the commission.

MR FITZGERALD: It's true to say that in the report we don't talk about - - -

MS MACRI: I don't think the commission is going to come up with something that should be reflected from - - -

MS CURRY (RCNA): From the community.

MS MACRI: - - - the academia and the industry itself, in terms of what it wants to be called. I could imagine us putting something in here and coming up with a term and everybody coming back and absolutely screaming at us; it's inappropriate.

MS CURRY (RCNA): They would, yes. When you look at the terminology that's current out there in the industry, whether it's nursing home, whether it's care home, aged care facility, residential care facility, I think there are a number of terms and I think that reflects how we as a community feel: that really there isn't any one label to put on to aged care. Aged care, as such, is the label that we all use and I think that's

a positive in that really we're not prepared to label high care and low care residential care. We're not labelling it.

MS MACRI: But that affiliation between universities and the residential aged care industry is an important one that we want to continue to promote. So I guess - - -

MS CURRY (RCNA): Whether they become teaching nursing homes or teaching residential facilities.

MS MACRI: We'll have to think about how we word it in the report.

MR FITZGERALD: It is true to say we don't refer to nursing homes anywhere else in the report. We struggled as to what we should call it. Just a couple of points. The mentorship program that you're talking about for aged care workers. You say resources should be allocated to provide structured, flexible and dedicated mentoring support for graduates and early career nurses. How would that actually work? Do you give the money to the educational institution, who then almost has this outreach of mentors or do you go through the providers? Again, I keep using the term, but how do you operationalise that sort of recommendation? Again, it's my ignorance, rather than anything else.

MS CURRY (RCNA): I think, depending on the organisation that you speak to, they will have a different point of view, but certainly a way of getting a mentorship program to those who are mentoring in the residential setting, that is the key. So, for example, whether it's funding of a program and then providing online learning capabilities, whether it's - it's got to be a way that accesses the greatest number of staff as possible, rather than funding it through whether providers pick up on the funding and then they use that. How much longevity is there in that approach? Whereas if there was an online learning component through an RTO of some sort or through the government where it's freely available, they can go online and access that sort of information, then you might be able to get a far broader number of mentor programs out there amongst the homes.

MR FITZGERALD: I presume there's no equivalent of the divisions of general practice that provides that educational supportive layer in the nursing and related areas.

MS CURRY (RCNA): No, there really isn't.

MR FITZGERALD: It has come up in the context of a totally unrelated inquiry and also an inquiry into early childhood development workforce and there's a huge issue around professional development. The systemic or structural response to that is playing on our mind at the moment, so it's a relevant question. Any other questions?

MS MACRI: Yes. Just the other one that you talked about, the building block and the language between specialised care and clinical and it's the first time I haven't had the report sitting under my nose, but I guess we'll go back and have a look at it because we take that's been raised. But I again just want to talk a little bit about when we look at that building block and we look at that specialised care, we're looking at that team approach that Robert has been talking about and not just nursing and clinical care.

MS CURRY (RCNA): I think it's more about saying clinical care, rather than specialised. From memory, there's dementia care, challenging behaviours kind of care.

MR FITZGERALD: Yes.

MS CURRY (RCNA): There's a number of speciality areas.

MS MACRI: Yes, that's right.

MS CURRY (RCNA): I think they're your specialist areas, but I think it all comes under a component of clinical care. So the broader overarching framework is clinical care and then it's broken down into these specialist areas.

MS MACRI: Yes.

MS CURRY (RCNA): It's just recognising that clinical care has a number of specialist areas.

MS MACRI: That's what we needed to clarify. So we'll go back and have a look at that.

MR FITZGERALD: The diagram will change, I have to tell you.

MS MACRI: Yes.

MR FITZGERALD: There's lots to be put on the diagram. Anything else?

MS MACRI: I've probably raised this. Just when you're giving us the other info, a little bit around perhaps the role of clinical nurse specialists and clinical nurse consultants might be a little bit helpful to fill that gap between the RN and the nurse practitioner because we sort of go out there with the nurse practitioner as the leading light, but in lots of instances, it's not going to be the appropriate care model. I think we've left the other out a little bit, so it would be good.

MS CURRY (RCNA): I think as a nursing profession, we've absolutely welcomed

the concept of the nurse practitioner, but you're right, we need to have those mid-layers to support both the registered nurses and the nurse practitioners themselves.

MS MACRI: Because that's about career planning as well and not everybody wants to go up through the management stream. There's a lot of people that will want to go through the specialised clinical stream and I think we're probably not - - -

MS CURRY (RCNA): Certainly in aged care traditionally the only career pathway has been through management, whereas now with the nurse practitioner structure, we now have a clear opportunity to create a clinical career pathway for the registered nurse.

MR FITZGERALD: Thank you very much.

MR FITZGERALD: That concludes our list of scheduled participants, but if there's anybody else in the audience who would like to make a brief statement, you're able to do so now. If you could just come forward, give your name and any organisation you represent. It's just an opportunity to make a brief statement on the record.

MS GRAUDENZ: Thank you very much. Pam Graudenz.

MR FITZGERALD: Are you representing yourself or an organisation?

MS GRAUDENZ (ARVRA): The ACT Retirement Village Residents Association. I'm also on the ACT Ministerial Advisory Council on Ageing and I'm on the management committee of ATACAS. Michael was here earlier today. I'd just like to say thank you very much. I would really like to say that I think this is a most wonderful opportunity. Thank you to the government. Thank you to the Productivity Commission and to the commissioners. It's a great opportunity to have a say in what is being planned, so thank you. There is just one thing I would like to say that I think is missing, and it's financial. I've listened very carefully. When you're considering, for instance, people paying high priced accommodation bonds so that they then get the pension, they're in actual fact pushing up the costs of accommodation bonds, which reflects on everybody else.

When you go into a retirement village complex, as we have here in the ACT, with the three levels on one site, we do not have prudential regulation as to statements of prudential finances annually, to the security of your ingoing contribution, as to whether your exit entitlement is secure because we have a code. There has been conflict regarding the code. People say it's working well. It's not working well at all because it's far too narrow. Most of the complaints that go to the Office of Fair Trading fall outside the code.

If you're going into one of these complexes, I am getting very concerned about what happens to the statements about your exit entitlements because they then go onto either paying accommodation bond in low level care or against your charges in high level care. I think when it comes to this, the general public is very uneducated. Until they have actually to deal with this, they don't really know what they're looking at, it's a real nightmare for them, and also families are stressed.

The other thing about that is what about all the people who don't have families? They don't have families here, they don't have people here. I've been in a lot of cases like this where I'm standing in for people who do not have families. They might be overseas, there might be no family, there might be no family connection, there might be a rift there. That's a real concern to me and I really am concerned that the prudential regulations cover what happens not only to your exit entitlements and to

its security, but to what happens in those extra cases.

MR FITZGERALD: So you're talking about the prudential requirements travelling through both when you leave the retirement village into the next level of residential aged care?

MS GRAUDENZ (ARVRA): Yes. When you go into the independent living units in the retirement village, there are no prudential statements as to the security of your money once you've paid it over, and then onto those other further ones. Thank you very much.

MR FITZGERALD: Thank you for that.

MR FITZGERALD: Yes, please come forward.

MS WONG (CMCF): My name is Chin Wong and I am actually here representing the Canberra Multicultural Community Forum, we are the peak body representing our ethnic communities. I'm also the convener of the Multicultural Senior Network that is encouraging the multicultural senior leaders to get together once a month so that we can address issues relating to aged care and ageing issues.

I'm also here just to make a statement to say - I think most of the CALD communities will agree with me - that we're no different and the care that we want is the same as anybody else. I don't think the CALD communities want to be treated differently. We just want to make sure the government and service providers are aware that we have heightened needs: the needs are based on the different culture; it is sensitive to our culture. The different types of demands we have, like different food and also the culture is that a lot of the communities rely on their community to provide support, because we come across with a lot of the seniors, they live by themselves, they've only got either the husband or the partners, the children may not be here, and a lot of them come here because for family reunion, and for one reason or another they may not have not the family support.

So the CALD communities have a lot of communities; for example, in ACT we have about 150 different communities. A lot of seniors rely on friends and community help. I'm from the Chinese community. If you look at the way that the family supports and the family structure, a lot of families now are what we call "air", because the children do business overseas, so we call them, more or less, the "air flight" families; they have no people and they rely on their grandchildren to support and to speak on their behalf, because of the language barriers.

So I'm really here to make a statement to say that I read through some of your 450-page report, but one of the things that we would really like you to pay attention to is for the Department of Health and Ageing to take back the cost for the interpreters' services and bear part of the cost and funding for the service providers, because I think at the moment it is more or less given to the immigration. Also, please don't use the interpreting services as an excuse as a language barrier, because we have community languages, we have different community languages, and the communities can help. The way that we want accredited interpreters to do interpreting - it works in the legal sense, but in the everyday life sense we all speak in different languages and I can't see why we can't use our own community to support those services. It's cheaper and also it's much, much more effective. That's all I have to say. Thank you.

MR FITZGERALD: Thank you.

MR FITZGERALD: Anybody else? Just the lady first and then yourself in a moment, sir. Please give your name and any organisation you represent.

MS BAIL: My name is Kasia Bail. I work with the University of Canberra, I'm a registered nurse doing my PhD. I want to flag a couple of things and, Maryann, I'm sorry, I'm going to contradict you and it's probably my fault for not submitting something to the RCNA in the first place. But the main thing is actually about, you were talking about nurse practitioner in multidisciplinary outreach teams, and I certainly think that is a feasible and active role and that is happening currently in the ACT: there is a RADAR position which is run out of ACT Health and there is one up on the north coast as well.

The ACT has conducted research reports regarding nurse practitioners and their potential role, and I think it's something that has been poorly explored for a number of reasons and a lot of those are to do with the culture in residential-setting workplace. I think that answers some of the discussion about speciality registered nurse roles in residential aged care facilities as well because it's about clinical support, that you can have an RN in a facility but if they don't have good medical support, the rest of that multidisciplinary team and ability to get mentoring, alternative advice and opinions, then that role is limited to what it can do. Nurses are autonomous but we are always collaborative, and a nurse practitioner is the same. So working out teams that can have that function I think is actually really crucial and easily overlooked.

MR FITZGERALD: You said a "RADAR position", what is that? I don't care about the name but what does it do?

MS BAIL: They try to prevent people going into hospital - so people with aged care issues - and they have a team of a nurse practitioner, geriatricians, registrars, and access to allied health is required. So that's a pre-hospital prevention program and then they also have employed a nurse practitioner for a post hospital readmission, preventing that readmission, as well. I've been involved with some research in New South Wales and in the hospitals that have specific aged care services, a lot of them will have an outreach service that does something along those lines, and it might be a clinical nurse specialist. It's not necessarily that somebody is staying in the area but something that is a program that can be accessed and developing a community that people have expertise that is accessible by phone, by visit, not by visiting the emergency department.

I think that perception about rural areas not having access and metropolitan areas having access is not true. Yesterday I worked in an emergency department and sent a really distressed patient home who was screaming the whole time because the nursing home couldn't cope with them any more and they felt that they needed better

assessment for mental health and dementia care, and the emergency doctors considered that it was not an emergency case and did not need to be seen through the hospital, and should be seen in the community and should be managed for their behavioural issues in the community. That tension is ongoing and I'm sure that you have lots of ideas about how we can relieve that and I think it's really crucial.

That other stuff about nurse practitioner and clinical nurses in clinical settings I think in some ways talks to your early childhood learning and teaching models about how do you encourage a culture of learning, and I think that the teaching nursing homes idea is an important part of that and talking about community as a practice and having workplaces that encourage active inquiry. Wherever you have a workforce that does not have a supernumerary capacity where your clinicians have a patient load, so that early childcare workers and the nurses are the same, the space for them to do that thinking and that learning is difficult, and them turning up to an in-service once a week to spend an hour being taught something is not the same and I think that that's something else that might be addressed about whether it's a day a week that they get a professional development day or something along those lines.

MR FITZGERALD: Thank you very much.

MR FITZGERALD: If you could your name and any organisation you represent.

MR HURLEY (SCOA): Peter Hurley; Superannuated Commonwealth Officers' Association. The association has a concern about oral health. From the feedback we've had from members and others we believe that that is an area that requires more attention in aged care facilities et cetera. The government did provide a little money a couple of years ago in that direction but because oral health affects general health we think that priority should be given to further assistance there. Much has been said about carers today and we would support the valuable role that they play and the hardships that they actually go through.

One area that we've identified is their inability to contribute to superannuation when they're looking after someone and that's because the work test applies to them, that they've got to do 40 hours in 30 days to be able to contribute superannuation. We would like to see some reference in the report whereby consideration might be given to removing the work test from these people so that they can at least start to provide for their old age whilst they're actually caring. I don't think that's inconsistent with the way Centrelink looks at - how some people fulfil their requirement to Centrelink and I think this would be a nice adjunct.

On the inclusion of the family home in the means test we would support the position put by National Senior today, so I won't go any further there. They didn't mention, but I believe that they have - I've just been involved in a situation where one party of a couple had to go into care and it caused a lot of consternation about the family home because the other partner wanted to stay in the home. So there should be consideration given to leaving the home out of consideration whilst someone is going to live in it.

On the staff numbers, et cetera our members have suggested that there have been some difficulties in some establishments and some unqualified staff et cetera. I'm not close enough to make too much comment other than others have suggested that that is the case. So I think that you just need to record it. We like the idea of the single gateway but we share the views of some others that it may not be a single answer to the whole of Australia.

MR FITZGERALD: Thank you very much for that comprehensive set of statements. Any other comments? That being the case we'll adjourn the hearings until tomorrow morning. I think we start again at 9 am tomorrow morning here in Canberra. You're a very lively group; that's terrific, thank you.

AT 5.32 PM THE INQUIRY WAS ADJOURNED UNTIL
WEDNESDAY, 6 APRIL 2011