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TRANSCRIPT
OF PROCEEDINGS

PRODUCTIVITY COMMISSION

DRAFT REPORT ON NURSING HOME SUBSIDIES

MR M. WOODS, Presiding Commissioner

TRANSCRIPT OF PROCEEDINGS

AT BRISBANE ON MONDAY, 16 NOVEMBER 1998, AT 9.30 AM

Continued from 13/11/98 in Hobart

MR WOODS: I will commence the hearing at this stage. Welcome to the Brisbane hearings for the Productivity Commission inquiry into nursing home subsidies. My name is Mike Woods and I am the presiding commissioner for this inquiry. In looking around, I think all of you are aware the commission released an issues paper in August setting out the terms of reference and some initial issues. Subsequently we have received over 60 submissions, and I and my team have visited interested parties in every state and the two major territories. I would like to express my thanks and those of my staff for the courtesy extended to us in our travels and deliberations and for the thoughtful contributions that so many have made to this inquiry already.

These hearings, which started in Hobart last Friday, represent the next stage of the process to be followed by the receipt of final submissions by 27 November, together with comments on background material which we have separately circulated to bodies. I would like these hearings to be conducted in a reasonably informal manner but remind you that a full transcript will be taken and is being made available to all interested parties.

I would like to welcome as a witness to these hearings Ms Josephine Root from Queensland Health. For the record could you please state your name and the position that you hold.

MS ROOT: Josephine Root. I'm the manager of the Aged and Community Care Reform Unit in Queensland Health.

MR WOODS: Thank you and welcome. If you wish, would you like to make an opening statement.

MS ROOT: I would just like to thank you for the opportunity to give Queensland's Health position on the inquiry at this hearing, and to say that basically we were very pleased with the proposals in the position paper, particularly as it relates to the funding for nursing homes in Queensland. We have tabled our submission outlining our points on the submission paper, and I guess we're particularly pleased to see that you think Queensland is particularly disadvantaged by the current arrangements, and that we should get some short-term relief, and also some suggestions on how that short-term relief should be provided. I think that's all generally I want to say.

MR WOODS: Thank you. As you'll appreciate I've only had a few minutes to look through your second submission but I will ask a few questions on that as we proceed. If I can turn first though to your original submission to us and just pursue a couple of matters that you raised. On page 5 of that submission you said that it was estimated that industry occupancy rates are more than 99 per cent, and that up to 700 beds are occupied at any time in Queensland public hospitals by patients who would qualify for nursing home admission if places were available.

MS ROOT: Yes.

MR WOODS: Is that a trend that is increasing or is that a figure that has remained

reasonably stable over the years?

MS ROOT: It's actually a figure that went down significantly from about 94 through to 96, due to quite an aggressive policy of discharge from Queensland Health hospitals. And come 96-97 the data, which has a lot of problems, mainly in the way our hospitals classify people as true NHTPs, we've seen a slight increase but it's not across the board but it's particular hospitals, and we're doing some more work on monitoring that. So the trend was going down and it has started to rise again, and whilst we're not saying it's as a result of the Commonwealth reforms or that it's anything to do necessarily with the level of subsidy, it's just a matter of concern to us.

MR WOODS: In your submission you use the phrase by patients who would qualify for nursing home admission if places were available. In your answer just then you attributed a fall down to that level as relating to the somewhat unilateral actions of the hospitals in concert with government for discharge. If that wasn't matched by an increase in the supply of nursing home places as such, then what were the consequences for NHTP-type patients?

MS ROOT: One of the things that Queensland Health did was actually establish a contract for interim care with the Mount Olivet Hospital in Brisbane where we pay for a certain number of bed days of interim care. So that was people who had been classified as having what used to be an NH5 as a nursing home-type patient, and were awaiting permanent placement in residential care; were unable to find it and so were sent - and still are - to Mount Olivet on an interim basis until a permanent place - so we were able to use that contract to take some of the pressure off our acute beds and still move them out. A number of our hospitals have set up interim care wards at Ipswich RBH. We've also brought the extended care unit on line at the Prince Charles Hospital District, and Rockhampton has an interim care facility, and a number of our hospitals have been looking at alternative ways of moving people out so they stop being classified as nursing home-type patients in the acute sector and move into interim care or through the Southern Non-Acute Program, the SNAP program.

Also in rural areas, how we took the pressure off the acute hospitals through some of the more aggressive discharge policies was to insist that people go to a nursing home bed that may be considered out of the local area or out of the community area. So we would have nursing home-type patients from Emerald, for example, being basically forced to take up a vacancy at the Longreach Nursing Home, and that is not considered an acceptable practice, so I guess we would allude that there were often vacancies in nursing homes - particularly in the Longreach Nursing Home, which doesn't belong to us, it's provided by a non-government provider - but there were often vacancies there and people were expected, and pretty much forced, to take a placement in Longreach. We've also looked to send people home to await placement if at all possible, so there are a number of strategies to get over the fact that there were just no vacancies.

MR WOODS: Are these interim facilities in effect state-run transitional nursing homes?

MS ROOT: Well, they're not always state-run. Mount Olivet actually has - - -

MR WOODS: State-funded, sorry. The onus should be separate from the funding.

MS ROOT: Yes, that's right. We would view it that the state government is picking up the tab for a shortage of nursing home places in Queensland; a little bit of cost-shifting from the Commonwealth to the state, and people often spend quite a long period of time in the interim care at Mount Olivet and many don't actually - because of the severity of their illness and their frailty often don't actually make it into a permanent placement.

MR WOODS: Is there a greater tendency in rural and remote areas for the local base hospital to be picking up the nursing home-type patient and keeping them within the hospital sector rather than in the metropolitan, or is that fairly even across?

MS ROOT: I think in the larger provincial hospitals there's actually less of a tendency for the hospitals to keep them than the metropolitans. And for some of our smaller rural and remote, nursing home-type patients would be the bulk of their work. Often without the nursing home-type patients, the long-term patients, they actually wouldn't have very many patients at all; one might question why we have those hospitals. That group is not the group that we're particularly concerned about. We've accepted that aged care is part of our core business in Queensland Health, particularly in rural and remote. It's mainly the metropolitan; particularly as we're downsizing our metropolitan hospitals, it becomes a more acute problem.

MR WOODS: Thank you. You also referred in that submission to preference for funding on an output or outcome basis and not on current mixes of inputs. The Productivity Commission's position paper also proposes that the Commonwealth set a final price as an output price for purchasing RCS care 1 to 4s, but having regard to the input price mix. In your view is there any inevitability of having some form of nexus between the two?

MS ROOT: I think you need to use either your current inputs or some best bundle of inputs to establish what your output price is going to be; the same as with case mix. When you've established a case mix price then you have to look at what it actually costs to do certain procedures rather than just pulling a number out of a hat. So you're always going to have a look at your inputs. I guess the point we were making there was we felt that the current system of state-by-state subsidy levels was very much determined by the estimated cost of the inputs so we were all being asked to produce the same output or outcome in terms of meeting the residential care standards or the previous outcome standards, but we were actually getting a different price and so we wanted to move away from just looking at the price of the inputs and making sure that both were taken into account. But you have to start off with the input prices in order to establish what your level of funding is going to be.

MR WOODS: But is the line of your argument though, not to prescribe what that

mix of inputs be that you declare for?

MS ROOT: Absolutely, yes. We don't believe that the Commonwealth or anybody should tell us or any providers how they should reach the outcomes. They should just be judged by reaching the desired outcome.

MR WOODS: The commission has received a number of representations to it to put some form of a fence around the care funding component of the subsidy to ensure it is utilised for care on the assumption that that's the only way that that can be achieved. What would be your reaction to that proposal?

MS ROOT: I think that would be going back to the old CAM-SAM-OCRE very much. I think it then is open to interpretation what is care, what is not care. Are hotel services care? Are operational staff - you know providing somebody with food - care? I would argue it's all care. It's an industry which needs to be integrated to meet the outcome standards, and I think it's very difficult to legislate for what is care and what isn't care. So Queensland Health would not support that position to fence off what is care, partly because of the definitional problems, and also because it doesn't allow for substitution of parts of the process of looking after people.

I guess the only thing we would say on that would be the money that is supposed to be for capital should be fenced off in some way. But until there is sufficient funding for care it is very hard to say to people, "You shall not use your $12 concessional supplement to care for people, you should keep it in a bank account and spend it on capital improvement", and the provider may not be able to provide the level of care.

MR WOODS: Yes, I understand the concerns you are raising about fencing off a particular component of an overall care regime, and you talked also about definitional issues. There is a perspective though that if it was possible to identify care from hotel services - putting labels at two ends of the spectrum - that you could then look at the care component that is currently applied in nursing homes and could also be applied in the community and how best to deliver that care as being a separate question from then those who needed that care to be delivered in a residential institutional context which would then also be delivered to those who were providers of such a facility. Is there merit in pursuing that line of thinking, or are the definitional questions and the inflexibilities too great to warrant pursuit of that?

MS ROOT: I know that's a model that some jurisdictions have used in terms of providing different sorts of care. It's a model that I know is being applied to palliative care where the care component is being separated out from the accommodation component of the payment in Victoria, and to allow the choice of that, to make sure that the same dollars are applied whether people are getting community care or residential care for their palliative care. I suppose if you were going to look at aged care as aged care rather than just looking at residential aged care, there might be an argument for that. I think the logical conclusion for that would be that you would separate out your accommodation and care components, and then whoever's funding

would also put that amount of dollars in HACC services or community aged care packages.

I think that would make it very difficult. I think it's very inefficient basically for residential care providers to have to care to account. They would have to go back to having acquit care dollars against other dollars, and when you're providing a service that is made up of all those components that's actually quite time-consuming. One of the main reasons for the reform package that the Commonwealth brought down was to actually stop people having to acquit various payments and say, "This is care" and "That isn't care." I think the definitional problems would be huge in aged care.

MR WOODS: That's a concern that I've been having in exploring those models, and you'll notice that in our position paper we have recommended that we don't reintroduce acquittal either. Flexibility and focus on outcomes as measured by outputs is the way we are heading at this stage. Nonetheless it is a debate that is worth exploring to see if there are models and ways of dealing with it. On pages 8 and 9 of your submission you refer to convergences in rates of pay with other states; that obviously being the most significant component of the cost of operating a residential facility. Do you have a view on whether that convergence has kept going over the last 5 years or so and will trend increasingly into the medium term?

MS ROOT: I think it will trend. I think you will see convergence, mainly because there's such a national shortage of nurses, registered nurses in particular. When you've got a labour shortage you're going to push up the price of the labour if you believe in a market. So I think if Queensland is going to be able to attract nurses from other states, which it will have to do because the current recruitment and retention of nurses in the state is not sufficient to meet both the acute and the aged care needs. Then we're going to have to offer similar salary packages and similar wage rates.

We have a particular problem, if you like, in state government nursing homes in that three of our state government nursing homes, the Eventide Homes, actually have higher pay rates than almost everybody else and they cost us on average an extra $5000 a year for an Eventide employee than for somebody who is in any other public sector nursing home. So that poses a particular problem. I think the issue of the national shortage of nurses is going to force the pay rates closer together and you may actually get some bidding of people trying to attract skilled staff. We have a ministerial task force on recruitment and retention of nurses in Queensland under way at the moment, and currently it's only looking at private sector, but it will be, I think, forced to look at the needs of the private sector as well.

MR WOODS: Just pursuing one comment you made there about paying above-award rates, you were saying - - -

MS ROOT: We don't pay above award, it's a different award.

MR WOODS: Okay. The consequence being a higher pay package.

MS ROOT: Yes.

MR WOODS: That presumably has consequences then for recruitment in the private and charitable sectors if the government sector is offering as a consequence of the different award a higher overall salary.

MS ROOT: Because it's only the three Eventides I think it doesn't. The fact that we've actually been looking to downsize the workforce in those three homes probably means it isn't having any effect on private sector recruitment at the moment. But the private sector will be able to answer that better than me.

MR WOODS: You were referring in particular to the registered nurses and the shortage being experienced both in Queensland and nationally. Does that apply to other labour sectors in the industry to the same extent, or particularly for the personal careworkers is it much more a local market rather than a national market?

MS ROOT: Yes, because it's not been seen as a career as such. We mainly have assistants in nursing in state government homes, rather than personal care attendants or personal service attendants, or any other nomenclature you care to think of. But we have assistants in nursing and you tend to recruit assistants in nursing from your local area; it's a much more localised labour market. People don't travel great distances to be an AIN.

MR WOODS: From your experience do you have a view as to whether therefore the rates of pay across jurisdictions in those fields are likely also to converge or will they just exhibit local supply and demand?

MS ROOT: I think they're harder to talk about, national rates, because the classifications and demarcation issues are so different. In Queensland within the state government nursing homes we have a debate going at the moment as to whether we would have assistants in nursing, AINs, or whether we'll have operational service officers, and because we're looking to multiskill, we're looking to either extend the AINs into the operational work or do the reverse with the operational staff and bring them more into doing some of the care, so there can be a cross-over between cleaning, feeding - we had a demarcation dispute about who can feed - there are obviously issues involved in which union covers them, and a whole range of issues.

The operational services staff are more expensive already than the AINs, so even within Queensland and even within the public sector you've got two quite different wage rates operating within the same set of services. So we haven't taken a position as to whether we're going for AINs or operational staff. We've been examining the issue and looking at a pilot to decide which gives us the better value and allows us to meet the care standards better. So I don't think there is a national wage rate for those particular care staff.

MR WOODS: Thank you. In your submission you refer to:

> The new basic subsidy rate calculations should be made which determines funding based on the average cost across all states of an agreed bundle of inputs or services required to meet the outcomes.

In our position paper we refer to:

> Basic subsidy rates should be linked to the cost of providing a benchmark level of care in an efficient-sized facility using an average input mix.

In your phrasing with the "agreed bundle of inputs or services", do you see that agreed bundle as being based on best practice, based on a standardised agreed negotiated bundle of inputs or on the average of the bundle of inputs across jurisdictions? Each has very different outcomes for the subsidy of course.

MS ROOT: Yes, I notice you say "using an average input mix".

MR WOODS: We intend to tease that out in our final - we also refer to a standardised as distinct from pursuing best practice. So we've flagged our view but I'm interested in where you see this debate should head.

MS ROOT: I think it would be hard to establish best practice, particularly across states. The current input mix has been determined by the level of subsidy and by the level of funding, so in Queensland we probably use fewer RNs and use more of other staff in an effort to be able to provide the care in the level of funding that we have. Some of my colleagues here will probably correct me at some point but I think there's general agreement that if Queensland had a higher level of funding we would actually have a different input mix at the current time. So to base it on an average of the current position would not be appropriate.

MR WOODS: Yes, you get the current because that's what it can afford.

MS ROOT: Yes. That's what we can afford. So in Victoria they have a very different input mix because they can afford it, same as the Tasmanians, I think to take the current. So you would need to have a standardised agreed input mix that would have to be negotiated within the industry to set your benchmark to fund - - -

MR WOODS: Certainly we have also flagged it in our position paper. Thank you for that. If I can turn to your subsequent submission which, as you'll appreciate, I haven't had a chance to read in detail.

MS ROOT: Yes, I apologise for that. It had to be cleared by the minister and she didn't do that until late Friday.

MR WOODS: That's all right. It's nice to know it's cleared by the minister. I notice your introductory comments - and this submission will obviously be made available to all - which seem to be supportive of much of our position paper. If I can pursue a couple of things that I did pick up, and I am quite happy to have any further

comments that may come from you as the need arises up to our deadline date. On page 4 you disagree with the application of a productivity discount, and I may say you're not alone in that particular view. Nonetheless, from my perspective I see it as important as having incentives for various parties to the process.

If productivity was retained only by providers, then employees who must implement that productivity may feel aggrieved. If it is only distributed between providers and employees, then arguably taxpayers who provide the bulk of funding for the subsidy may equally feel aggrieved. Is there no scope or room to consider some distribution of productivity between the various elements - particularly if you separate out the question of quantum of funding to the industry as it currently is which, as you will appreciate, is not within my terms of reference - from how best to move forward into the future?

MS ROOT: I think one of the problems with the productivity discount is the requirement under the residential care standards to have continuous improvement. I think if you are asked to deliver continuous improvement and to continuously raise the benchmark of performance and to keep raising the standard, then I think there's a great tension there between being asked to continuously improve and have better quality and better buildings and better care and, to then be asked to also take a discounted rate for productivity, I would have said that if you are able to achieve productivity gains, then that should feed back into improved quality of service and improved standards rather than being seen as a way of saving money.

MR WOODS: Redistributing taxpayer funds between competing sectors as distinct from saving money perhaps.

MS ROOT: I would say that to have a productivity discount at a time when there's general acknowledgment that the level of funding nationally is insufficient is a bit of a problem.

MR WOODS: I understand your point. With achievement of productivity, doesn't that in itself though enable improvement in the quality of care, so that will free up resources and it's just a question then of how much of that freeing up is directed to that industry? I guess your point is that the industry is at a state at the moment where you're arguing a hundred per cent of that needs to be reinvested one way or another through the labour force or through the facility or - - -

MS ROOT: Absolutely in Queensland at the current time I think there's no doubt any money that is freed up would have to go to improving the standards. I think also there's not a lot of scope for actually delivering productivity gains when the industry is still fairly heavily regulated. You've got your outcomes regulated, you've got accreditation, you've got a whole - and there's still some playing in some states by state governments in determining inputs. So while you've got those constraints, it's very difficult to actually deliver productivity improvements.

We've had a process for 2 years in the state government nursing homes under

the enterprise bargaining agreement which has just finished - our second enterprise bargaining - which was supposed to deliver significant productivity gains for our state government nursing homes and we've actually found it very difficult to deliver on those productivity gains whilst maintaining the standard of care. The current government has actually put the program from a 2-year to a 4-year framework - extended it by 2 years - to slow down on their productivity gains which our state government nursing homes have been asked to deliver on in order to maintain and improve quality. We think we have some evidence to show the two are quite difficult to do together. Perhaps when everybody is accredited, you could start talking about productivity dividends.

MR WOODS: We have in Queensland some employers who have some experience also with enterprise bargaining and I look forward to pursuing that same point later in the day.

MS ROOT: The public sector has more constraints on it pursuing enterprise bargaining than private providers do.

MR WOODS: Thank you. You refer in your supplementary submission to workers comp not being relevant to state government nursing homes. Is that because you self-insure?

MS ROOT: Yes.

MR WOODS: Does not the state government impose or assess a level of premiums for the purpose of program budgeting and funding?

MS ROOT: We do it but we would do it internally in Queensland Health but on a district basis so not specifically for a particular facility. Each of the state government nursing homes is run as part of a district health service and we use global budgeting and so all of those costs are rolled into the district and it would be very hard for us to actually - we wouldn't keep it as a line item in the budget.

MR WOODS: Does that mean you don't manage it as a line item either?

MS ROOT: That's right.

MR WOODS: Presumably you manage occ health and safety as a discrete item or as a program?

MS ROOT: That varies by facility.

MR WOODS: I understand your point. We put forward in the position paper a draft proposal that government-run homes and those transferred to non-government sectors should receive the same basic subsidy as private sector and charitable counterparts. I notice that you attribute as your comments being that you strongly agree. There is of course a transitional question of those homes who have already

transferred and have factored into their price that they pay to state governments the fact they were receiving a lower subsidy. Do you have any comment on how that particular issue could be addressed?

MS ROOT: That would depend on whether the state government had offered any kind of top-up payment. When we were considering disposing of some nursing homes, which we're not doing any more - when we were considering that, one of the options we were looking at was to offer a top-up to replace the discount for people who bought our approvals. So it wouldn't have been a problem if that model had been adopted. I guess if it truly discounted the price, the price paid for the approvals, then it becomes an issue. I would have said that the one-off discount on the approval paid probably didn't really compensate for the ongoing loss of revenue as the subsidy level rises.

MR WOODS: The transaction presumably was still freely entered into by both parties.

MS ROOT: Yes, and that was a transaction entered into under the circumstances at the time. So when it's changed, I don't think people should be penalised for having made a transaction.

MR WOODS: It's not a question of penalising; it's a question of the quantum of the windfall gain that's addressing the commission's mind. You offer support for the views we expressed about special need funding for services in rural and remote. We are very conscious that they're already is a viability supplement and we've been at pains to acknowledge the work of industry and others in putting forward the criteria for that. In your view, is the greater difficulty with the criteria currently applying to viability supplements or to the quantum of funds allocated to them or is it some combination of both?

MS ROOT: I think the view that we would have is that the viability funding is designed for small nursing homes as opposed to those that are just rural and remote because it's based on the number of approvals. In Queensland the average size of a nursing home is greater than in some other states, so the current arrangements where it's based on the number of approvals has actually led to quite a distortion if you are thinking about rural and remote, wherein a large number of Victorian nursing homes can get support, additional funding, in addition to a very higher rate of subsidy to start off with, and a number of Queensland homes don't get that even though they are extremely rural and quite remote.

Because there was a tendency to build larger nursing homes encouraged by the Commonwealth government to go only for 40-bed nursing homes, which is why there is a 40-bed nursing home at Longreach which often has a fairly high vacancy rate because there's not the catchment area, we have a particular issue here in that we think that there should be a re-examination by the Commonwealth - and this is possibly not within your area but we'll mention it here anyway - that when they're looking at multipurpose health services, the rate of funding for the aged care

component of that which is linked to the RCS, needs to be re-examined.

So we have decided to go the route of multipurpose health services using our rural hospitals with some aged care approvals to provide residential aged care in the community and people live in as opposed to asking them to go from Emerald to Longreach. We aren't able at this point to access the viability funding for the MPSs, so it's really in that context that our remark in the submission is made.

MR WOODS: Thank you. Are there any other matters that you wish to canvass while you're at the witness stand?

MS ROOT: In the position paper you ask for comments on specific questions and one of the questions you ask about is the current two-tier concessional resident supplement. I would just like to say for the record that we believe that the two-tier concessional resident supplement should be discontinued and there should be one rate of payment. If it's supposed to be a payment for capital, then it shouldn't matter how many concessional residents you actually have, so I think it's quite inappropriate to have either a 7 or a 12-dollar supplement. It should be a flat rate and so we'd make that point, I think, that there, there needs to be some work done.

MR WOODS: Can I just pursue that a little further. In your view is that an example of trying in several different ways to provide an incentive structure to achieve an outcome?

MS ROOT: Yes, but it's obviously designed to encourage facilities to take concessional residents if they get more than 40 per cent. The problem is if you believe the data that the Commonwealth use to generate the cut-off levels for concessional residents and what the ratios should be in regions, there probably shouldn't be 40 per cent concessionals everywhere and so not everybody can get to the 40 per cent. It's actually lead into a rather perverse effect where people who are not concessional residents are having access difficulties, because many facilities have decided to try to boost it up to over the 40 per cent concessionals to try to get to their $12 a day as opposed to $7. I think it's inappropriate use of a tool really. You should have one tool to achieve one objective and when you try to use one thing to achieve several different things at once, it doesn't work.

MR WOODS: For those who are not concessionals, is that suggesting there aren't sufficient number of extra service places that they could seek?

MS ROOT: Not everybody who's not a concessional wants to or can afford extra services. There's a big difference between concessionals and extra services. Another point about the concessionals is that the asset level before becoming a concessional resident is actually very very low and many people with higher level of assets than that would find it very difficult to actually pay the accommodation charge. So the asset testing level needs to be reconsidered as part of any reappraisal of the concessional resident payment.

MR WOODS: Thank you. Other points?

MS ROOT: In relation to the concessional supplement we also think that testing for the concessional resident status should be done by the Commonwealth government, seeing as it's their scheme and they shouldn't be asking providers to be acting as their agent in assessing people. All other asset and income testing is done by Centrelink or the Department of Veterans Affairs, so we feel quite strongly that this should be handed from the providers and back to the Commonwealth government who can then take the downside of people being assessed instead of asking the providers to do it for them. I just make that point.

I think the rest of the questions that you asked we've covered. Question 6 in your position paper was the combination of the resident daily fee and the accommodation charge, so it's rolled into one payment for residents. We have real problems with that mainly because the Queensland government has decided not to charge the accommodation charge and so if it was rolled into one and tested centrally or something, we would have to get all of our residents probably treated separately by whoever was doing the testing for the two charges. So we think there would be some administrative problems there and it could lead to the conscious decision of the Queensland government not to charge, the charge being undermined, so we wouldn't support that.

MR WOODS: Thank you.

MS ROOT: You ask about an appropriate time-frame. All I can say is the sooner the better.

MR WOODS: We did pick that up both from your first submission and your supplementary submission.

MS ROOT: And I am sure you picked it up in other Queensland submissions.

MR WOODS: It seems to me a theme that's recurring.

MS ROOT: What we would say is that we think the two things should be linked, that a national rate of funding and a requirement to meet national accreditation standards should be linked. We shouldn't be asked to reach the same standards as other people if we're not getting the same level of subsidy.

MR WOODS: Thank you very much.

MS ROOT: Pleasure - thank you.

MR WOODS: I propose that we have a short adjournment and then we will resume with our second set of witnesses. Thank you.

MR WOODS: I would like to resume the hearing and welcome as our next witnesses the Reverend Dr Don Stewart, Mr Jim Toohey and Mr Michael Isaac. Would you please for the record state your name and the position that you hold.

DR STEWART: Don Stewart. I'm the president of Aged Care Queensland and also executive director for the Churches of Christ Care.

MR TOOHEY: Jim Toohey. I'm the deputy president of Aged Care Queensland and the chief executive officer of TriCare Ltd.

MR ISAAC: Michael Isaac, chief executive officer, Aged Care Queensland.

MR WOODS: Thank you and welcome - and your opening statement.

DR STEWART: Commissioner, we welcome you to Queensland and we welcome the opportunity to present to you some further matters in relation to the inquiry in which you are engaged. For you it is an inquiry which we know you will do well but for us and for our residents it is crucial.

Aged Care Queensland began a campaign which we called a Fair Share for Aged Care in Queensland Now. Because of the fact that high care residents in Queensland were receiving up to $20 less per resident per day than that in some other state jurisdictions. That campaign led to the holding of these commission hearings. The reason for the campaign was the injustice that was being done to the high care residents of aged care facilities in this state. The decisions of over a decade ago have caused a prolonged injustice which we wish to see corrected. As an aside, it has fascinated us that there was never any thought by the government that residents should pay differently in the various state jurisdictions and the government pay the same amount all round. Residents missed out we think.

Aged Care Queensland strongly supports the proposal by the commission that there should be a movement to national uniform basic subsidy rates in a speedier way as possible. We believe that there were no significant cost differentials between the various state jurisdictions and the work by the commission provides data to support that contention. We strongly support the recommendation by the commission that Queensland and South Australia receive immediate assistance to redress the present injustice but that it must not stop with that but move as quickly as possible to nationally uniform basic subsidy rates.

While this has been our central issue, the holding of this commission has raised a number of related issues and we wish to put forward our points of view on some of those issues. The first one is productivity. It is our contention that the presently two higher subsidised states of Tasmania and Victoria have a lowered productivity because of the resident nurse ratios which apply in those states and that a higher productivity can be obtained by the abandonment of the requirement for resident nurse ratios. The second matter on that we want to deal with later on relates to documentation.

On productivity, we are of the view that one of the impediments to greater productivity in Tasmania and Victoria is a requirement that those two states have for resident nurse ratios in which there's a prescription, that for X number of residents there will be Y registered nurses and Z enrolled nurses, etcetera. This is a very old method of trying to achieve acceptable outcomes and, as an old method is now outdated in terms of modern efficient management practice, efficient management demands that the decisions for the employment of a workforce be made at the workshop floor by the enterprise in the most efficient way. What other enterprise would tolerate the imposition of X number of foremen or supervisors for Y number of employees?

In the case of aged care, this could be justified if one of two conditions could be clearly demonstrated: (1) it is less expensive to do it that way, or (2) it produces significantly better care outcomes for the people for whom we provide care. Obviously it's not less expensive. That leaves the question as to whether there are significantly better care outcomes that the resident nurse ratios have produced. Better outcomes have not been demonstrated; rather it is a leftover from the past inefficient management practice. I understand it was introduced into Victoria in 1932. As a concept it remains an industrial fossil from a bygone era.

Over the past decade under the former government's reforms we had an outcomes monitoring process which was making largely independent judgment of the outcomes of nursing homes. While the Department of Health and Aged Care will argue that the results from the different states are not comparable because of risk management strategies, I believe that the results are indicative of the fact that there was no significant difference between the results of standards monitoring in Victoria and Tasmania than that in the other jurisdictions. In fact, there are some indications to the contrary that care delivered in Victoria and Tasmania may not have been as high, taken as a whole, as in the other jurisdictions.

There was a period before the introduction of the risk management procedures which seem to indicate less compliance with the standards of Victoria and Tasmania. Also later on there were proportionately more homes of concern in Victoria and Tasmania and the outcome of the certification process showed Victoria with a large number of facilities that did not meet certification standards. That the risk management process of the Department of Health and Aged Care does not indicate whether one state jurisdiction was better than another does not make the assumption that that care in Victoria and Tasmania was at a higher care level. They may have been at a lower level. We suspect that the introduction of the risk management process was to seek to prevent interstate comparisons which were beginning to prove embarrassing politically at that time.

The point I am making is that it has not been demonstrated, nor do I believe that it's able to be demonstrated, that overall the resident nurse ratio has produced a significantly greater level of good quality care to warrant the additional expense. The resident nurse ratio is a very expensive way of operating on so little evidence for

significantly better care outcomes. What we are saying means that there is room for productivity improvement. Our continued existence in Queensland has got to be evidence of the possibility of productivity improvement.

The second matter, in terms of productivity, is about the documentation process. There are two areas I'd like to mention: the RCS assessment and the use of computers. At the present time RCS assessment requires assessment over a 3-week period. That is for 3 weeks detailed reporting is carried out in order to assess whether the person will be in a category between one and eight. In our view this is bureaucratic overkill. If one of us required major surgery and if we add together the time of our local GP, the specialist, etcetera, in the whole process of assessing whether we need that surgery, it's doubtful that the time taken to make the assessment would be as long as 24 hours. I suspect it would take much less. Yet it has to take 3 weeks of costly recording of everything that is done to make an RCS assessment. I accept that there is a value in waiting 2 or 3 weeks for a person to settle into an aged care facility before the assessment starts, but to take 3 weeks to make that assessment is excessive. It seems to us 3 to 5 days would be sufficient, particularly if the person has been under observation for the past 2 to 3 weeks.

We've been surprised that some outcome monitors are objecting to the use of computers for recording information as part of the care process. We believe that it needs to be generally accepted that computer recording should be accepted by DHAC as a normal way of recording data and providing information in an aged care facility. We accept the need for security and reasons for privacy. Now, I am not sure whether you want to ask me some questions about that at that point.

MR WOODS: I'm picking them up. We'll go through that later.

DR STEWART: Okay. The next part that I wanted to say something about was the nature of aged care and its staffing. Residential aged care is different from acute care in that it is long-term care in which the facility in which care is given becomes the person's home. What predominates and must predominate in those circumstances is that the facility must provide a homelike environment, with the clinical care having to fit in with the homelike environment, rather than, as in acute care, where the clinical care predominates. That has important implications for staffing.

I have to say that here in Queensland, because we did not have the requirement for resident nurse ratios, we were able to be more flexible. Add to that our lower income base through lower subsidies, and you can see we needed to think through the issues more thoroughly to enable us to reach the standards set by the outcomes standards monitoring process. We did in the process discover some important things. The aim was to produce good quality care in a homelike environment. The use of care provider staff without formal qualifications meant that we drew staff from home duties. These were people with a great deal of expertise in homemaking and caring for people in families. They brought some important insights into our work. Their lack of skills in some of the direct care areas has and is being addressed by additional training.

What is now beginning to emerge in our workplace practices is the self-directed work team which incorporates the skills of both the registered nurse and the homemaking skills of our other staff. This means a change in the way in which registered nurses are employed. Instead of the registered nurse being a supervisor of care, the registered nurse is a member of a team and has a role as a provider of clinical nursing care alongside other care professionals such as the physiotherapist, diversional therapist, speech therapist and our assistant nurses with their homemaking backgrounds and expertise. Each has an important role to play in the delivery of care and in the preparation of the care plan and other documentation. It means a practical empowerment of staff in their various roles.

This needs to be contrasted with the model of care provided by the director of nursing in the ANF South Australia submission before the commission in Hobart in which the registered nurse was in control, made all the decisions, did all the documentation, and made sure that things did not get out of control. In our view, this is an outdated model that operates on far too narrow a focus of interest and concern. It certainly does not empower anyone except the registered nurse. Sadly, for us, one of the difficulties we have encountered in the introduction of the sort of changes set out above has been the resistance from a proportion of the registered nurses who have wanted to institute a clinical regime more like that in an acute setting in the nursing home.

It seems that it is difficult for some registered nurses to grasp that the nursing home is the home of the aged person. We have observed that while residents in aged care have a desire to know that a registered nurse is available in the event that their expertise is required, there is no desire to live in a clinical regime. The important thing is to get a good balance to meet the needs of each individual through the individual care plan, and to keep residents enjoying life to the greatest extent possible. That means providing for as much freedom for each resident as is possible, and to encourage them to avail themselves of the dignity of risk. No-one likes to live in a cocoon.

MR WOODS: Thank you. Mr Isaac?

MR ISAAC: Commissioner, I'd like to deal with just three issues - it will only take a little while - in a prepared opening statement to supplement what Dr Stewart has already said. The first issue deals with the independence of the aged care industry or, rather, what for decades has been the dependence of the industry. The commission is examining an industry that has not been renowned for taking the lead in innovation or the development of new concepts and models of care. In fact the industry has had little choice but to follow the lead of government.

New models of care delivery have been developed, but they have flowed from ideas of government and have often been created for reasons less philanthropic than may be obvious, usually to reduce government outlays. This is not to say that the ideas are not valuable or indeed contributing in a major way to improvements in

quality of life for older people. My point is the stifling of innovation by tight restrictions on income through subsidies.

If I may give an example, I'd like to consider community aged care packages, a genuine improvement in quality of life and choice for older people. Their evolution lies in the government's need to restrict expenditure on capital works, namely new hostels, rather than finding a flexible alternative care model. The industry has embraced these, but attempts to develop similar concepts further have been progressively reduced. The idea of an option to a hostel that involved no cost of new buildings was put to the test with hostel outreach packages, hostel care delivered to independent living units on the same or other sites. These worked very well in Queensland but, with the so-called more flexible aged care reforms, the Aged Care Act abolished the option. As of now, there can only be care packages or hostels, no hybrids of the two.

Meanwhile, of course, the Queensland retirement village industry sees a future need for just this option, and is now calling out for the invention of something scrapped just 12 months ago. Aged Care Queensland is particularly supportive of those elements of the commission's position that may free the industry from such restrictive controls over time, and we would seek a greater emphasis on government supporting rather than driving aged care generally.

The second matter that I'd like to raise flows from this concept. The commission has identified that the income available to nursing homes comes from subsidies and resident fees. In fact, in a less restrictive regime, income would actually flow from three sources: subsidies, resident fees, and the selling of infrastructure produce. The commission has identified one area in which the latter may occur. The proposal to free up extra service limitations to allow residents to purchase additional services from the provider is a definite step in the right direction. We believe that will work well and can be entirely at the residents' choice.

In such a case the infrastructure of the facility supports additional accommodation or hotel-type services. Aged Care Queensland has been participating in preparing the industry for these inevitable steps. We have this year conducted a pilot traineeship course that amalgamated an existing hotel services curriculum with elements of the certificate in aged care course. But this is only one small step. Nursing homes generally have the necessary infrastructure to sell services used in the home. Kitchen, laundry and gardening services are all marketable to wider sectors of the community, and so, too, are the care services. All have the potential to develop into income sources to supplement subsidies and fees and reduce dependency on government.

In a way, the co-location of nursing homes and hostels or nursing homes and retirement villages is just another example. Many nursing homes in Queensland still exist only because of the cross-subsidising of income shortfalls by surpluses in the co-located service. A nursing home in a retirement village may not be profitable, but it may add to the viability of the village. This is why we support the commission's

finding that there should be no return to full accountability for care dollars or any other portion of the subsidies. Such policies serve only to make industry more conservative, less innovative and more dependent on government income. Inevitably this centres the power structure with the subsidising body.

Our position would be that subsidies be recognised as a portion of the operational base of a nursing home, and that this therefore does not give the subsidising body the right to such total control over operations as has been exercised to date. Government has the right to demand certain outcomes in return for its investment on behalf of the people of Queensland, but it does not have the right to specify inputs, wage rates and care models as well.

If a government funds an organisation to provide full nursing care to a person, does it really matter whether the care happens in a nursing home, in a retirement village unit, or in the person's own home? Or, for that matter, would it matter whether the care happened in a new model closer to a hospital than a nursing home? And before everyone flinches, it happens all over Queensland in rural areas too small to warrant their own nursing homes.

There is another area that is disturbing us greatly at the moment, and I would like to cite it as another example of restrictive regulation. Because of the drafting of the Aged Care Act, the department is now saying that any person who has been assessed by an aged care assessment team is subject to the fee-charging restrictions of the act, and that this applies even if the person is in a bed which is not subsidised by the act. In effect, the department wants control over all beds used to meet the needs of the potential client group, while only funding the needs of a predetermined portion of that group. We believe the section the department relies on, actually a footnote in section 53(1), was meant to cover people assessed as category 8, no basic subsidy, but because of the wording is being interpreted as any person with no subsidy.

I cite this as an example of what we are having to work against all the time. If we think approved bed numbers are inadequate and wish to provide some outside the system, the department ropes them into the system. It shows how difficult it can be to free the industry from the clutches of the department.

The third area I would like to address in opening is a comment that we know you have heard and which has often been presented to us. It goes along the lines that this industry has no capacity to make efficiency improvements or, if it does, they will be one-off and not continuing. Let's be clear about this. When clever organisations are presented with inadequate subsidies to do the task at hand, what else can they do? They find solutions to the problems. Industrially we know this is not easy. The nursing unions are not renowned for innovation towards efficiency. In Queensland we are presently attempting to fight off changes to industrial awards that would have the effect of letting the nursing union dictate to management staffing numbers, staffing qualifications and shifts. We are not just calling for more subsidies to cover this. We feel it runs contrary to every organisation's right to manage its own affairs, and wouldn't it set a wonderful precedent for the retail, tourism or, dare I say, public

service sectors?

During the last election campaign we also saw nursing unions around the country seeking a return to the separation of care and other subsidies, and the acquittal of care funds, so that there would be no scope for varying the formula of expenditure either up or down. While the task of finding efficiency in such a climate is difficult, it is not impossible, and we believe that the beginnings of real movement towards efficiency are already taking place in Queensland. We hope some of the instigators will be willing to share their aims and values with the commission.

Our willingness as an industry in this state to pursue efficiency in return for a better deal comes from our experience over time, bred out of necessity. We are willing to try, but part of the deal must be funding that starts us from the same point as everyone else in the country. For that reason, we seek an urgent correction of the subsidy rate in Queensland, and a national rate of funding that is based on the care, services and accommodation required to meet the government's prescribed outcomes.

MR WOODS: Thank you, Mr Isaac. Mr Toohey?

MR TOOHEY: I've nothing further to add, commissioner.

MR WOODS: Thank you. If I could pick up some points arising from your opening statements and then pursue some matters in your submissions, but is there a point you wanted to make?

DR STEWART: Yes. I have some further points that I wanted to make as well.

MR WOODS: Do you wish to do that now?

DR STEWART: I think so, yes.

MR WOODS: Dr Stewart.

DR STEWART: A comment on incomes and outcomes - inputs and outcomes. One of the facts of life is that no matter what the inputs into something are, they can never guarantee the outcomes. All sorts of things go wrong, and if you're Murphy, they will go wrong. It is possible to have fully qualified staff and all the equipment to all the standards and yet not produce a good outcome. Quality inputs have a greater chance of producing quality outcomes, but they can never guarantee them. Measuring outcomes, on the other hand, is measuring against the desired result. If the outcome stacks up against the desired result, then we have a good outcome. Good outcomes imply good inputs. If there is a choice between being able to measure inputs or outcomes, then we are much more able to guarantee the result if the outcomes are measured.

The question is, however, what are the outcomes that we wish to measure? In the case of high level aged care, we must decide what the outcomes are we wish to

measure. It could be that the outcome we wish to measure is a sterile environment or nursing procedures and practices or staff satisfaction or technical sophistication or resident satisfaction or good administrative procedures and practices. We believe that paramount among the outcomes we need to achieve is resident satisfaction and comfort. Secondarily is staff satisfaction and, thirdly, good administrative procedures. It's doubtful that you will get resident satisfaction and comfort if there is poor staff satisfaction and poor administrative procedures.

The simple point we want to make is that the provision of specified inputs does not guarantee a good outcome. It seems to me that there have been some trying to argue before this commission that good inputs equals good outcomes. We contend that is not true. In the complexities of aged care, it is important to measure the outcomes and seek to be sure that the processes are in place for the quality outcomes to be maintained.

Then some comments on rejigging the subsidy rates: Aged Care Queensland put forward to the commission a different way of rejigging or rebalancing the subsidy rates to become nationally uniform basic subsidy rates. We know that in some quarters there has been a rejection of this process because those people seem to be pinning their hopes on the government providing a greater quantum of funds. As a consequence, they do not want to think about the question of rejigging the existing quantum of funds. To put in an argument about rejigging the existing quantum of funds is to argue against the need for a greater quantum.

I do not want to go through telling the commission again how our proposal works. You have that in our first submission. I do, however, want to remind the commission how some of the components could be made to work. The Queensland proposal for the use of the indexation moneys has in it an important proposal as to how this might work were the government to utilise the outstanding 128 million which Aged Care Australia have identified. The more that the government injects into bringing up the Queensland and South Australian deficiencies to a uniform national level, the less the impact upon the subsidy rates of the other jurisdictions through the indexation proposal.

There is also room in our proposal for less than full indexation to be transferred into the adjustment of the subsidy rates to nationally uniform rates. These can be acceptable in the process, provided it does not extend the time of implementation by an appreciable period. We would expect to be on nationally uniform basic subsidy rates within 3 to 5 years, with a strong preference for 3 years.

MR WOODS: Thank you, Dr Stewart. I appreciate those opening comments. Some of the matters that you raised I would like to pursue a little further. Dr Stewart, you referred to self-directed work teams. That will have, and has in Queensland presumably already, had consequences for the mix of staffing in your facilities. What do you see as the future evolution of that trend? Will it increasingly be applied in homes in Queensland, and do you have any evidence of it also being taken up in other jurisdictions?

DR STEWART: I'm certain it will continue in Queensland and increase in Queensland. In terms of other jurisdictions at the present time, I'm not aware of them working that way, but I would expect anyone looking at modern management practice would be beginning to look in that direction.

MR WOODS: If you extrapolate the trend out over the next 5 or 10 years, do you have a view as to what sort of profile of staffing might apply in a home of 60 to 80 beds over that time-frame?

DR STEWART: I don't have such a profile with me, but broadly there will be a number of registered nurses, much smaller than would be the case say in the Victoria-Tasmania situation at the present time, and probably than in some others. The use of the assistant in nursing I believe will increase because, as I said, they bring a lot of important homemaker-type skills into the situation, and our further training in care matters I believe has improved their skills. Up until recently, the enrolled nurse was a bit of a cost burden because they couldn't do any medication work, but with the medication certificate that begins to change their usefulness from where it was previously.

MR WOODS: Is that a consequence of the Poisons Act?

DR STEWART: Yes, the state regulations in that area, and I think the Nursing Act had some implications there too.

MR WOODS: The training that's available for the people providing the personal care - is that becoming more widespread and the courses becoming more oriented to aged care specifically?

DR STEWART: We've developed in Queensland a course or courses to certificate level 3. That is certainly becoming widespread in Queensland, much more so I think than in other states, and in fact I understood from something that Michael was at recently that some organisations believe that they had to have their staff to level 3. Now, my hope is that in the not too far distant future we will have all of our staff with a minimum qualification of certificate level 3.

MR WOODS: One of the pressures on registered nurses that this commission has been advised of is in the recording of RCS documentation and care plans and the like. You made some reference to technological improvements, particularly computerisation. Could you expand on that for the benefit of the commission, to understand what impact - or what direction that's taking and what impact that may have then on the pressures on RNs?

DR STEWART: It's still early days, but I think good recording means that it's not just the RN who should be recording the data, because it's what's happening to the resident across a range of different areas, some of which are in the RN's area of expertise, some of which are not, and therefore it's important that it be much more

widely recorded that simply by RNs. The use of computers is new. We are still exploring some of the ways in which they're going to bring benefits, but I believe they are going to bring benefits. Our concern where they're being tried is they're being told it really needs to be handwritten, and that seems to be a little old-fashioned.

MR WOODS: Is that pressure coming from departmental sources or from custom and practice?

DR STEWART: Well, as we're trying to innovate and try for new things, we're trying to use it, but the monitoring teams which are coming from the government are saying in some cases this is not acceptable.

MR ISAAC: If I could add to that, commissioner, the basis of the nursing officers from the Department of Health and Aged Care's objections to the system is that the use of common phrases and common terminology across a number of residents is depersonalising the care plan, and they're then suggesting that the plan is not targeted specifically for individual residents, whereas of course the nurses are documenting in phrases that they know exactly what it means, and so does the next nurse, whereas the suggestion that everybody must have the same thing written about them in different words is the fundamental objection to it.

MR WOODS: So it may be a question of the menu of choice of phrasing rather than the intent behind the recording?

MR ISAAC: Yes.

MR WOODS: In terms of measuring outcomes which is a longer-term perspective and a more immediate perspective of measuring outputs the government is purchasing through its subsidy payments, do you have a view on whether the accreditation profiles will in themselves be a sufficient basis for that purpose?

DR STEWART: I believe that nursing homes in Australia took a big leap forward with the introduction of outcome measuring, and the quality of care in Australian nursing homes in that 10-year period rose very significantly - not perfect, but rose. The present accreditation process picks up those outcome standards and also picks up some outcome standards which relate more to the administrative side of it as well, and I don't think that's a real problem in doing it, and I would expect that that's going to give us an adequate view of the way in which care is being provided. I give this proviso: human beings being what they are, they'll find ways round it, and by 10 years' time we should be reviewing it very thoroughly.

MR WOODS: Yes, and we do recommend that there be appropriate reviews during the course of the future. Another point raised in your opening comments was the actual RCS assessment that you were saying takes 3 weeks. We have a process in the industry where ACAT identify people as being high care. In your experience, are there divergences between what an ACAT will assess as being high care and then the subsequent RCS in fact showing residents may be at 5 or less?

DR STEWART: In the main they get it right, but there are occasions when they get it wrong, so that they may put somebody who they regard as high care - that's the classification made over a fairly brief period of time - and then they're put into a high care facility and when the assessment is carried out, it turns out to be low care. Now, that's a difficulty. However, I don't think that alters the fact that - I don't really think we need 3 weeks. We'd have known that within 3 to 5 days.

MR WOODS: I'm just wondering, though, whether it also tempers the view that it can be done reasonably immediately, that the ACATs, as I understand it, are usually assessing the person fairly promptly but in the situation of them in an acute perspective as to whether they then warrant moving to a residential facility, and if there are then subsequent more lengthy assessments showing that there is an error rate in that, does that suggest that moving to the spectrum of too great immediacy might also cause an error rate?

MR ISAAC: Commissioner, I'd suggest that the ACATs are actually using different criteria to what the RCS instrument uses. They're essentially following a similar process to before the reforms, where they're deciding whether a person is best cared for in a nursing home or a hostel, rather than high care or low care, which are not the same things now. With the structure of the RCS designed to pick up much more in the way of behavioural problems, for the scoring of points, then a lot of those things can't be assessed in that climate anyway, and the ACATs, we don't believe, are being asked to do that. They're simply deciding essentially nursing home or hostel. The behavioural issues that affect the RCS category so much are in fact the determinant of high care and low care, and they're actually looking at two different things.

MR WOODS: Thank you. I noted in Dr Stewart's opening comments a strong plea for a single recurrent subsidy that allowed providers to manage according to the circumstance and requirements and the efficient practices and the like in a particular facility. Mr Isaac, you were referring in some instances to opportunities for care funding to be applied in various circumstances, whether it be multipurpose services - and particularly in rural/remote - by isolating out the care component of the subsidy, separate from the accommodation component. Doesn't that lead to difficulties then of creating boundaries of introducing rigidities, and of just the sheer definitional issues involved in determining what constitutes accommodation or constitutes care?

MR ISAAC: It does, particularly in terms of services. There is care, there are services and there is accommodation and we need to get the accommodation factor beyond just the bricks and mortar. That's why we've been focusing on hotel services as a particular element of our service to the customer.

MR WOODS: Yes.

MR ISAAC: There are a number of issues. I would like to make sure we come back to multipurpose services later in the piece because our understanding of those is actually quite different to what we see happening in practice around a lot of the

country. The separation of the subsidies into care and non-care, shall we say, were seen as the major force behind conservative management of funds. It was a common practice under the old system for under-spends to occur, and the department made much of the fact that, "Well, we must be giving you enough because you always underspent what we gave you." In fact that wasn't because of the lack of need but because of caution and conservative management always afraid that you would overspend in the first half of the year and not have enough staff to manage in the second half.

Many of those who did reach the target for spending the care funds weren't staffing more than the others, they would find they'd underspend coming to a point around perhaps May or June, and suddenly decide to go on some massive training exercises so that the money was spent on nursing and personal care purposes rather than the actual care. So we had a great blossoming in Queensland of consultants every May and June so that we could balance the CAM budget. It didn't lead to better care or to more staff.

MR WOODS: Thank you. Perhaps if we go straight into multiskilling purposes, on page 9 of your second submission you refer to multipurpose services having their own difficulties, one clearly being the averaging of funding rather than the individual RCS levels, but then you say, "in the long term have their own viability problems". Although this inquiry relates to residential care for RCS1 to 4, we're clearly interested in understanding the context within which this care is delivered amongst the broad spectrum of care. Could you elaborate on what is meant by that paragraph?

MR ISAAC: If we go right back to the original intention of multipurpose services - and I personally feel that has been lost over time - when they were first suggested, the concept was that a community that was too small to support any one type of service would be able to cash out its entitlement to health funding across a whole range of services, both health and community services. That money could then be placed in a pool, a bucket of funds, which could be spent how the community best needed it, and I remember the minister at the time who suggested it - Brian Howe - actually had a vision that perhaps communities of 200 people would be able to cash in their pharmaceutical benefits entitlements for those 200 people, their Medicare entitlements, their aged care entitlements, ambulance, a whole range of things that have never been thought of in multipurpose services since, and use that money to perhaps hire a doctor, create a surgery, ensure that a pharmacist is in town - perhaps its own nursing service.

The whole idea of the multipurpose was to meet the needs of the community with funding that may otherwise have not come to that community at all. I think that has been lost over time. Now we will hear multipurpose services spoken of as a nursing home or a hostel on the same site as a hospital. You can go to the service and receive a range of choices but each one is still pigeonholed in its own funding regime. It's in that respect that we think some of those models will have long-term viability problems, because the size of the aged care funding still linked to the current model is not sufficient to support the size of the facilities. In fact, the whole premise of the

multipurpose service is that some money won't be spent on the service it was originally pigeonholed for but will be spent on aged care or on hospitals or on medical services.

MR WOODS: So a pooling of funds distributed according to need.

MR ISAAC: Yes, rather than a pooling of funds distributed according to the original source of the funds which is happening in many multipurpose services now.

MR WOODS: Do you envisage that a use of multipurpose service concepts, as you describe them there, could be a way through of dealing with this question of special needs in rural and remote?

MR ISAAC: I do. I believe that funding from a number of sources can be used to share common infrastructure costs. I'm sure that Dr Stewart would be happy to talk about one of his facilities which is doing something similar in rural Queensland, but by pooling itself the funding from different sources, it unfortunately remains accountable in many ways for each of those dollars.

MR WOODS: Dr Stewart, I think Mr Isaac has just given you the baton.

MR ISAAC: We pass.

DR STEWART: He's talking about what we're doing at St George in south-west Queensland.

MR WOODS: I know St George well.

DR STEWART: Where we have a hostel, we have some units, we have a day respite centre and we have some care packages. We also have a child care centre and family day care scheme; we all operate out of the one campus for all of those different services. There is a health ageing program we have which is called Sixties and Better, I think is its correct name, which is helping in a much wider area than that, and a home nursing service. That's all the things. That's not an MPS. We have to deal with each one separately, deal with them separately, account for them all separately and work that way.

MR WOODS: What has been the impediment to trying to collect, devise the funding and apply it as best needed?

DR STEWART: MPSs only apply to state government - is the answer we got.

MR WOODS: Thank you. We understand that point. Looking at the question of the extent to which the subsidy design can dictate inputs rather than purchase outputs, on page 5 of your second submission at the bottom you refer to:

> Funding according to costs of inputs is an extremely tempting precedent to

fixing those inputs as requirements rather than as variables used in the calculation of a figure.

Then on page 10 you identify towards the top that you have some concerns about the use of an average input mix: "an average in this instance will include inadequate as well as excessive inputs". In our position paper we refer to standardised input bundles but we look at the average cost of those across jurisdictions, but a question I asked of a previous witness, what in your view is the appropriate approach, that if you pursue the concept of looking at your input mix as best practice you'll get one subsidy answer. If you look at the average where you express concerns because that will pick up inadequate as well as excessive inputs, or else a standardised input bundle as we were proposing.

MR ISAAC: We would clearly come down on the side of the standardised model. The concern with the best practice model of course is its strong prejudice against those - either at sizes that don't match the model or more particularly the rural and remote areas, not so much because of cost and distance but because of the difficulty in the flow of information to those services so that they have a means to stay up to date with best practice. We are reluctant to support anything that would head down the track of making it more difficult to operate in small remote communities. The average system - as the response from the previous witness - we would be concerned that it would head us down the track of looking at our costs based on our subsidies, and the point of our first submission of course was that if you look at what we're spending you will find what we're paid to do it.

The overlap between page 5 and 10 is that if we go for a standardised model it will be very tempting for a department that is used to the restrictive regulations to then say, "Well, that's what we're funding you for. That's what you must start as." And it removes all the incentives for a national rate of funding to see efficiencies found for those whose costs are above what that funding provides to actually find solutions to the problem.

MR WOODS: Yes, there's certainly nothing in our position paper that would at this stage give a department support for that contention.

MR ISAAC: No, but we know this department.

MR WOODS: I won't enter into that particular issue. The productivity discount on page 12 of your second submission, you make the point that:

> Full cost reimbursement has in the past bred dependency and suppressed the need for management initiative.

You appear to be supportive for having a productivity discount, although you do have the caveat of "Not yet, please", which I note. But that is a different view than that expressed by many in the industry. As you have heard their evidence and seen their submissions are you still confident of your position that some distribution of the

productivity dividend to the various parties is the right approach?

MR ISAAC: I guess, commissioner, what we're saying is we're not afraid of it and we are willing to explore it as an option. We won't immediately back off and say that nothing can be gained from enterprise bargaining on the staffing side, that there are no efficiencies that can be made for our costs, and we think it is rather presumptuous of anyone in the industry to come out and suggest that they currently have the most efficient operation in terms of cost both in the staffing and the infrastructure sides. We are willing to explore that. Our caveat was also that the productivity discount, if there was to be one, applied to - we would like to see it rather apply to the annual increases in funds rather than to the base, which is always a fear.

MR WOODS: Rather than to the base, yes.

MR ISAAC: We seem to look threatening to lose so many staff at the moment on the basis that the dividend is applied to their base. We're conscious of that having been applied in government over the years but let's not forget that what are the real consequences if government departments don't meet the targets? There aren't many really; they just have less money next year. We are willing to give it a shot, and I don't know about actively supporting it but if it means the other recommendations contained in the proposal go through, we wouldn't let the concept of a productivity discount frighten us off.

MR WOODS: Thank you. In a related area you refer to the dangers of fully reimbursing workers compensation premiums. Again that's an area where we've had various views put to us and to some extent it will ultimately be a judgment as to the significance of the variation across jurisdictions in terms of the overall subsidy. It will be a judgment about the degree to which there is operator capacity to affect the level of premium that they incur, and also an acknowledgment that there are changes over time in and between states as to the form of the workers comp scheme that they have, the intentions behind that scheme in terms of recouping or distributing surpluses and the like. So we understand the dynamics of those but if you could elaborate a little on your views on that area, that would be helpful.

MR ISAAC: The workers compensation funding under the OCRE model for nursing homes for years, as you know, were totally reimbursed the cost of the premiums. While it's not one of the pleasant aspects of the industry, the fact remains is that it did remove any incentive on providers to deal with the problems of the management of injuries. While many did deal with it, and they are now reaping the benefits that the system has moved to an averaging model, the fact remained that if staff were injured, there was no penalty on the operator of the service, then staff continued to be injured. That's not applying across the industry but certainly in a lot of case that was the case.

It is one of the dangers of full-cost reimbursement where there is scope for the operator to control the consequences of it. We wouldn't take a similar position with the payroll tax ideas of the supplement because the incentive isn't there to vary your

payroll taxes by dismissing staff. That's the danger of complete reimbursement of workers comp premiums.

I would like to also take the opportunity to talk about something that we know was raised in the Hobart hearings, where the percentage premiums across the states were talked about, and we just caution the commission on those. To quote the actual figures -and it came from one of the witnesses down there - was that the costs in Tasmania were 7 per cent of the wages, New South Wales 5.5, South Australia 6.1, Victoria 3.9, WA 5.1 and Queensland 3.9.

If I could actually give an example without naming the facility: a nursing home in north Queensland had a premium calculated at a model similar to using that - around the 3.9 per cent. The premium was $30,000. On top of that this year they had a $6000 surcharge to help catch up the deficiencies in the workers comp fund, and because of a third party damages claim their actual premium for the year was $68,000. Assuming that in Queensland premiums are being paid at 3.9 per cent, in this particular case - and there are many like it - that was less than half the premium they actually paid. So simple percentages of the premium applied to gross wages does not give a picture of the real workers comp position.

On the other hand we do understand that that facility is paying the price for an injury and while it may not be what we call an unfair one - say an accident on the way to work, which is completely beyond the control of the employer - this was actually an injury at the facility, then the incentive is certainly there for this facility to correct the problem in the future although they'd be wearing the penalty for a couple of years. So just a caution that while some jurisdictions have a premium and a discount for good performance, others have a premium and a penalty for poor performance, so the final percentage actually gives no picture of the position.

MR WOODS: We do understand the intricacies of the workers comp schemes around the jurisdictions and that just the simple percentages don't reflect the total premium paid, but thank you for bringing that to our attention. On page 15 of your second submission you refer in terms of supporting the proposal for special needs funding to recognise services in urban metropolitan areas which are meeting the needs of special needs groups, and in our visits to Darwin for instance, we saw very significant evidence of such a facility. Does that cause you to reflect on the viability supplement criteria as they currently are and would have a view as to how there should be modifications to such a set of criteria as distinct from the question of whether there are adequate funds applied to that criteria?

MR ISAAC: Yes, it does. One of the points we also made in this of course is that when you talk rural and remote here our minds are casting a distance considerably distant further than some of the people in some of the other states. I think in the submission we actually said that what they're calling remote we'd call suburban. In the case of some of these special needs groups though, the similarity does exist to that concept of remoteness. One of the particular problems that the Aboriginal and Torres Strait Islander Services have around south-eastern Queensland, where we would by

no means consider them remote, they are certainly remote from providing services to similar target groups. So we have the difficulty of sharing the problems between a service at Beenleigh, a service in the suburbs of Brisbane and the next one being at Cherbourg out from Murgon. So there is that distance to services with similar issues and dealing with similar target groups certainly needs to be addressed.

MR WOODS: Presumably also some of the residents may be from distant communities and - - -

MR ISAAC: They are, yes.

MR WOODS: - - - you have got reverse respite issues and the like to deal with.

MR ISAAC: And if we have three services targeting a particular group around effectively south-east Queensland this side of the range, then you have people from a wide range of communities geographically and the further from their communities they are the more difficult it is for them. So we have all of those problems. There's also an issue in Queensland with just the sheer population size of some of the special target groups that would fall within the sort of criteria we're talking about, and while they're not operating a nursing home or even a residential facility as yet, one example would be the Islamic population around this part of the country is small enough that by the time they've accumulated 10 people requiring care they're actually dealing with eight or nine different languages and cultures.

So while the first client on the list may be Egyptian, the next one will be Pakistani and the third Indonesian, and such a wide range of cultural and language issues that arise in such a small population can make these services particularly difficult. You effectively need one staff member per client. How do we deny them the right to provide that service? We've been working with them in the area of community aged care packages, but it's an example of where flexible employment solutions have to be found; you know, one person - we're needing very short shifts of one particular carer who can speak the language and understands the culture.

So there is an enormous range of issues and we do think they need to be recognised for some of the metropolitan areas. I'm not so sure about services targeting people who are all concessional residents, for example, because the existing system, by building in those incentives, can offer some support to those sort of people. So issues of homelessness and services targeting homeless people are not quite as severe as facing some of these other special target groups.

MR WOODS: Thank you. You expressed general support in your submissions on page 16 for the views on extra services, and I understand that in some particular regions in Queensland, some facilities actually have higher than the national uptake of extra service, but that is limited to very particular regions and facilities. Is there a view by Aged Care Queensland as to why extra service to date has not been taken up as actively as a ceiling of 12 per cent could suggest?

MR ISAAC: Yes, it essentially comes from experience and the way word is expressed across the industry, not always entirely accurately but the way word has spread around. When we're talking about extra services places in Queensland to my knowledge we're still only talking about four facilities, and naturally they're going to be in a small number of geographical areas. One of the facilities at the Gold Coast for many years had the specific problem where because of low service rates on the Gold Coast, we feel the allocation there was because of the nature of the population rather than the actual population numbers at the Gold Coast because it is underserviced, even according to the department's own benchmarks, yet two of the facilities now are extra services. It is a most unusual situation.

Because of that and underservicing generally, that facility found people were coming to it as a holding facility, a temporary measure until they could find a place offering the usual rates of resident fees. Word did spread across the industry that this is particularly stressful on the staff - which it would be, people coming and going very fast - and that it wasn't really ideal and not working that well. Subsequently facilities around Brisbane have been more successful. There's a general feel that this capital city doesn't have the income of other capital cities and in a way that might be shortsighted. We do believe that some of the fees for extra service residents are paid by their families and not from within the residents' own means, and in that respect we see some of the proposals you're suggesting of subjecting the resident to an income testing but allowing the extra fees to happen without the government claw-back, as facilitating that to a much wider range of people where it is possible for the family to support the highest standard of services for the resident than the resident's own means to do that.

DR STEWART: I think, commissioner, further on that is that in the church and charitable sector there has been a resistance simply because it is inequitable, or feelings about inequity, and they have drawn back - I know our organisation has drawn back more for that reason than for any other. The sort of suggestion that you're making there is one that would make us rethink.

MR WOODS: If you can differentiate extra services primarily in the accommodation component as distinct from the care component and make that even more overt than it is, would that help assist the church and charitable sector to reconsider its position?

DR STEWART: The last two nursing homes we built were all single rooms with en suites. It means that there are then other equity problems that arise out of that.

MR WOODS: Yes. Certainly a number of operators have proposed that single room be a basis for determining extra service, in which case then you've created an extra service facility which isn't your intention nor would be your practice.

DR STEWART: Yes.

MR TOOHEY: Commissioner, could I just add to that point about extra services?

MR WOODS: Yes, Mr Toohey.

MR TOOHEY: From my perspective I believe there are three main reasons that the industry hasn't taken up the opportunity to avail itself of extra services, and as I speak we currently have five applications we have been waiting over 3 months for a response on. I think the first of them is that to operate an extra service facility places some demand on proprietors which they have not yet been exposed to, and I am speaking particularly in the area of marketing. They require some fairly extensive calculations with regard to ABS data on regional income amounts, house prices, etcetera.

That's not something the industry has ever had to deal with and some people find that very difficult. The second aspect of it is there's no going back. You set an extra services fee which is approved and the department takes a cut from that. If your projections turn out to be a little ambitious, if you reduce that fee the Commonwealth does not reduce its clawback. So in other words you're stuck with it, which tends to mean that you either set your fee very low initially or that you don't bother. I think the third aspect of extra services which makes things difficult is there's a belief inherent I think in every nursing home proprietor that at some stage the Commonwealth will seek to be very prescriptive and a market-base solution which has at its core consumer choice is not consistent with an overly prescriptive regulatory regime.

In fact not long ago there was a movement in Canberra to set particular minimum standards for extra service facilities. That is completely inconsistent with the concept. People may want to pay for two star accommodation or five star, that is their choice, and fees should be set accordingly and that should be left to the proprietor and the resident. One final thing, taking on from what Don has said, up until recently I think the main attraction of extra service facilities was the accommodation attraction. With the broadening of the sector into hostels and with the fact that new nursing homes are being built predominantly on the single-room en suite that is being diminished. The focus is now going to come more and more on to services and that's an area again that the industry finds difficult.

Incidentally, the extra service facility we operate at Stafford, where there is an $80 a day additional fee, a significant number of the residents there are full pensioners and it is being paid for on their behalf by families or from the capital from their home. So people are quite prepared to pay the money to get the service. The increased services they also receive, incidentally, includes increased nursing services. You cannot differentiate. They are paying and even paid in the days of CAM for additional nursing care.

MR WOODS: Thank you, and I will look forward in a later session to pursuing TriCare in particular as to how it's dealing with some of those issues.

MR TOOHEY: I might start running then, commissioner.

MR WOODS: Please don't. I think that largely concludes the issues that I had wished to pursue in your submissions and I was prompted to raise from your introductory comments but are there other matters that you would like to bring to the attention of the commission before we conclude?

MR ISAAC: There are a couple actually. Commissioner, one of the issues we did want to raise, and it concerns bed size and the optimum number.

MR WOODS: Yes.

MR ISAAC: We speak at length about that in the submission and I won't go over that again, but Queensland has had a particular situation for a number of years now where the number of new nursing home or high-care places allocated each year in a funding round has been at that number that's not so low that it can only be add-ons to existing facilities, as happens in maybe Western Australia and occasionally South Australia, and not high enough to allocate large numbers of viable nursing home beds. So you will find over the years the number of high care places allocated to the state will vary from 90 down to about 50 or 60.

The issue about the size of facilities is often not such a decision of the operators as to what's economical as a factor of the number of beds allocated in the particular funding round for the application. If Queensland has 60 nursing home beds and the department decides to offer 30 at the Sunshine Coast and 30 at the Gold Coast, what are we going to do? Do we ignore them; do we knock them back; do we just try to make 50s 55 beds across six facilities? No, the reality is that we apply for the 30 beds in the hope that some time in the future we will pick up another 20 or 30, or whatever number it takes. So the department's allocation policies in a large way will dictate the average size of facilities and it's one of the reasons we are supporting the idea of working on an average number rather than an optimum number, because the optimum is where we might want to be but for a number of reasons an allocation policy is (1) we can't get there.

MR WOODS: We are conscious that a number of submissions put to us that 60 is the start of the point on the curve where efficiency is at its greatest but that more than half of all homes were less than such a figure. We're also conscious that if you move to 80 you get even further increment of efficiency but if you head out towards 120 you might be looking at the other end of the curve. So we understand your point about averaging, which would put it closer to 50 or thereabouts from our assessments. If you could elaborate a little further on departmental practice, because you made mention of Longreach, which, as I understand your evidence, was required to put in 40 because that was the minimum that the department would offer, and in fact made it almost mandatory, as I understand your evidence.

But also we had a situation in evidence in Hobart where a home which had 51 beds when they wished to redevelop was only given 40 in that redevelopment process which in fact brought it down below where we see the efficiency curve, and

we will pursue these with the department, quite clearly, but from your perspective as provider organisations do you have the views and evidence on that activity of not allocating bed numbers according to what might be the most efficient size in an area?

MR ISAAC: I think it was the witness before us that actually spoke of Longreach.

MR WOODS: Was it? My apologies.

MR ISAAC: However I can deal with the issue, and that is that in the Longreach situation a number of regional shires around Longreach were asked to contribute to create a viable facility at the one point, and it wasn't originally just a 42-bed nursing home it was also a 48-bed hostel on the one site. So you've created 90 residential care beds in a town the size of Longreach and of course the community itself doesn't support them; created in the days before community aged care packages were able to address needs in a number of the communities around there. Gradually of course with an overnight stay just to visit your relatives people stopped coming to the Longreach facility and my understanding is that they're attempting to down-size the hostel considerably, if they haven't already done so, and I suppose that's questionable for the nursing home in the future as well.

I guess it stems from even older departmental policy of creating something, what they thought was viable. They thought the 90-bed two facilities would be and if they were full all the time, they would be. I guess the situation is more that since then there has been quite a number of places allocated, maybe over the last 6 or 7 years, in terms of 30s, where the department has actually allocated around Queensland 30 nursing home beds. They have often supplemented that in the same funding round, or a later one, with 30 hostel beds or low care beds, but the number of what would be a minimum has been considerably less and I would have to say in not all cases unviable.

Some of our smaller members are satisfied with the viability they've got because of other things. They might supplement a retirement village, make it more attractive for people to come there, so they sell more units and the entire site performs better. So there is a wide range of issues. I think it has been the department attempting to divvy up numbers that are too small to do that and thinking, "Well, I've got 60 beds to allocate. Let's get two nursing homes for the price of one."

MR WOODS: Thank you.

MR ISAAC: There was one other issue I did want to raise, and you had asked the previous witness the question about the effect on the rest of the industry of the state government nursing homes employment practices. I would just like to add that, yes, it does create the occasional difficulty but perhaps not as much as we might imagine. The state government operated nursing homes, particularly the Eventide that the previous witness was talking about, are considerably larger. The one at Sandgate is 400 beds or so. Not everyone wants to work in that environment, not everyone wants to work in the staffing mix they have there, and not everyone wants to work with the

model of care that they had over the last decade, and it's suffice to say that we have a number of facilities around the same geographical part of Brisbane and they have managed to staff themselves despite the existence of Eventide at Sandgate.

MR WOODS: Thank you.

MR ISAAC: Final point, from me at least, is the question of bed licences which keeps coming up. We think it is quite inappropriate of the Commonwealth Department of Health and Aged Care to say this is a viable industry just because bed licences in their view are high because no-one has gone broke and because when new bed licences are advertised people apply for them, which is being used as a case to support the way the industry currently operates. We would just like to point out that consultants do overvalue the price because that's where they get their income from. A number of the high prices that are being paid have been paid because of the pressure to deliver.

I can think of one charitable group who would have paid, I assume, a premium for the facility they purchased just to be able to meet the needs of their membership, and would have probably paid more if they had to because their overriding existence was for the purposes of supplying those services to that community. I just don't think that the price of the bed licences and that people are willing to pay for them is necessarily an indicator of the health of the industry. It may well be an indicator of the speculators who are coming in or their lack of experience in prices and I think if we actually measured prices we will find them coming down substantially from, say, 2 years ago onwards.

MR WOODS: I understand your point that particular bed-licence payments may reflect particular circumstances but nonetheless when you put together on average what the licence premiums are together with the degree of new investment in the industry, together with a number of very successful operators - some in the private sector whose shareholders presumably consider themselves still getting at least adequate return on their investment - together with evidence that facilities that are comparable in many respects - some of them can still produce a reasonable surplus - doesn't paint a crisis picture to the extent that some of the material put to us would suggest.

So we're not relying on any one indicator but when you put together a number of indicators we recognise from that that there can be circumstances within the industry where you can deliver care and we will wait to see if that level of care is accredited, and that's an important benchmark point which we acknowledge, but nonetheless it may be possible not only to provide accredited care but to receive a return on funds invested.

MR ISAAC: Yes, thanks, commissioner. I guess the point was that the department does have a tendency to use just the one factor.

MR WOODS: Yes, and we're conscious of that. Any other points that the

witnesses wish to put before us?

DR STEWART: No, I think we're thankful for the opportunity to put forward our points of view on this matter. It has been something very important to us. We do recognise that these changes may occasion some pain in those jurisdictions presently on higher subsidy rates, and we're very sympathetic to that, but we've borne the pain for a long time. The pain those states presently with higher subsidy rates may bear is nothing to compared to the pain we've endured without a word of sympathy for a long time. We do want justice.

MR WOODS: Thank you, Dr Stewart, Mr Isaac, Mr Toohey. I will have a brief adjournment at this point.

MR WOODS: Thank you. If I could resume the hearings and we have witnesses, Mr Jim Toohey and Mr Michael O'Connor. Could you, please, for the record, state your names and positions?

MR TOOHEY: Jim Toohey, chief executive officer, TriCare Ltd.

MR O'CONNOR: Michael O'Connor, general manager of corporate services for TriCare Ltd.

MR WOODS: Thank you, gentlemen, and welcome. Do you have any opening comments you wish to make?

MR TOOHEY: Just a very brief one, commissioner. We welcome the opportunity to meet with you today and to answer any questions that you have. We approached this exercise with an eye to it being as simple as possible. It wasn't very possible but we did the best we could. We first of all sought to compare the relative costs of meeting the care accommodation requirements of a like-for-like group of residents right across Australia and we make the point that there are identical expectations across Australia, although obviously not identical funding. We did attempt to take account of state differences, such as staffing mix, etcetera.

The only one I am aware that did not meet award requirements was in Victoria where our data sampling led to the same conclusion that you've yourself noted, most proprietors we spoke to complying with the award in respect of resident-staff ratios, so we also excluded it. We believe the results of the study we did are self-evident and don't need any dwelling. In summary, Queensland is significantly disadvantaged relative to costs and the expected standards, which are common throughout Australia. We welcome the opportunity to assist you in your deliberations. We trust that you can continue your investigations with an eye to improving the system we work within and ensuring there are mostly just deals for residents, staff and proprietors.

MR WOODS: Thank you, Mr Toohey. Can I put on record the appreciation of the commission to TriCare, not only for their first submission but for a subsequent submission which dealt with further data analysis that we asked of you and then for your subsequent material in your response to our position paper. So we appreciate that we've identified some issues, you've devoted resources, and we've been assisted by that process. So if you could thank those involved.

MR TOOHEY: Certainly.

MR WOODS: A couple of matters I would like to pursue with you. One is in your first submission you make the point about financial incentives and the proprietors, for instance, had little interest in opposing award variations where there was direct reimbursement. Is that something that applies to many areas of the industry and would you relate that also to a view on funding for such areas as workers compensation?

MR TOOHEY: Yes, commissioner. We would have the view that there has been a distinct lack of incentive in the system for some time and in fact there's really a disincentive under the system financially to pursue a quality model if that equates to higher spending. The same could be true of workers compensation. We dealt internally in TriCare, and in our submission to you, at some length with workers compensation. It was our view ultimately that that is a cost that can be significantly influenced by policies and procedures and the industry, to its detriment in the past, because of the full cost reimbursement, has done very little about workers compensation costs and work injuries, and significant inroads can be made if you put the time and money into it.

With regard to the previous system whereby award changes were fully funded under CAM, I think what we see today in Queensland are the fruits of a mind-set which said not only do we attempt to really make some changes in the workplace but also that it wasn't our problem that we had a workforce which was paid less relatively than the public sector and to some extent other states. We should have pursued a policy whereby we dealt more proactively with staff and their representative bodies and we may have found we had more funding today and more flexibility. So to some extent we're in a mess of our own making.

MR WOODS: We have received a number of submissions that suggested there is very little opportunity for productivity gains to be made, particularly post SAM innovations. Your organisation has pursued enterprise bargaining. Can you identify what has been the essence of your success, to the extent you've achieved it, in that field and what does that suggest in terms of scope within the industry to pursue further productivity.

MR TOOHEY: All right. TriCare does have a certified agreement with its staff and two of their trade unions. I think it needs to be said from the outset that productivity improvements as a result of enterprise bargaining in this sector are difficult to quantify but they're not impossible. Also we have to get our minds around, I think, a core belief for a number of years in the industry, that more hours of care or more resources in care equates to better care, and we would contend that that is not necessarily the case. We pursued enterprise bargaining as a result of discussions we had had with staff and the unions and of a program we had had in place for some time, which was known as the Best Practice program. That was initially funded via a DEET grant and later extended throughout the company.

It's aimed at establishing self-directed work teams, consultative committees and empowering the workforce to some extent to address what issues they can at their level with the resources they have to hand, and that has been quite successful in the organisation, specifically some of the things we are measuring and we've noticed improvements in. Sick leave has greatly diminished throughout the group since we introduced our certified agreement. Can I just clarify that? We did reduce some sick leave or pay out some sick leave entitlements for some categories of staff, so I'm not talking about the accrual. I'm talking about the actual amount of sick leave taken has diminished.

We will receive this year an incentive bonus for our workplace health and safety costs. They have significantly reduced. We have noticed a significant reduction in the use of casuals and we had cause recently to quantify this at one of our centres and the amount over the last 3 or 4 months - I can't recall - is an 84 per cent reduction in the use of casuals. That is that permanent staff are filling up the position previously taken by casuals, and I think the degree of casualisation in the industry is a direct reflection on the funding system to some extent, and also on the lack of incentive and innovation that proprietors have had to try and bring that down.

The use of casuals is an important point. One of the issues raised most by our work teams at work-team level is that if a staff member calls in sick and our administrator spends an inordinate amount of time trying to replace them with a casual quite often the staff, the permanent staff member on the wing, may find themselves working with one or two people who have never worked there before. That is extraordinarily stressful. It's extraordinarily inefficient and non-productive and that's an area where I believe there's been very little done to address some of the costs involved. One of the biggest savings we've been able to achieve as casuals have reduced is linked with the abolition of the demarcation between various categories of staff, particularly in the unskilled staffing area.

One of the features of our enterprise agreement was a common pay rate for unskilled staff and therefore there was to some extent common competencies. So that people were working on a level playing field and that seemed psychologically to reduce the barrier some people had to looking outside their area. One of the requirements for progression under our enterprise agreement - and progression is competency based rather than seniority - is multiskilling in another area. We've had a lot of success with that, particularly with former SAM staff members who are now becoming competent in, say, the area of kitchen and laundry, although obviously they're not working in the kitchen and laundry on the same day, hopefully.

Self-rostering has worked well when teams have been set a budget to work within or a specific number of hours to work within. They have been quite innovative in some of the rostering arrangements they have come up with and that is a great benefit administratively and it's a great benefit in terms of the quality of care. The people doing the rostering have a much better idea of what the real staff requirements of the particular wing or section are. We have had in place for some time, and this predated the enterprise agreement, policies with regard to safe handling and lifting. The results here have been extraordinary.

These policies are reinforced and monitored by staff at their own level. They have involved some extraordinary initiatives, including at a couple of our centres where literacy was identified as a problem, which was relating to workplace health and safety. Simply put, some of the staff weren't taking the time to assess whether a resident they were lifting was a one or two-person lift. With a colour-coded bar chart at the bottom of each bed, and particular training for the staff so that they could look at this bar chart and immediately assess how many people were required to lift, was

there a hearing aid involved, could the resident be aggressive at times, it was quite dignified. It was also very innovative, and that was something that came up with the staff and that's to a large extent helped us with our workplace health and safety costs. We did of course trade off. The staff traded off some elements of the award to fund the increases in the enterprise agreement and we obviously had an eye to the indexation increases which were coming in prior to the 2 years.

Interestingly our quality assurance process, which involves regular mail-outs to residents and relatives and a quality assurance questionnaire of postage paid that guarantees anonymity at each centre, has shown a distinct, though not huge, increase in resident satisfaction over the last 6 months, and we regard that as very encouraging. One of the core competencies for staff progression was resident advocacy, and this seems to be being pursued with great vigour, and we welcome that; that is that staff wishing to progress must demonstrate where they've acted as an advocate for residents, where they've listened to a resident complaint and dealt with it via the appropriate mechanisms. That's been a significant improvement to us as well.

MR WOODS: Thank you very much. You made reference that more resources does not necessarily equate with more care. Do you see the accreditation process as providing the benchmark that we're searching for in our inquiry to assess whether the care itself is adequate as distinct from the resources?

MR TOOHEY: Commissioner, I would confess to not knowing a great deal about the accreditation tool as such. I know more about the process, I suppose, and our organisation has a nursing home qualified under ISO, which we did deliberately to prepare us for the new accreditation instrument. The short answer would be whatever the minimum standards that are set under accreditation are they must be transparent, and in the past they have not been under the outcome standards.

They must be dealt with objectively but most importantly, and I think this is vital, is there have to be real sanctions attached to non-compliance. We would regard that as essential to improving quality in the system. The stories in the industry of proprietors, to some extent thumbing their noses at the Commonwealth because there was nothing the Commonwealth could do, are all over the place. Our view is that whilst you could speak of productivity discounts, perhaps a more apt term would be a quality incentive for people reaching various benchmarks of care and maintaining it.

MR WOODS: Thank you. You operate a number of facilities. We've received submissions that suggest around about 60 beds might be the start of the efficient side of the curve. From your own analyses where would you put most efficient - but a view on where that range is, not just on the single figure?

MR TOOHEY: There was a study done at TriCare some years ago that predated my time there which seemed to suggest that 93 was the best number - but of course that was an accounting exercise - for achieving efficiencies. Our view would be around the 90-bed mark is what you should aim for as optimum. Certainly at our larger facilities where we have 140 and 148 beds, there are significant diseconomies

there due to the fact that you require obviously some specialised on-site support that you could share elsewhere.

I think it's important to note as well that where nursing centres and hostels are co-located with retirement villages, you can achieve economies. We have a retirement village at Cypress Gardens on the Gold Coast where we introduced a single-site administrator who was previously the director of nursing at the nursing centre. That has achieved savings and costs but it has also smoothed the transition for people from the retirement village to the nursing home. So generally our view would be about 90 we think is the best.

MR WOODS: From your evidence it's not just a question of size but it's a question of what other support and the way the facility is integrated into other activities that also contributes to efficiency.

MR TOOHEY: Yes, I'd agree with that. I think the site administration is an important factor in that too, commissioner. One of the changes that we introduced after the abolition of CAM was making our directors of nursing administrators and to some degree, when they left, employing non-nurses in that position. What we were seeking to do was to get rid of the previous system whereby our directors of nursing had operated basically under instructions from ourselves at central office as to the tolerances they would operate within and how they'd make their rosters. We've left accountability with that at centre level and in fact rostering is quite different throughout the TriCare group as a result, and I hope better.

MR WOODS: You make a point in your first submission that:

> TriCare maintains that a demonstrated commitment to high standards of care and facilities should attract a greater financial reward.

Do you mean via some additional subsidy or are you suggesting that the efficiency will generate surplus which can then be distributed either back into the facility or awarded to shareholders?

MR TOOHEY: I would say a bit of both, commissioner. I use the extra services model as an example. The staff at our extra services facility receive more training - it is not care training but hotel-type services training - than any other facility. They do a bar course, for example, and that sort of thing, and we get a better dividend from it. Certainly the standards of accommodation are far better and the standards of services are better. I understand the necessity from consolidated revenue's perspective to work within tolerances that are achievable and acceptable, but I would suggest a little bit of both. Pursuing the quality model in the industry if it means higher cost, you would have to question commercially.

Our organisation has done it to some extent but we've done it because the good reputation and name we have fills our retirement villages. Where we co-locate facilities there are economies to be achieved. Most of the residents we get coming

into the retirement villages will cite as the reasons they've come there that they've had a parent in a TriCare home. If we were a stand-alone facility of 12 nursing homes and nothing else, perhaps commercially we would have taken a different tack.

MR WOODS: The expected demand for extra service - your evidence earlier suggested that even in the TriCare group there was a limited level of extra service, although you did talk about five applications that have been in. Is this some resurgence of interest in extra service or a new perspective or just part of an ongoing view for the company?

MR TOOHEY: It would represent for us, commissioner, an extension of the success we have achieved at our first extra services facility. We opened the first purpose-built extra services facility in Queensland. It has been very successful. We now have a fairly good grip, or we hope we do, on the extra services market and what's required. There is significantly better profitability from the extra services facility we believe, via that experience, we can extend into other areas. I suppose it represents a bit of a different commercial venture for the company but we are quietly confident that we can be successful in it.

MR WOODS: With the increase in frailty that has occurred in the profile of nursing homes and for some years a reduction in the average length of stay, although that seems not to be still occurring, does that mitigate against an increased demand for extra service? Is there some trade-off in that process?

MR TOOHEY: There's certainly a link. Generally our extra services facility has the lowest category of all of our places. There's no doubt about that. We initially built at this extra services facility a dementia wing which represented a third of the beds. That too was a mistake. We've significantly cut back on that. There did not seem to be the attraction for people to put a relative in a dementia wing of an extra services facility. We still operate 10 beds there and they're always full but we've cut back on them significantly.

Yes, to some extent I think there is but people will still pay for better quality or, more particularly, relatives quite often will. I mentioned in the previous evidence where the number of residents at this extra services facility who are full pensioners were either living off the capital from the sale of their home or whose fee is being met by the children. That's greatly appreciated by the residents and we have a good waiting list of the place as well. It has an impact on it but I don't think it's significant enough to say that extra services shouldn't flourish or predominate.

MR WOODS: Will an increase in number of superannuants over time change your view and the demand for extra service?

MR TOOHEY: I think it inevitably will but I think a greater pressure will be, as we move into the next generation, if you like, of ageing people who probably didn't have to struggle through the depression and probably didn't have to accept they had to enter standards of accommodation in nursing homes that weren't ideal. As those

people start to enter homes, I'm sure there will be a great consumer backlash, a great backlash from people who demand better standards and are prepared to pay for them.

MR WOODS: If the proprietors who are offering the basic standard of care are doing that in single rooms with en suites and the like, where is then the product differentiation that would warrant people paying extra for extra service?

MR TOOHEY: There is no doubt that's made it harder and most new nursing homes built these days are of a single room or a single room/en suite. That has diminished the attraction that extra services has in terms of accommodation. It hasn't completely negated the attraction they have in terms of services, and that's where proprietors are going to be very pushed, and I fully confess when we opened our extra services facility it was on the basis that you received beautiful standards of accommodation and we're certainly moving to better standards of service, more innovative standards of service, and people are prepared to pay for that, particularly in the meal service area which is very important, and you can be quite creative there and people appreciate it and are prepared to pay more for it.

MR WOODS: In your third submission you put to us which was in response to our position paper, you talk about a system of funding to individual facilities annually based on a projected resident mix. There are obviously concerns about the selection process by proprietors at times once they understand what their annual subsidy will be. If you counter that by requiring some form of extensive audit, have you in fact then saved on any of the paperwork? If the paper trail has to be as extensive as it is by having daily accountability anyway, where are the savings in such a proposal? Also you were referring earlier to reducing the number of casuals employed at TriCare; that if you increase the number of permanent staff, aren't you in fact reducing the flexibility needed to cope with changing numbers in the different RCS categories? There are various competing pressures arising from your evidence. How do you reconcile those?

MR TOOHEY: With regard to your first question, the short answer is I don't know. Until someone has done it and we see what the effect of the auditing would be or how it would work, I'm not sure. We were approaching it from the basis that funding can fluctuate virtually daily. It doesn't fluctuate daily but it fluctuates based on daily movements. You don't have, nor should you have, the flexibility to adjust staff numbers as quickly. That would be inherently unfair to staff. It's still not desirable from an efficiency perspective to maintain the level of casuals that you have to be able to make movements quickly enough to stay within certain tolerances. We are lucky in that due to the size of our facilities to some extent we can absorb those movements and only make changes when it's actually necessary, if there are changes to resident frailty.

I would think that it would not be in a proprietor's best interests to accept residents of a similar category to that which had been assessed because there would therefore be no capacity for him ever to increase the funding he received. He would have to do it judiciously, but I would think it would be in everyone's direct interest to

continue to admit residents who are as frail as possible, given that your capacity to do that now is significantly reduced under the new system. Where waiting lists have been cut, you can't be as selective as you were and, from the evidence previously introduced, whereby quite a lot of residents come in as theoretically high care and are reassessed as low care at some point on.

All we're saying, I suppose, is that it would be more ideal in terms of creating more permanent staffing positions to remove some of the variability in income, to know what your dollar figure for the next 6 or 12 months would be and to work perhaps off a minimum core base of staff with less casuals. We've had occasion recently to make a reduction at some of our centres, and we freely admit it causes a great deal of upheaval. It's not ideal, but it's the reality of the system. We'd like to look at anything that to some extent mitigated that.

MR WOODS: You think it is feasible to come up with an annual average and to be still auditable on that and for the outcome still to be efficient?

MR TOOHEY: We'd be happy to provide further detail if we thought that it was a prospect the department would look favourably at. Yes, we believe it could occur. We haven't gone into the detail of it though.

MR WOODS: You were one of the submissions that made reference to ACAT assessments of high care defaulting to low care upon reassessment of RCS. To what extent for TriCare has that been a difficulty?

MR TOOHEY: It's been identified as one of the major factors at one of our largest homes that we've had to make staff reductions, in that residents coming in as allegedly high care residents default to low care. I'd hasten to say I think ACATs are generally very well-intentioned. That's not done for any reason other than they want people to receive what they believe is appropriate levels of care and, when we question it, the response we get is, "We were doing you a favour. High care residents have more funding." It hasn't occurred at a level yet where we'd make a big fuss about it but it is significant. For instance, if you got 20 per cent of your nursing home resident population as low care, then that's going to have a very big impact overall in terms of the funding you receive and the staff mix you're going to have to employ. We would see it as being ideal that people coming into nursing homes could not default lower than a category 4 as with the old system.

MR WOODS: Thank you. The question of quantum has been one raised by very many people and organisations putting forward submissions to this inquiry and, as they understand, that is not in our term of reference - nonetheless it hasn't prevented the comments. We have noted that there is a residential aged care review in process, but in your submission you make reference that the industry generally is not supportive of the process as it currently stands. Is there any perspective that you would like to offer to the commission on that?

MR TOOHEY: As carefully as I can, commissioner. The first-hand experience we

have is that review is not a consultative review. It is a review based on what the department thinks it would need to find out and how it would need to go about that. People we have had who have attended the review have advised me that the views of the industry are not being actively sought and that seems to be common with most other proprietors I've spoken to.

MR WOODS: Thank you. Volunteers - when you look at various forms of data that the church and charitable sector, from information we have, seems to draw quite heavily on volunteers in the nursing homes, and the private sector to a very minimal extent, is that because the private sector doesn't value contributions of auxiliaries and the like? What causes such a significant variation between the two sectors?

MR TOOHEY: I haven't given it a lot of thought and, with respect, sir, it's because you raised it that I dealt with it. We experience at all of our centres some community involvement to some extent but it's initiated by the community - a local school might want to put on a concert or something of that nature. We don't count - because they don't perform any of the work that we're really required to meet under prescribed services - any of that in our calculations. We don't get a lot of people admittedly coming to TriCare and asking if they can do volunteer work. I would think that would be expected seeing we're a privately owned company. So to some extent it's not being offered - is what I'm saying.

MR WOODS: Or being sought?

MR TOOHEY: Or being sought. Yes, I'll admit that. I might have some ethical problems, and perhaps members of our board would, with putting an ad in the local paper and saying, "Private nursing home company seeks volunteers to assist us in caring for elderly people."

MR WOODS: I think we're talking about integration into the community rather than a subsidised workforce in this concept.

MR TOOHEY: You've put that very diplomatically, commissioner. We do get a lot of the time, and it occurs quite frequently, money left to us from the estates of residents which we have never accepted and never will. It's always refunded to the relatives, or in some cases to the public trustee. That is another aspect of which I'm unsure of the impact in the church and charitable and government sectors. As far as integration of the community goes, perhaps we should rethink that policy.

MR WOODS: Thank you. On pages 7 and 8 of your submission in response to our paper you discuss the question of the value of bed licences and you put various caveats such as:

> To the best of our knowledge no credible independent study or review of nursing homes has ever indicated that it's highly profitable -

and the like. Nonetheless, you are a private sector organisation whose investors

presumably at this stage consider that they are earning a sufficient return to remain in the industry and I draw on the submission by the National Association of Nursing Homes and Private Hospitals Inc which talks about that:

> Despite the inappropriateness or inadequacy of the funding package that currently prevails, the industry is still enjoying a significant growth in capital investment for new facilities and bed licences are transferring at a premium for providers who wish to aggregate licences in order to build efficient facilities.

Is there some disagreement within the private sector on profitability?

MR TOOHEY: Some of the comments that were made by the previous witness I would support in that a lot of the discussion we hear of bed values relates to what consultants or brokers believe they are or should be worth. What I suppose I was trying to address in this submission is I'm talking from a purely commercial perspective and our own perspective. The last time TriCare purchased bed licences - we purchased them as part of an entire facility. We paid, and it's a matter of public record so it doesn't matter, $32,000 per place 8 years ago for a bed, building, land, equipment and infrastructure. We're looking at it very much from that perspective. If we purchased nursing home licences for $10,000 a licence without a facility - I've referred to the study that I've based my figures on quite conservatively - we'd be looking at an all-up capital cost of 80,000 from which return could be derived only from the operational subsidies in resident input. There's no accommodation bond payable in an ordinary nursing home.

I can say categorically as a company that's quite successful commercially, we simply wouldn't do it. We simply would not do it and we're not interested in doing it when we're approached for these sales. I think the proof is going to be in the pudding in a couple of years' time. If there are people out there paying 25 to 30 thousand dollars for a bed licence and are going to have to spend 70 to 80 to construct a purpose-built nursing home that needs accreditation and building certification standards, then they are borrowing incredibly low amounts, they're investing huge amounts of their own capital, or they know something that I don't know which is an entire possibility. I think there has been an element of speculation in the industry.

I know some of the recent sales have occurred because there is a broader strategic issue in place, mainly co-locating with retirement villages which adds enormously to the occupancy of your village and the attraction of your village, and there are reasonably good profits to be made from retirement villages. So I don't seek to enter into, I suppose, an attack on people who are paying these sort of prices. I am simply saying from our perspective we would not do it. Incidentally, all of our nursing homes and the net worth of our shareholders you can put down as largely attributable to capital appreciation, not profitability. All of our nursing homes represent off-balance-sheet securities for retirement village development; in other words, there are no borrowings related to the operation or the expansion of the nursing homes any longer, and obviously that's a big saving. I would love to meet someone, commissioner, who has got the formula. I am most interested in finding

out.

MR WOODS: Thank you. Talking formulae, page 4 of your latest submission refers to within the TriCare nursing home division approximately 500,000 per annum expended in sales tax and FPT. Could you - and I'd take this as supplementary information at a later date - break that down into a percentage of cost basis so that we can then apply it to various size facilities to assist our understanding of that?

MR TOOHEY: I am happy to do so.

MR WOODS: Preferably by the 27th.

MR TOOHEY: 27 November?

MR WOODS: But at your earliest convenience.

MR TOOHEY: I don't get overtime, commissioner, I might just add for the record.

MR WOODS: Yes. I think that deals largely with the questions that I want to raise from your various submissions. Are there other matters that you would like to put before us?

MR TOOHEY: Not at this stage.

MR WOODS: In which case I thank you and your organisation for the assistance you have given this inquiry and we will adjourn until 2 o'clock. Thank you.

(Luncheon adjournment)

MR WOODS: We'll resume the hearing. I'd like to welcome as witnesses from the Queensland Nurses Union Ms Bonny Barry, Ms Nancy Cole and Mr Steve Ross. If you could please state your name and your position for the purpose of this inquiry for the record, please.

MR ROSS: Thank you. Steve Ross, industrial officer with the Queensland Nurses Union.

MS BARRY: Bonny Barry, professional development officer with the Queensland Nurses Union.

MS COLE: Nancy Cole, a member of council of the Queensland Nurses Union.

MR WOODS: Thank you, and welcome. Would you like to make an opening comment.

MR ROSS: Yes, thanks very much, commissioner. What we'd like to do today is address the commission on one particular aspect of the whole imbroglio that is aged care. It's our intention to make a comprehensive submission on the commission's first report by 27 November.

MR WOODS: Thank you.

MR ROSS: And we're also aware of the submissions that the ANF will be making later on today, and we don't propose to transverse the same areas that they intend to cover when they are on. Peppered through the Productivity Commission's first report and through the submissions of the various parties that have contributed to the process is terminology such as quality of care, the care needs, the benchmark care - the benchmark care standard is one the Productivity Commission has developed. What we'd like to do is focus today on what our understanding and our membership's understanding is of care and care needs and quality of care, so I address those sorts of issues because we are firmly of the view that an understanding of the nature of quality of care and what quality of care means is vital in any development of funding policy in respect of aged care.

Bonny Barry will deliver the substantive part of our comments this morning. Bonny is both a registered nurse and has worked in palliative and aged care prior to working for the union. Nancy Cole, who is a registered nurse employed at Coorparoo Nursing Home, will deliver some comments on her experiences as a registered nurse in aged care at the moment.

MR WOODS: That will be very welcome.

MS BARRY: Thank you. I'd just like to start by the Queensland Nurses Union acknowledging a number of the Productivity Commission's preliminary views, and that is in the matter of the rejection of a planned coalescence over 7 years, a situation that was untenable for Queensland, a state that already suffers from a chronically

inadequate funding base in aged care. It is a base that has failed to provide for Queensland residents an adequate level of nursing staff for many years, and inadequate access to a safe and satisfactory working environment for the staff.

It is an environment in which one registered nurse can be expected to provide for the planning, assessment, evaluation and delivery of complex care for up to on average 30 to 60 residents, with regular reports of that population swelling to anything up to 120 residents across aged care complexes in this state. It is an environment where one enrolled nurse or one assistant in nursing can be expected to provide a complete care for up to 16 residents during the day and the evening, and can increase between - and it's a conservative estimate - 25 to 30 residents at night for each single nurse.

The QNU acknowledges the commission's view that Queensland requires urgent redress of this historical under-funding. We do remain concerned that the commission does not address the matter of timing and quantum at all at this time. the QNU acknowledges the commission's preliminary proposals that state-run facilities have the removal of the deduction arrangements for those homes. We do remain concerned that there is a failure to acknowledge the unique nature of state-run facilities in terms of their placement within the public sector and the role that they play in the continuum of care within the provision of public health services. This unique service provision becomes critical in light of the likely impact of a number of the commission's proposals on how private facilities may manage their high care residents.

The QNU is concerned by the speed at which the commission must complete its inquiry. The matter of the inadequacy of the remuneration for Queensland's residents through the state's poor standard hourly rate has been long standing. We remain concerned that the unrealistic time lines provided to conduct the inquiry will ultimately have a negative impact on the analysis done by the commission, and can we say that the effect on the older person in aged care is that they are simply too vulnerable to withstand any impact that's not well thought out.

The commission in its position paper has regard for the objectives of the Aged Care Act 1997, and the first one is to promote a high quality of care and accommodation to protect the health and the wellbeing of a resident. The commission's preliminary proposal number 2 requires that government funding should be sufficient to support the level of care required to meet accreditation and certification. The QNU notes the reference to a benchmark level of care and for that requirement of the benchmark level of care to rise if the government mandates a higher level of care. The QNU clearly believes that mandatory accreditation by 2001 is evidence that such a mandate for higher care is government policy at this time.

The QNU's view is that there is little evidence contained within the position paper at this stage that the commission fully understands what care needs are entailed in the provision of care for a resident in a nursing home. The principle that a funding model must support and provide for the meeting of quality of care objectives is evidenced in the commission's report, but the knowledge by the commission of what

actually contributes to that health and wellbeing is not really clear to us. So it is that focus to the discussion and the information that we wish to provide to the commission today, and we've brought Nancy along to address the matter in detail and perhaps take you on a bit of a journey into the life of a registered nurse in aged care, and to be available for questions from the commission.

The QNU reflects that the scope of the inquiry is in particular with reference to the provision of subsidies for nursing homes that are also known as high care facilities, where the resident category is usually between category classification 1 through to 4, residents who by the existence of mental and/or physical debility, often as a result of complex, multi-system failure, are unable to be cared for anywhere else in the longer term but in a nursing home. That is, they require the provision of professional nursing care in a nursing home, where it is a requirement that a registered nurse is present 24 hours a day. The protection of their health and their wellbeing demands the presence of that registered nurse, as does government policy under the prescribed services of the Aged Care Act principles, a position that was reaffirmed recently by the previous minister for family services, Mr Warwick Smith.

The QNU notes that the majority of industry submissions to the inquiry fail to provide detailed exploration about the nature of nursing service within aged care, other than to comment on a cost perspective. The QNU has noted the changes to legislation and classification during the past 2 years of aged care reform have diluted the reference to the provision of professional nursing services to all residential aged care recipients. The QNU believes that when the commission addresses the concept of quality of care that it must make detailed consideration of the provision of professional nursing services by nursing teams to residents by virtue that their health care requires it.

The commission would be aware that the majority of residents admitted to nursing homes are admitted from their private homes. As stated in the QNU's original submission, they often come from an environment where they have previously been supported by community care packages, domiciliary nurses, home help, handyman services, meals on wheels and, can we say, most importantly, the constant and caring attention of family nearly 24 hours a day. Despite this intensive package of care, the needs of those older people are more than the care that can be provided for within their home setting.

The rest of the admissions are usually through hospital referral, where an acute episode of illness or significant health deterioration results in a person requiring admission to a nursing home because they cannot return to their homes. There is an expectation that an average 50 per cent of residents live less than 12 months, and on average 25 per cent live less than 6 months. The average age of a resident is on the increase, moving towards the old old. There are the young old, the middle old, and the old old, and they are the 70 years plus. The majority of residents are female. The care needs of nursing home residents are unique to each individual, but they are grouped by the government classifications for funding system, which I'm sure you understand really well - the resident classification scale - as I said previously, category

ranges 1 to 4.

What we'd like to do for you is to provide you with a synopsis of the characteristics of the care needs of someone in the first three categories, with your understanding, of course, that each care resident has unique needs. A category 3 resident is usually one who perhaps requires dementia care. They often suffer from extreme emotional dependence, they need professional nursing planning in order to meet their care needs. They require medication management and administration because they cannot take responsibility nor understand their medication regimes. They require constant observation, supervision and intervention for safety and mobility and for interaction with others. Nancy is going to talk to you a little bit later about what that means.

They can suffer a sense that they are losing their capacity to care for themselves, and they have an innate fear of loss of control of their surroundings and their deteriorating health physically and mentally. Such dementia care for these residents requires them to be supported not only in the meeting of their physical needs, but to support them in the fulfilment of their social interactions, what we would consider to be normal life. Their behaviour is distressing at times to other residents, their families and, for many residents, themselves. Many residents in this category possess the knowledge that they are losing their mental integrity which of itself causes significant distress. A nurse must deal with that fear and that distress by minimising the negative and the fear, and by optimising the independence and the normalcy of life for a category 3 resident.

Nurses commonly refer to the category 2 resident as the frail aged, that is, that they are usually physically dependent upon nurses for their every need. They are infirm by physical frailty, loss of muscle tone, reducing and sometimes prohibiting mobility. They have loss of bone density, often due to osteoporosis, which is common amongst women. The result of their reduced mobility is often brought about by falls, fractures and fear, leaving them confined to bed or by full support chair systems. They need feeding, dressing, second-hourly passive limb movement and skin care to prevent contractures and decubitus ulcers or pressure sores. They need attention to every aspect of their physical care. Most often this physical frailty is not accompanied by a loss of mental faculties but rather the resident is acutely aware of the limitations that their bodies place upon their lives.

The resident in category 1 is often a person whose care needs include a myriad of complex care needs, including nursing care needs that are life-sustaining, regimes in particular that control physical symptoms in order to achieve a quality of life. For a large number of these residents they need palliative care and, in particular, pain management. Palliative care is the coordination of medical, nursing and allied health services for those people who are terminally ill. It provides for the physical, spiritual and emotional support of residents. It also includes the bereavement and support services for family and friends of the terminally ill resident.

A recent study in South Australia indicated that the care needed to provide

palliative care to dying residents in a nursing home should consume on average 6½ to 7 hours of care a day, despite the fact that under the classification scale previously of the RCI they were funded on average for 3.5 hours per day. The majority of nursing home residents would have care need profiles that were not dissimilar to the ones that were described above. The reality for nursing home residents is that the classification afforded to them by the Commonwealth is that they receive on average between them in Queensland 2.8 to 3.2 care hours in a 24-hour period. That is between 170 minutes and 190 minutes every 24 hours.

Some recent reports in investigations into aged care facilities in Queensland indicate that this level has fallen to as low as 1.7 hours or 102 minutes every 24 hours. In an average day for a resident a bath takes 20 minutes, skin care and passive limb movement takes 56 minutes, feeding takes 18 minutes, transport to and from meals takes 12 minutes. Movement in and out of bed takes 10 minutes. Diversional therapy for individual attention takes 6 minutes. Dressing and clothing changes takes 8 minutes. Bed changes take 10 minutes, toileting takes 20 minutes. Medicine administration takes 20 minutes, drinks take 12 minutes. The total to date is 3 hours and 13 minutes, or 193 minutes. Complex care for things such as dressings, catheter care, pain control, dialysis, intravenous line management, enteral feeding, soma care, tracheostomy care, in some cases post-surgical care following fractured legs, stroke care. It goes on. Documentation, nursing assessment and planning are not yet included in this 193 minutes.

The possibility of a relative visit or something not going according to plan is everyday life in this incredible analysis of daily life. It is the aspect of complex care, nursing assessment as well as social interaction that we expect is normal and vital in life that is not properly accounted for in funding. Accountability for funding documentation required by governments also contribute significantly to mean that the provision of quality of care in a nursing home is simply unrealistic in Queensland, particularly in the absence of anything other than an overwhelming extra effort by nurses, staff and the family of residents.

The commission in addressing quality of care of residents' life must consider not only what is sufficient to meet the untested accreditation system but also quality of life to residents. Care that comes even close to be something that we can accept for our residents is only possible, not only by the commitment by nurses, staff and families but by the presence of a nursing model of care; that is, a holistic approach to care delivery, where the care is carried out, despite the unrealistic time lines and the attention of the need to complete that dreadful list of tasks that I gave you, through an approach called An Holistic Nursing Model of Care, an approach that has been used by nursing for decades.

It is where a registered nurse working in collaboration with an enrolled nurse and in cooperation from assistants in nursing delivers care to residents as whole people, not a set of tasks but a person with a life, a personal history, a desire for choices and autonomy, and for some for whom they develop a friendship over time. Holism is not the ability of a worker to be able to function in the laundry, the garden,

the kitchen and the bathroom, but a professional approach to individual care delivery that enables care to transcends tasks and to ensure that life is liveable for residents by treating them as a complete person. That is what holistic care is.

Can I also just add the dimension that as a cancer nurse for some 17 years I can describe to you how difficult it is to manage just a small number of people who are dying, but my time in aged care really gave me a lesson in what professional nursing care was all about, because in amongst all of this, we remind the commission, that between 25 and 50 per cent of these residents are dying within 6 to 12 months, and they require palliative care. For every minute removed from a nursing roster, for every dollar taken out of a nursing budget, for every loss of a registered nurse - can we say to the planners of this rich holistic approach to care - for every enrolled nurse restructured out of a job, for every assistant in nursing not replaced on a shift, the impact is totally and completely felt by the residents that they care for; so fine is the balance in their lives. So important is the need for a thorough analysis of any impact of any changes proposed by the commission.

The QNU provided for the commission a 12-month survey on the impact of aged care reform on nurses in Queensland. It demonstrates to you that nurses are attempting to minimise the impact of hours cuts by working overtime unpaid, through their meal breaks, but the situation is not sustainable for much longer. The loss of registered nurses in particular indicates a lack of understanding about their pivotal role in ensuring that a nursing model is implemented in the delivery of resident care. It also indicates the exodus of registered nurses from the industry because their professional ethic is so compromised that they would rather leave than get (indistinct) to do a job that they cannot do well.

I am sure the commission has seen the document. It's called the Giles report. It was done in 1985 and it was, Investigation into Private Nursing Homes in Australia, Their Conduct, Their Administration and Their Ownership. Experienced nurses talk to us these days about a fear, a fear that the return to the dark days prior to the Giles report is upon them. A return to where there was a task-orientated approach that really meant nothing more than a custodial approach to care; where an absence of the professionals best educated to ensure a holistic approach to care is fundamental to care delivery. A distressing increase in elderly clinical depression is already at unacceptable levels in aged care facilities. The fact that the industry can believe that residential care can be provided for in the absence of the most significant contributor and indicator of quality care, and that is professional nursing care, is disturbing.

The delivery through professional models of care to make holistic residential aged care a reality for residents is done by nurses and it's not just a concept that we talk about. Can I say that quality of care of life for a resident is achieved through an approach to care delivery. It transcends just size, furnishing and appointments. In the absence of that approach you simply have a pauper's care in a prince's palace. Thank you.

MR WOODS: Thank you very much.

MS COLE: I would just like to take you through an evening I experienced at my workplace. For many of you I am quite middle-aged in this field of aged care. I have worked in England and in Jerusalem, in theatres and in casualty wards and now I find myself working in a local nursing home, 61 beds, 61 residents there, so it's a fairly small place but the atmosphere is very homely. We find with that size we get to know everyone fairly well; they know the staff and we know the relatives that come in, and it's with that setting in mind that I take you through my evening.

I had 30 residents in my care and the two AINs I had on with me were of non-English speaking background, but very devoted and very committed and good at delivering care, but I have to take time with explaining things to them. I had a resident who was just about to pass away and I had family members who had been there and unable to accept that their mother was dying. I had to take considerable time with them. I found it very difficult to make sure that I was providing care to all the other residents who are demented, wandering outside, opening the gate, going downstairs, falling into rubbish bins looking for cigarettes, and I had to be there; I had to make sure someone was looking after them - trying to open the gate and then someone ringing in sick. I had to replace staff, I had to get the doctor in, I was trying to find the priest who was at mass and I had to get him there in a hurry.

Meanwhile I still had people that needed supper; there are diabetics there. I had people who with their incontinence needed to be taken to the toilet. They need two staff and, as you heard, most of them are quite frail. Their skin breaks very easily, so you have to take time with handling them, you have to explain things clearly, it has to be one on one, so with two staff members whose English is limited, I had to make sure that they were able to give directions clearly and in a way that they could understand them.

I had further behaviour problems with other residents, who felt persecuted, that people were taking things from their rooms, that they weren't getting the right food or care or medication, and meanwhile I had half a dozen family members standing around anxious about their mother. There was a commotion downstairs and the other registered nurse who was down there had come up to help with finding phone numbers to get a staff member, and on going back down I could hear what was happening. One of the demented residents had taken a biscuit from another one sitting near him, and that particular gentleman had raised his voice and his stick and hit the demented resident. An assistant in nursing had said, "Don't do that, come away." She was unable to recognise the need to cope in a better way with handling that behaviour in just removing him. So then the Milo was thrown across the room and he took off out the front and I could hear him out there banging at the gate trying to get out.

So it is important that we look at what is happening with our care needs of our elderly people. It is more than just the physical tasks, it is coping with their emotions, their feelings, the family that were having difficulty last night that couldn't come to grips with it, that I had to spend time and be concerned for them, and really make sure

that we had some privacy with other people that were trying - they were intrusive and people that demanded to go to bed, that "I always go to bed at 7 o'clock." I am just setting the scene a bit. That was a good night. Generally it's far more complex than that with people who are rustling around in other people's rooms and taking off their clothes, stripping, and needing attention. We have got a number of residents whose English is not good - Russian, Greek, and people like that - that we need to spend time with. We need to find other staff members that can understand and talk with them.

At the same time I'm required to give out medications. I have to ensure that they actually do take them. I have to monitor them. I have to make sure that they're not having too much, that they are taking it with adequate food or fluid or whatever it is that is required with those medications. Then of course I have a sedation round later when I have to get around and give those out. That is quite time-consuming with administering and making sure that they do take them. So it is quite a complex area. I have worked, as I said, in theatre and with other patients in other settings but I have found that coming into aged care quite complex.

MS BARRY: One of the things that Nancy talked about before - and she hasn't raised it - and one would wonder why anybody would want to work in this environment as we've just described, this incredible day which she describes as a quiet day. She said to me on the way in that what was really wonderful about it was the capacity of her to take a very distressed daughter whose mother was dying, and to move her to a stage that she was actually relatively at peace with that process and that gave her pleasure. So despite this incredible day that Nancy has described, there was a great sense of satisfaction and joy that she was actually able to apply her professional nursing knowledge in achieving that outcome for that family, which I can say contributes to a very healthy Australia.

MR WOODS: Thank you very much and I appreciate the time that you have taken to put that evidence to us. Can I also assure you that as part of the process of this inquiry I have spent many, many hours walking the corridors and sitting at bedsides and discussing both with staff and with residents their lives in nursing homes but certainly the evidence that you give is fully consistent with those experiences and reinforces a number of those points and it is very useful to have that on the record, so I do appreciate the time that you took on that.

One of the issues that you raised in your evidence is - I think your phrasing was along the lines of "assessing quality of care versus an untested accreditation system." That gets to the nub of not only your submission but a lot of what we are dealing with here in terms of looking at funding methodology. The position paper that the commission has put out has a preliminary proposal which talks about a basic national uniform subsidy which is linked to the cost of providing benchmark level of care and it is a matter of the commission being satisfied that there is such a benchmark for that subsidy to be operational. I would appreciate any further explanation that you might wish to give of your views on whether such a benchmark is possible to construct and to what extent the accreditation process provides a basis for such a benchmark.

MS BARRY: Thank you, commissioner. One of the things that we found interesting with the position paper was particularly the aspect of benchmark level of care and the ability and its linked with accreditation. The QNU has been very involved in the development of the standards and is following closely the accreditation as it becomes, hopefully, apparent how that process is going to work. It is our understanding that when the government expected that residential aged care would move away from the minimum outcome standards provision towards accreditation then in actual fact the underlying philosophy of accreditation was to say to providers, "Don't just target at a minimum standard but move towards better and improving all the time."

We have some difficulty in marrying the concept of a benchmark level of care in which homes are then funded to that benchmark level of care because, to us, what that says is that it recreates the minimum standard level by virtue of a funding base, which appears to us to be inconsistent with the philosophy underpinning accreditation, which is continual improvement, so I think perhaps that the notion proposed by the commission might be inconsistent with the philosophy of accreditation.

MR WOODS: We are certainly very conversant with the concept of continual improvement embedded in accreditation and what that would lead to is for that benchmark therefore to be rising over time and we understand the dynamics intended to underlie accreditation. What I am searching for in wanting to design a subsidy system is how do you ensure that there is equity in the quality of care and that it can be assessed and that residents can be confident that it is being delivered, as can government. So any views on whether there are alternative forms of assessment or whether using accreditation as the benchmark, recognising the dynamics of it, may be imperfect but the best available, I leave open to you to offer some comments.

MS BARRY: There are a couple of issues that you raise there: in terms of equity in quality of care, I think what is proposed by the opening up of extra services is the fact that there is an acceptance that there won't be equity in quality of care; that there will be ranges of levels of service, dependent upon a user-pays mentality and in fact, if I recall, the commission comments that government should not provide for anything above what is the benchmark level of care and leaves that question open. I mean, our interpretation of that is, if you can pay for more then therefore your quality of care service will be invariably better.

MR ROSS: Certainly we can address that question in respect of our submissions. One of the things that we have been concerned about with the current arrangements, however, has been the removal of the accountability mechanisms that are inherent in a structure involving the nursing hierarchy and the accountabilities that nursing have to their registration authority and to their profession, which are separate from and independent of and, probably, for nurses, more important than the accountabilities to government or to their employer. So principally there is that accountability inherent in the nursing hierarchy with the directors of nursing through to the delegated responsibilities down to the assistant nurse - is something that has its own internal

accountabilities - that is being removed and, as you have heard this morning, altered in the name of efficiency and productivity.

MR WOODS: Certainly there is nothing in the design of a subsidy that from my point of view would affect that accountability in the professional sense as you describe it, but the accountability through government to the taxpayer for the outputs - the care, the quality of care, delivered - is in itself fundamental to the design of the subsidy but they can be related but separate processes, I would have thought.

MS BARRY: Can we say that the opportunity exists to create a bridge between the two of them, and in particular the role of the director of nursing. The QNU has particularly been keen to see the role of the director of nursing in the - for the accountability of taxpayers we already fully understand the role of the director of nursing as the final last point of accountability from a professional nursing model point of care - "The buck stops here", if you talk to a director of nursing - but essentially the director of nursing under the previous CAM acquittal, laborious as that was, was in actual fact in control of a certain amount of funding in order for her or him to deliver nursing service.

What we would seek as an alternative and a marrying of both professional models of accountability and a requirement to provide some accountability for taxpayers' funds is to have joint verification of the provision of sufficient enough funds for resident care needs between the provider and the director of nursing. We would like to see the restatement of the director of nursing's role in the authority for care needs being met.

MR WOODS: I noted your views in support of reidentifying the care-funding component of the subsidy and the role of the RN and the DON in particular in that area. If there is a progressive move to ensuring that it is the quality of care in the holistic sense that you describe does the proposal to revert to identifying parcels of funds within the subsidy limit the flexibility within each facility as to how best to provide that quality of overall care? I mean that in the sense not only of nursing care but of the accommodation services and the totality of the life experience. I do have some concern that by re-parcelling parts of it you will get particular resource allocations and expenditure patterns and things which are not optimal. Is that a concern that you would also share?

MS BARRY: Can I say that the director of nursing is an incredible position occupied by some fantastic nursing leadership and that directors' of nursing focus is not specifically just about nursing, though can we say, as we have stated before, we believe there is the major care service contained within nursing home care provision. Any director of nursing would tell you that they are required by the running of the home as a whole, and indeed for those services that we haven't seen deteriorate significantly in the last 12 months, it is clearly nursing leadership through the director of nursing that - and can I say their authority through the philosophy and the links that they have with their provider - has ensured that they have not deteriorated with respect to nursing service.

I think that directors of nursing by virtue of that broad approach to the running of the home would be the safeguard against the allocation of care funding at the expense of say food. Do you know, I think it is the "whole of home approach" that directors of nursing have and, can I say, what we said was "in conjunction with providers" that it is the joint authority that we seek to say that there must be - where the director of nursing indicates how much she believes is required for the nursing service because, let's face it, that is fundamental to what we are saying: if you don't provide the nursing service it is pauper's care in a prince's palace. We believe that the director of nursing has a whole of home approach.

MR WOODS: Although there is currently no model where there is that level of control and authority, I have personally witnessed many examples of close cooperation between the facility provider and the DON in terms of ensuring that the holistic quality of care is most appropriate to individuals.

MR ROSS: Can I perhaps just address that point further?

MR WOODS: Yes.

MR ROSS: I think the commission, in examining accountability mechanisms, needs to be cognisant of the maturity of the aged care industry and, while the commission has heard from some proprietors who have been in a position to - and perhaps have had the vision to - invest considerably in quality processes and improvements, etcetera, there are a large number of proprietors who have not had that vision and who require a big stick. We have recently had the experience with one particular proprietor going into receivership where care money was allegedly - based on the receiver's report - spent on things like earthmoving equipment, where money for wages and things was diverted into another courses, etcetera.

In the absence of strict accountability mechanisms and with an untested accreditation quality system how is the government going to justify to the taxpayers the expenditure of that money? To repeat my opening statement, the commission needs to be cognisant of the range and the level of maturity of the industry in looking at those accountability mechanisms.

MR WOODS: We have certainly experienced diversity in facilities in our various tours and examinations as part of this inquiry. In pursuing the question of subdividing to some extent the subsidy the question of workers compensation has been raised on many occasions and occupational health and safety is clearly a very important issue, not just for your organisation but for the labour force in total. I notice you talk in terms of looking for a proactive approach to improve the industry's poor workforce health and safety record. Do you feel that a form of direct reimbursement of workers comp premiums is a way that would achieve that or what other proactive mechanisms are there that can be embodied within the design of a subsidy to assist in this?

MR ROSS: With the leave of the commission, that is quite a complex area which

we were intending to address in respect of our written submissions by 27 July. We note the comments of the commission in the paper but our preference would be to address that in writing rather than seek to do it at the hearing at the moment.

MR WOODS: Okay. When you are preparing your comments on that if you could look at not only the desired outcome, which is the proactive approach you are seeking, which many providers - and certainly the workforce - are very keen to ensure happens, but how to build that into a subsidy process, my concern being that if you try and achieve too many fine-tunings of particular elements within a fairly blunt instrument called a subsidy that picks up funding for various RCS levels, then you may not be looking to the right mechanism to achieve the outcome that you want and it may be more appropriate to look at other ways of achieving some of those goals, but if we try and crowd the subsidy out with a whole lot of competing desires the instrument you get might be the average of something that achieves very little. I just pass those comments on.

MR ROSS: We note the comments. Certainly in the area of workplace health and safety we see that as a pivotal component of any system, not just in respect of the workers comp premiums but the entire cost to the industry.

MR WOODS: Yes, quite true. We have received evidence from various sources that suggest that the acute sector sets a wage trend for the aged care sector for wages. We have also heard some evidence that the two sectors are somewhat different in the work experience and career paths offered and that the degree of casualisation and things suit some workers in aged care more than acute care. Could you give the benefit of your experience from your organisation as to whether the two sectors are similar or that they do operate and have attraction to different parts of the nursing workforce?

MR ROSS: Again that is an area that we intend to address comprehensively in our written submissions. We will make the point though that the accountability required of registered and enrolled nurses to their registration authority and the requirements for registration and enrolment are the same, be they within the acute sector or within the aged care sector, so the competency level expected of those people is the same. We are concerned in examination of the nursing market as to the impact on the entire aged care industry if it becomes - or continues perhaps as a second-rate area of nursing. That has implications for the attraction of quality skilled staff; it has implications for the attraction of money to be spent on training and, ultimately, it has implications for the quality of care that is delivered in that area. So we are concerned about suggestions that staff in aged care - nursing staff, in particular, in aged care - somehow are not worth as much as their colleagues in the acute sector.

MR WOODS: I note your phrase "second-rate". I guess what I am searching for is whether the sectors are different but not necessarily hierarchically ordered in the way you suggest and so in your submission I would appreciate your reaction to those issues. Enterprise bargaining is something that has been brought before the commission, in some cases as evidence that there is very little scope for productivity

improvement and, in some cases, as demonstration that productivity improvements, albeit not large, can be achieved. What perspective does your union have on the enterprise bargaining process in Queensland?

MR ROSS: In our view we have given enterprise bargaining a pretty good shot. We have run joint projects with employer associations based on project subsidies from the state government investigating the whole area of enterprise bargaining. We have been seeking to negotiate agreements and continue to seek to negotiate agreements through the aged care industry to cover nursing staff. There are currently approximately 300 proprietors in Queensland, as a rough figure. There are, after some 4 years, some seven enterprise agreements which cover nursing staff within Queensland; six of those QNU is a party to, one of which we oppose, which is the TriCare agreement. I think there are some lessons to be drawn from the extent to which enterprise bargaining has been embraced. As far as the productivity matters are concerned, again that is something that we might address in our written submissions, too.

MR WOODS: I would certainly appreciate you addressing the productivity issue in that submission. We have also received evidence that there is a degree of differentiation in wage outcomes between the jurisdictions and also evidence that with a prospective shortage of nurses, particularly at the RN level, over the coming years that it may cause - at that level of nursing - for wages to come back to a national level because there will be a national demand and bargaining and bidding process. Clearly this is important in the commission forming a view on whether the differentials in the cost of providing aged care services between jurisdictions is likely to increase or decrease, and therefore I would appreciate your view on looking forward 5 years or so as to whether you see nursing wage outcomes converging nationally or diverging or staying roughly where they are.

MR ROSS: I think there is little doubt that the answer to your question will be dependent upon the take-up rate of enterprise bargaining. If I can give an example: in July 1994 every nurse in Queensland for their classification, irrespective of whether they were working in the acute public sector, private sector, aged care or a doctor's surgery, was earning the same amount of money. Now, after some 4 years of enterprise bargaining with different take-up rates in different sectors there is probably 15 to 20 per cent difference in wage rates between say a nurse working in the public sector, who is currently finalising negotiations for their third certified agreement and, say, a nurse of the same classification working in a doctor's surgery, who has relied on the safety net things. So going back to my earlier point, enterprise bargaining, in our view, certainly creates a divergence of - - -

MR WOODS: But do you also see whether that is part of the initial reaction of enterprise bargaining and that, over time, convergence might re-establish itself, or do you think that that divergence will continue on into the future? I realise this is purely speculative but I am looking for the recommendations I make to have some validity into the future and not just address today's problem.

MR ROSS: If it is possible to put something on transcript on a without prejudice basis, I think that a convergence of those rates in an enterprise bargaining system is somewhat unlikely.

MR WOODS: Thank you. One of the matters that you raised in your initial submission was the cost of time spent on documentation and how that was taking away from actual delivery of personal care at the interface. I understand that concern, particularly if you are also then having greater - or a reduced length of stay so more residents and therefore more admissions and the like. Are there technological improvements possible? One that has been put to the commission is in the electronic documentation of both care plans and the translation of those into RCS documentation and the like. Is that something that is being explored by your union and do you see that that is just useful but minor or can actually add some efficiency to operations to allow you to spend more care time?

MS BARRY: It is interesting you make the comment about turnover because some of our members would tell you that the residents die before the paperwork is completed.

MR WOODS: I actually didn't use the word "turnover", but - - -

MS BARRY: No, but we will.

MR WOODS: - - - I understand its meaning.

MS BARRY: The issue of documentation, in particular for funding, is a particular subject that the Queensland Nurses Union has sought to make progress on with the department and the government for some time. For the commission's understanding - I may be saying something that you already know - there are two roads of documentation that nurses must travel simultaneously: the first one is the road that is required for the professional and legal documentation of any care delivery for the purpose of the provision of not only the care and the continuity of care but for evidence.

MR WOODS: Yes.

MS BARRY: So that is non-negotiable, regardless of what specialty within nursing that you are practising. Can I say that the unique situation of funding for accountability is something that aged care has suffered for many years, and whilst nursing as a profession has certainly embraced the types of innovative documentation records that you're talking about there, wouldn't that be lovely in aged care? The fear is of course that when it comes time to validation time, that we're never really sure and haven't been for some - what is it - 7, 9, 10 years, whether we'll get over the line in terms of validation for funding, because let's face it, if you don't get the money you're done.

So we certainly now are encouraging our members to embrace nursing

documentation from its professional model and to take advantage of those innovative tick-and-flick sheets, certainly whatever computerised care planning that's available to us. However, at the same time the requirement from government and the processes for validating documentation must keep pace. There's no point in the profession going ahead and being creative, which indeed it's more than capable of, if when the validators turn up that by the absence of the fact that we've called the wall beige and not white that we can suffer the possibility of lost funding.

So in terms of making it more efficient can I say that the requirement for the validation of a registered nurse's care planning and evaluation is something that we would question. As we have previously stated, the requirement for a - in a registered nurse's professional duty of care in the state of Queensland and in most other states it is the registered nurse who is required to plan, assess and evaluate care, and it's the development of that that work is being done: a nursing care plan is developed and then work is delegated therefrom.

It's just incredible that then on top of this professional duty of care that is designed to ensure that the public is protected - that's the idea of a duty of care; that is, that they are answerable to the Queensland Nursing Council on the matters of whatever they do in terms of - and they must evidence it by documentation - that then the government requires an entirely separate process, that despite the fact they say that the RCS does no drive planning, indeed it does; regardless of how many times they want to put to us that it doesn't, it does. We would welcome the opportunity to have some efficiency created in the funding for accountability process that is required in aged care.

MR WOODS: Thank you, and that's clearly on the record now and no doubt it has been several times before. You talked about delegating some aspects of care. Can you also therefore delegate some aspects of the recording of the care given?

MS BARRY: As I previously said, the Queensland Nursing Council makes it very clear that it is the registered nurse who possesses most importantly the education, the qualification, to plan, assess and evaluate nursing care. The Nursing Act enables that delegation of nursing work can be delegated from registered nurse to enrolled nurse, and in our case, in a nursing term, the assistant in nursing. So clearly when a registered nurse assesses, plans and evaluates their care they must evidence that by documenting it.

The Queensland Nurses Union view is that the documentation of the progress notes, which is the ongoing notes, is the registered nurse's assessment of that resident's response to those assessments, evaluations and interventions and so therefore is part of a whole process. That does not mean that for enrolled nurses who are, by virtue of their role, responsible for functions - that is, a hygiene function that they can't contribute to nursing assessment and evaluations. That assistance is nursing by virtue of their very close and continual contact with residents can't also contribute to the assessment and evaluation.

The issue comes down to workloads. As we described to you, some assistants in nursing, enrolled nurses, are looking after 16 residents. There comes a time when they simply are unable, by virtue of workloads, to then go ahead and participate in documentation as well. As Nancy described, there is an issue of non-English speaking background, illiteracy. It's not unheard of for assistants in nursing to tell us that they just merely copied the comments from a person a few days ago.

The documentation in aged care should be driven by the residents' care needs and by a professional's duty of care and the recording of evidence and recording of quality of care. It shouldn't be driven by this incredible notion that you are required to write reams and reams and reams of rubbish to satisfy validation, and so therefore how you cope with all those reams of rubbish is to ask everybody who's running Nancy's nursing home to then write; that makes no sense. There should be some sense in dealing with the documentation for accountability so that indeed documentation in aged care is professional documentation and that accountability for funding just simply is really lifted from professional documentation.

MR WOODS: Thank you for the eloquence of your answer.

MS COLE: Commissioner, can I just seek your indulgence.

MR WOODS: Yes.

MS COLE: It's interesting to be here as a nurse, because in my other experience in the community I'm a strong activist within the education system here. The question of computer literacy for our teachers has been quite considerable here in Queensland. I don't know about other states, but the majority of teachers are 44½ years of age, they're female and they're not computer literate. I think we might find the same sort of issue within our registered nurses in aged care and I just think that it would have to be considered in greater depth before that was put to them.

MR WOODS: I'm chairman of our local school board and I share your views and concerns, but there are actions to improve and address that situation and I'd hope that carries across also into the nursing profession, which I'm sure it will. One final area that I'd like to explore while you are before me as witnesses is the question of special needs. I've identified in the position paper a concern that they aren't being sufficiently addressed at the moment in rural and remote areas or for particular groups in society who may require such assistance. I'd appreciate your views on whether you share those views and, if so, whether it's a question only of quantum or whether in your view the viability supplement criteria at the moment themselves are not sufficiently grappling the needs that are very evident in those areas.

MR ROSS: I was just discussing some of the earlier comments that were made in respect of this question, and it seems to me that some of the participants and perhaps the commission was distinguishing between special needs in the nursing area and special needs in other areas and the accommodation example was used.

MR WOODS: Certainly some of the direct evidence from my own travels has demonstrated very vividly your point about holistic care, because we're talking about residents who need not only medical interventions but need support with their every existence, that they don't have immediate ability to draw on relatives or friends, that they're culturally isolated at times, that simple things like buying bits and pieces and daily amenities that can just add to their life existence, looking after their finances. I mean, it's a totality of care quite often in those areas that you don't have to draw upon and provide in nursing homes in some metropolitan areas where there are family, friends and others, and also an understanding on the part of the resident as to what they can contribute. So it is very much a "whole of life" care being provided, so I don't differentiate between accommodation and nursing care in a clinical sense.

MR ROSS: I guess the question that flows from that then is where you draw the special needs.

MS BARRY: I was going to say, if you were to go to Queensland up around the Rockhampton area, which would be considered to be provincial not rural or remote, you would find that significant numbers of those residents have actually been pulled out of their remote and rural homes and actually brought into a provincial setting, and those sorts of things about no access to family and getting - for family to see them and things, it's real for provincial, and those sorts of areas are unique. Of course it's a long-term approach to having care where people live, so it's important that whilst not losing the very unique - in Queensland in particular - needs of our rural and remote homes, and that is in reference to in particular the remotes where we have our Aboriginal communities - I'm sure you wouldn't have had the opportunity to go up to Thursday Island and witness - - -

MR WOODS: No, but I've been through the Northern Territory and seen - - -

MS BARRY: Yes, witnessed the extreme difficulties that they have. But the same sorts of things that you describe are as relevant for, you know, someone in a provincial or a metropolitan in terms of accessing. So I guess it's this whole issue of being - not generalising, which is very difficult when you're trying to create something that's an average. We would consider that "special" also includes state facilities, okay, "special" in their unique particular role within aged care within the state. They are found everywhere. They're mostly in rural and remotes where we wouldn't find a lot of profit providers, though I do note we have got perhaps private providers in even more remote sites than some state government nursing homes.

But they are to us a special need area because they are the homes of, as they described it themselves, last resort. They have traditionally taken the 160-kilo man that the private sector couldn't possibly take because of virtue of equipment and personnel. They take the expensive wound dressing people; they take the people who scream, "Help me, help me, help me, help me," 24 hours a day that you wouldn't have a hope in hell in the past of getting through the standards monitoring teams. They're special needs too. So I think that we certainly will be making comment in our written submissions on the matter of the viability funding in special needs. We probably will

give that area a bit more attention.

MR WOODS: I'd appreciate that because, as you said - and I agree - every resident is unique, but to then try and devise a subsidy system that picks that up will defeat the purpose, so there are always trade-offs in this process. What I'm looking for is some guidance from you on where those trade-offs should be. Do you have any further matters that you wish to bring before the commission? Jump in.

MS BARRY: We have been involved in the last - well, for many years, but in particular the last 12 months in lobbying about the issue of equity for Queensland. So we're enthusiastically awaiting some urgent redress of sufficient enough quantum to begin to address the very real needs of Queensland.

MR WOODS: A heartfelt comment from a previous witness. There seems to be a lot of common view expressed in the state.

MR ROSS: I think it's one of the few things we'll get agreement on in this room.

MR WOODS: When you are preparing or finalising your written submission I would remind you that my terms of reference don't extend to the issue of quantum, and I'm sure you're totally conversant with that and will direct your submission to the terms of reference I'm addressing. Thank you.

MR ROSS: We note that. I think there is some capacity to make recommendations outside the terms of reference, if I understand the brief of the Productivity Commission.

MR WOODS: We address matters that we consider relevant, yes. Thank you very much.

MS BARRY: Thank you.

MR WOODS: I'll adjourn briefly.

MR WOODS: I'd like to resume these hearings and welcome as witnesses Mr Denis Jones and Ms Jenny Orr. If you could please, for the record, give your names and the positions that you bring.

MR JONES: Yes, I'm Denis Jones and I'm the assistant federal secretary of the Australian Nursing Federation, and I would also add that I am a member of the advisory committee to the 2-year review of the act.

MS ORR: I'm Jenny Orr from Tasman Asia Pacific. My position there is senior policy analyst.

MR WOODS: Thank you and welcome. Do you have an opening statement?

MR JONES: Yes, thank you. The ANF welcomes the inquiry into nursing home funding and subsidies and, in particular, the view - the commission's view - that it expressed that coalescence as advised by the department was not a satisfactory solution to the historical differences in funding across states and territories. The primary interest of the federation is to participate in the examination of a new funding methodology in the hope that that will offer a reasonable certainty in the delivery of quality of care to residents over the medium to long term.

Clearly our primary interest stems from the nursing profession's legitimate viewpoint that care delivery should be centred on resident care and then other matters will flow from that. We are, I believe, able to distinguish that we have a singular interest, which is resident care, while providers have multiple interests or objectives, and I don't intend to say that their objectives are any less worthy, but nursing has a singular one.

The federation has a strong interest in future requirements for transparency and accountability as this involves substantially the use of taxpayer funds and its relationship to the delivery of quality of care. We also have that view because the use of funding or subsidies does and will have a direct impact on the capacity and capability of nurses to meet or exceed the relevant standards that may be required by legislation or by the government or its statutory authority in the future.

The federation also supports the view that's expressed by the industry, and in particular in Queensland, that the funding for Queensland and of course South Australia should be addressed as a priority, and we believe that should be reflected in the federal government budget. Our view is that the matter has reached a crucial stage and an excessive delay would be quite harmful to the industry in Queensland and in South Australia and to nurses and of course to residents.

I would add that whilst not the responsibility of the commission under its terms of reference to consider the relationship of subsidies to capital infrastructure needs, the ANF believes that it is a strategic issue of considerable importance and significance and that it should be drawn to the attention of the federal government,

and that's simply, we think, from an entirely logical view that you can't divorce infrastructure and standards and delivery of care from subsidies and the efficient use of taxpayer funds over time.

The commission has also placed some emphasis on the 2-year review of the act and its role and perhaps it believes that some matters can be solved by that process. I would say that the 2-year review as its currently comprised or composed is a ministerial committee and very much a relationship between the minister and the chairperson of that committee. The industry participants are advisory only, and the general consensus out there is that the industry may give some advice but it doesn't have ownership of that 2-year review, so I'm not sure that it is as strong as you might think it is in terms of a consideration of some of the matters you've raised.

I would also emphasise that the matter of workers compensation, which the commission has taken an active interest in, is a matter of considerable importance insofar that substantial subsidies are paid or the premiums are met when a great deal of work could be done on reducing the cost of premiums by more active management of occ health and safety, and some of the initial work in those practices was of course done in Queensland in the mid-nineties, 94-95, initially by TriCare. We're just also interested in the accreditation agency and its role and contribution to the influence of the commission's determination about the level of funding. It doesn't seem to have been included in the discussions, and no doubt you intend to consult them. We think that that's an important consideration before you tender your final report.

If your findings are accepted by government and there is a process of implementation we would also be of the view that the commission in collaboration with the industry and the department should be involved in the implementation of any new methodology. It would be of benefit, I think, to the industry if the commission had some continuing oversight role or involvement, given the history of funding and the problems that have arisen in the previous decade. That's all, commissioner, at this stage.

MR WOODS: Thank you, very much. Perhaps if I can draw upon your document dated 16 November which identified some matters that you would like to raise at this hearing. Picking up your first one, which you preface with "internal inconsistencies in the position paper", but perhaps if I can draw on that, you identify the question of what constitutes significant variation between jurisdictions, and it's certainly a matter that has occupied my thinking and that of the team, because it's ultimately a very pragmatic question as to whether you go to a national uniform basic subsidy or whether you recognise the differences between jurisdictions.

The evidence from Aged Care Australia's submission and to the extent there is other supporting data suggested variations of the order of 4 to 6 per cent between states and territories in the standardised labour costs. If you are then devising a national uniform basic subsidy of course the variations either side of that would only be in the order of 2 to 3 per cent, not the full 4 to 6, so I suspect you may have reached an early conclusion. The average would hopefully be somewhere between the

extremes, and so the question then is is 2 to 3 per cent also still very significant and so significant as to warrant having subsidies that relate to the circumstances of individual jurisdictions? And then if you pursue that path, how do you adjust and how often do you adjust for the dynamics in the process whereby success or otherwise, in particular wages claims or outcomes of enterprise bargaining or other changes in underlying costs, cause states to leapfrog each other and to move around?

You may end up, by having - if you judge 2 to 3 per cent to be significant it will be a different 2 to 3 per cent for different jurisdictions over a course of a 3 to 4-year period, depending on who gets what increases when, and what are you achieving successfully in that process compared to moving toward a national uniform basic subsidy, which then over time recognises the broad sweep of changes but causes any one jurisdiction that moves too far out of line up-front to incur the cost penalties of that process. Would you like to react to that?

MS ORR: First of all, the ACA data, which you're talking about, I guess the ANF and others were a little disappointed that the commission didn't undertake its own independent assessment of costs, but I guess, subject to time constraints, it's not always possible. But if the magic number is 4 to 6 per cent variation and therefore distils down to 2 to 3 per cent, once you factor in an average rate across the states it may actually be -TriCare are suggesting 12 per cent, so I guess it puts a lot of pressure on the commission to validate that Aged Care Australia figure.

I take your point too that this instrument at the end of the day - simplicity is a good thing - that you can't keep factoring in very subtle differences between states on a regular basis otherwise it becomes too unworkable to manage. The question is though at what point is difference across states significant and therefore does it warrant some supplementation to a basic national rate, even for a transition period, especially as it seems that this issue of convergence - whether wage rates are actually converging - seems to be a little up in the air still. Did the commission give consideration to a state-based supplement to the basic national rate?

MR WOODS: Certainly the state supplement would in practice constitute separate jurisdictional subsidies; that would be the outcome of that.

MS ORR: Not necessarily. It could just be for high cost states. Perhaps if two states are recognised as high cost do they just attract - just as there is a supplement for rural remote, perhaps people in facilities in particular high cost states would attract - - -

MR WOODS: Well, that's just dividing it twice rather than eight times.

MS ORR: Yes.

MR WOODS: You can divide it any number of times less than eight to have subsets, but it still is a threshold question of whether you start to make those divisions. You identified correctly one of the very key issues that the commission

must consider and that is what is the prospect over the medium term of wages outcomes across jurisdictions as to whether there will be a trend of convergence or divergence, and I was certainly looking to the ANF for a view of what the next 5 years will hold in that respect.

MR JONES: Well, it's quite unclear. There are the existing differences in Western Australia and Victoria and the Northern Territory and ACT where a gap, if you're comparing the aged care to the public sector, is in the order of 10 per cent. One can't predict with any confidence that there will be a convergence, given the current industrial relations system and possibly the overlay of funding and funding difficulties. Until that's set right it's hard to see how you can reasonably predict a convergence in the current context. It's simply not possible. There's no basis for having confidence there will be a convergence in the current context.

MR WOODS: Do you feel equally uncertain, though, as to whether there would be increasing divergence?

MR JONES: Well, there are a number of states coming on line for negotiations with providers outside of Victoria and WA and the ACT and Northern Territory, so you've got another timing factor that will emerge in the next 12, 18 months, and Queensland would be one of them, where if there are no successful outcomes to negotiations and no basis for it - the parties are unable to resolve an outcome - then the same pattern will start to emerge here. There already are differences.

MR WOODS: In your view will the increasing tightness of the market in relation to registered nurses have any impact on the evolution of a national labour market and therefore wage rate?

MR JONES: Well, shortages in nursing seem to be cyclical. They're not confined to aged care. There already are significant skill shortages in some of the key nursing specialties in the acute sector, but I can say this, that as part of the 2-year review and at a session with senior nurses in Newcastle several weeks ago it seems that there already is a growing shortage in the country, in New South Wales, and there are major vacancies at the director of nursing level in New South Wales. Now, I found that interesting because New South Wales is one state where they've maintained a proximate parity with the public sector in terms of nursing wages and it's a totally a state jurisdiction, state awards, and there's no any enterprise bargaining of any significance, yet there's a shortage emerging.

Allowing for other things, to simply put one's hope in a shortage, a skills shortage, and some pressure from the market for skilled nurses as a way to drive up wage rates or to close the gap, I think, has some shortcomings in that you'd also try to introduce a system based around quality management, which is what the accreditation system is. Unless my understanding of that system is incorrect, it relies on a skilled workforce; cross off any argument about the ratios, internal ratios between registered nurses and enrolled nurses, so I don't think an emerging shortage is necessarily going to be a solution if other fundamentals such as funding and funding methodology aren't

set in place. You simply can't deal with the matter in isolation, I'm afraid.

MR WOODS: I'm not aware of anyone proposing there would be a solution to anything but whether the dynamics of it have an impact on wage rates, of course - - -

MR JONES: The providers may have the view that they don't have the capacity for a number of reasons to deal with the skill shortage to compete against the acute sector. They would have a number of reasons why, so they may not have the capability for a number of good valid reasons.

MR WOODS: In devising a national uniform basic subsidy or even one that recognises jurisdictional differences, there must, underlying it, be a reliance on an assessment of the quality of care being delivered to ensure that that is at least at the minimum acceptable level. In your view, is the accreditation process a suitable basis for relying on assessment of minimum suitable quality of care?

MR JONES: In your report you somewhat qualified yourself about what it may deliver. The accreditation agency is approaching the matter with some rigour and commitment. It's a large undertaking - some 3000 facilities in a relatively short time, but that's not the fault of the industry or the ANF. I should say at that point the industry and the ANF supports the concept of accreditation and what it implies. We all look forward to it doing what it's intended to do and there's a fair bit of scrutiny all round on that. So ANF is prepared to contribute and participate but it's still a bit unknown because it's a large undertaking, it's new ground, and there are a number of issues relating to introducing accreditation and implementing it which go to issues of training and infrastructure and certification and the industry's other competing priorities. Allowing for those difficulties the industry is fairly committed, as we are. We certainly would like to see it given a reasonable run.

MR WOODS: Yes, and you talk about the 3000 and if the accreditation is for between periods of 1 year and 3 years it's a very high ongoing workload then to monitor that closely over time into the future as well as the initial assessments.

MR JONES: Well, it's going to be necessary that there would be periodic review of accredited facilities. Certainly with the 1-year ones it's not so much but the 3 years is, so that people having got their accreditation don't then abuse that right. So the first 3 years of accreditation will be probably the test of its integrity.

MR WOODS: Yes. Another element of our design of a subsidy is to base it on some measure of a facility that is within the bounds of efficient, and submissions put before us today suggested that 60 beds is a useful benchmark, recognising, of course, that the majority of facilities have beds of less than 60, which is a cause for some consideration. Do you have a view as to the size of facility to be drawn upon or whether, in fact, that is in any way relevant to the design of the subsidy?

MS ORR: I guess 60 beds is consistent with what we've been told, too, in discussions with people in the industry. I guess informally, though, we've heard back

that the department considers 40 beds - something like 40 beds as being the efficient number.

The department thinks it's closer to 40 and I just wondered if there has been any reconciliation process between the commission and the department to reconcile this difference between 40 and 60 beds and whether - how much of a cost driver is size as opposed to other factors which might be mistaken as a function of size which are, say, management expertise, staff skill, and just the layout and design of facilities.

MR WOODS: The commission certainly recognises there are a number of factors that affect efficiency and has evidence before it of facilities of comparable size and profile achieving very different financial outcomes which highlights, as we're all aware, the role of management and the best practice that's instituted in certain facilities. So it's but one factor to take into account, and we know the views of the department and we have evidence from industry and are drawing our conclusions accordingly. So we will resolve a final position on that in our final report.

MS ORR: Yes. I guess one thing that would be helpful perhaps if the commission noted in its final report - is that any inefficient sizes or sizes of less than 60 beds, if that is the final figure or the start of the range for efficient size, its often been a function of - as has been said earlier today - government bed allocations and not a commercial decision on the part of the industry, and indeed any rationalisation in the industry that a subsidy arrangement that is pegged to that 60 bed might encourage cannot occur overnight. With government regulations, again, on bed allocations it's not always possible to just add 10 beds to achieve the desired size and so, again, out of the hands of the provider.

MR WOODS: Thank you. We are aware of the impacts on industry, both of past practice and what would be required to achieve a transition to future, but although you need to settle on a figure of facility size to be able to generate a standardised set of inputs that that then doesn't backwardly dictate what should be the size of facilities; that merely is a basis upon which you design the subsidy and then funding will flow to all-size facilities and depending on their practices as to the degree of efficiency that they achieve. So it doesn't dictate size, it merely is a component in devising a subsidy. In that respect things like Grants Commission hearings have a similar basis of identifying standardised facilities and programs but not dictating what the actual should be in practice.

MS ORR: Yes, well, in practice that has been stated before, too, and has been perceived as - I guess just as it doesn't drive reform of its own right, it does play a role in encouraging rationalisation within industry.

MR WOODS: And rationalisation has been occurring significantly, particularly in some jurisdictions long before the term of reference came to the commission, which we also recognise.

MS ORR: Indeed.

MR JONES: Since you're going to have such a light hand on rationalisation, you have obviously also had a close look at the Victorian set of circumstances, the leasehold component and the - - -

MR WOODS: We are very aware of the Victorian situation.

MR JONES: Yes. Thank you. Well, it interests all of us, I think.

MR WOODS: Yes. In fact, in our position paper we make particular reference to the situation in Victoria, so we have spent some time and received many submissions on their particular circumstances. In terms of the question of a productivity dividend, as I have put forward to other witnesses, in devising a subsidy one of the things you look to are what are the incentives that such a subsidy offers to various stakeholders in this area. What views do you have in terms of the scope for productivity discounts in indexing future subsidy amounts?

MS ORR: In discussions we've had, the ANF isn't opposed at all to the concept of a productivity discount. It's a question of whether, though, the industry is being asked to pay twice in a sense through accreditation requiring continuous improvement. They're required to undertake ongoing works and then incur a financial penalty, if you like, to encourage them to do those financial works. So the notion is fine but I guess it's just a question of how you link that to this notion of an ongoing improvement regime, and it will be easy in setting the value of X in that scrutiny is given just to the ABS productivity index without an annual adjustment for what is happening on the certification accreditation front. I notice in the report the commission says periodic reviews are to take such things as that into account. I just thought that perhaps it could be useful if it was a little more prescriptive there because periodic reviews to a government department mean 3 to 5 years, in just the use of the terms.

MR WOODS: Yes.

MS ORR: I think in some circumstances, and especially in the next 5 years that won't be enough to factor in the increases in certification arrangements.

MR WOODS: So given the dynamics of the industry over the next 3 years or so you would feel it would be more appropriate to have a shorter period between now and the next review and then to assess at that point whether there is sufficient stability in the industry to warrant a longer time in between. Is that the thrust of your view?

MS ORR: Basically, yes, and presumably the ABS stats are coming out annually and so X can be revised annually.

MR WOODS: Yes.

MS ORR: It should just be a matter of process that when X is revised a check is made against what is coming with the certification arrangements and the ongoing

improvements that are occurring through that process.

MR WOODS: The trade-off clearly is between recognising and adjusting to the dynamics that the industry is undergoing versus some certainty for providers in what their funding might likely be over a period of time.

MS ORR: Sure.

MR WOODS: It's a matter of getting right that tension.

MS ORR: Understood.

MR WOODS: We recognise that. Again, a feature of the subsidy design that is put forward in the position paper is to look at the average cost of a bundle of inputs, not so much to dictate then the inputs that must be applied, just as it wouldn't be dictating the size of facility, but to provide a basis upon which the government could then determine a price it was willing to pay for various levels of RCS care. Again, in assessing the basket of inputs you can either choose a best practice basket of inputs, an average - which previous witnesses have suggested might just reflect the consequence of current levels of funding - or some form of standardised input basket that has been negotiated with industry. Does the ANF have a view on the most appropriate approach to that issue?

MS ORR: Well, the standardised input basket in principle has a lot of merit over average and alternative approaches. I guess it depends - the process that you're going to - that actually gets put in place to arrive at that standardised model and sometimes those processes can actually end up in outcomes that are less desirable than perhaps a simple blunt average. But assuming that all went well, then a standardised model is - - -

MR WOODS: I understand the caveats you apply in your answer. Are there particular further matters that you would like to underline to the commission in your evidence?

MS ORR: Yes, I might just raise a couple of things. In deciding the input mix I guess the commission rightly points out about this idea of concept of building in depreciation and a rate of return on investment as relevant to the basket of inputs. Does the commission have any views on how to factor in something like depreciation and come up with a standard input cost for depreciation and what sort of methods there, given that building values across Australia diverge quite substantially?

MR WOODS: They do, and also not in that field but in a related field the source of financing of those buildings has diverged quite significantly and some stock is not in the hands of the operators but in the hands of the lessor and some stock is very old and some has only recently been built. So we do acknowledge the variation in the size, style and condition of facilities and of ownership. The reason that we made reference to that is we feel it is important to reinforce that we don't perceive this as a

cash flow issue and we have come across circumstances in some sectors where the operators have been living off the cash flow and not making adequate provision for depreciation, for example, and we wish to reinforce the importance of looking at the function of operating facility on a long-term viable basis. So we understand those diversities and will be grappling with that in our final report.

MS ORR: Is the commission going to be saying much about the method of how these things should be factored in or will that be left as a secondary process, the implementation side?

MR WOODS: If you have views that you can put to us that will assist us in that process we'll take them into account.

MS ORR: Okay.

MR JONES: I just want to ask you, in terms of depreciation - and it goes to section 57(3) of the act, which is to how you may use accommodation bonds, which is for the purposes of meeting capital works, retired debt and for care, and depreciation is a factor of that. The act is not clear, nor does it seem to impose an obligation on providers to actually make the allowances that you say are for depreciation. It sets out three things that you may have as options arising out of accommodation bonds. So your point about depreciation is, I think, very pertinent to provide a responsibility for the longer term if we are going to consider a component which recognises depreciation. At the moment there doesn't seem to be an obligation. Prudent providers will do that but others may not. So the government has an interest in, I think, some obligation being carried through in the long term.

MR WOODS: I'd be pleased for you to address that, then, in your final written submission.

MR JONES: Yes, all right.

MS ORR: Just on the subject of transparency, I guess seeing the last changes - or reading about the last changes that were made to the system and then this feeling that things fell off the rails as time went by, I think it's quite important that if the commission can cast some light on how government and providers can best track the outcomes achieved under a new model over time it would be most helpful and I guess the commission's expertise in performance will come into play here. I wondered if the commission could be more prescriptive perhaps in its final report about the sorts of indicators, for instance, the department might want to report on on an annual basis so that everyone can keep an eye on how effectively the outcomes are being met.

MR WOODS: Not only to recommend on change but to recommend on how to assess whether that change has occurred and what the outcome of that has been.

MS ORR: That's right.

MR WOODS: Quite appropriate. Other matters?

MS ORR: Just as a final thing in relation to the productivity discount, I guess there is some scepticism that while in principle it's fine to impose a discipline on providers that might not otherwise be conscious of improving efficiency over time, the value of X is crucial and there are, I guess, a lot of people in the industry that are concerned that rather than encouraging efficiency improvements, if X is set inappropriately it could actually have an opposite effect, especially if averages are set in a way that already are a bit out of kilter for some residents. Then it can just compound that effect and leave some residents financially unattractive to some service providers. I guess in the absence of detail it's hard to pick which residents now would become unattractive. That probably depends on processes down the line to determine in detail what it's going to look like, but I guess there is concern there that if some residents become unattractive the department might move to - it has a more interventionist culture than perhaps the Industry Commission, shall we say, and there might be - - -

MR WOODS: One accepts this as the Productivity Commission.

MS ORR: Sorry, yes, so there may be some temptation there to move to quotas or other controls, and if in coming up with its solutions the commission could recommend light-handed approaches to anticipated problems and perhaps give examples of something heavy-handed that might not be appropriate down the track, that could be a useful guide for the department.

MR WOODS: I take on board your views as to departmental behaviour, so I note those. I also have some long experience with productivity discounts and behavioural responses to them and will take that into account as well in putting forward the final recommendation.

MR JONES: I just wanted to ask you a question. In terms of these hearings has there been much in the way of consumer representation or consumer submissions? Funding methodology ultimately affects consumers and relatives.

MR WOODS: Absolutely. We have had discussions with Council of the Ageing, with - - -

MR JONES: APSF. There are probably others.

MR WOODS: Yes, Alzheimer's Association - I remember attending meetings with them, and we've certainly ensured that they've been copied into all of the documentation, so we're encouraging them. There will be parties from the consumer side at the Melbourne hearings, so we will be having meetings.

MR JONES: Right. If I may, part of the 2-year review the question of payments of the subsidy since October 97 - there has been considerable difficulty in terms of the payment system from the department to the industry where there is - have you received comments from the industry on that aspect?

MR WOODS: We have received evidence about substantial diversion of resources into acquitting the payments and - - -

MR JONES: And delays.

MR WOODS: - - - ensuring that - both delays and having to reconcile in great detail - correct payment has been given. Yes, we have evidence on that.

MR JONES: I suppose the pertinent point about that is that very considerable weight has been placed upon providers and nursers to go to a system of quality management, which is what accreditation is or will be, yet at the point of where the revenue is derived from there seems to be a breakdown in the same degree of effectiveness and efficiency that is required of the industry prospectively. So if we're to have a proper look at efficiency, however that may be described - and it's quite relevant to look at the point of origin of subsidies and whether there is any quality assurance mechanisms - that should be brought into play in terms of the department's role and its relationship with the industry, and I thought the question of overpayments brought home rather a telling point when I was participating in a 2-year review. If we had continuous improvement then we should start with the department and work across, that's all.

MR WOODS: Thank you very much. Are there any final matters that you wish to raise?

MR JONES: We thank the commission for the opportunity.

MR WOODS: I appreciate in turn the submissions and the evidence that you've provided and look forward to receiving your final submission by 27 November.

MR JONES: We'll give it to you on time, commissioner.

MR WOODS: Thank you. At this stage then I would like to close the Brisbane hearings and hearings will recommence in Melbourne on Wednesday. Thank you very much.

AT 4 PM THE INQUIRY WAS ADJOURNED UNTIL
WEDNESDAY, 18 NOVEMBER 1998

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