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TRANSCRIPT OF PROCEEDINGS

PRODUCTIVITY COMMISSION

DRAFT REPORT ON NURSING HOME SUBSIDIES

MR M. WOODS, Presiding Commissioner

TRANSCRIPT OF PROCEEDINGS

AT MELBOURNE ON WEDNESDAY, 18 NOVEMBER 1998, AT 9.30 AM

Continued from 16/11/98 in Brisbane

MR WOODS: Welcome to the Melbourne hearings for the Productivity Commission inquiry into nursing home subsidies. My name is Mike Woods. I'm the presiding commissioner for this inquiry. As most of you would be aware, the commission released an issues paper in August setting out the terms of reference for the inquiry and some initial issues. Subsequently we received over 60 submissions, and I and my team visited interested parties in every state and the two major territories. At this point I'd 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 of you have made in the course of this inquiry already.

These hearings represent the next stage of the inquiry to be followed by final submissions due on 27 November together with comments we would appreciate on the background material that we've also circulated. I'd like these hearings to be conducted in a reasonably informal manner, but remind you that a full transcript will be taken and made available to all interested parties. I'd like to welcome as first witnesses to the Melbourne hearings Mr Bruce Salvin, Mr Greg Knox and Ms Jane Gilchrist from the Victoria Healthcare Association. For the record could you please each state your name and the position that you hold.

MR KNOX: I'm Greg Knox from the Victorian Healthcare Association, an executive officer with that body.

MR SALVIN: I'm Bruce Salvin, general manager of North West Hospital, part of the North Western health care network.

MS GILCHRIST: Jane Gilchrist from the Victorian Healthcare Association, policy analyst.

MR WOODS: Thank you, and welcome. Is there an opening statement that you would like to make?

MR SALVIN: Yes. I know we've submitted some material which basically covers our position, but you would be aware that the Victorian Healthcare Association actually represents a large number of organisations in Victoria, public sector organisations which run nursing home beds. I guess you could say that we were really quite supportive of the general thrust of the views put in the document. There are a couple of issues that we wanted to really draw attention to, in particular a proposal for the annual indexation of the standardised input bundle.

Obviously we're concerned about this automatic productivity discount. We would argue that we have been subjected to annual and productivity discounts every year for the past 8 or 9 years, and obviously it gets more and more difficult; costs continue to rise. Our position on respite care funding - although there are extra subsidies for respite care in both high and low-care facilities, we believe that the actual subsidy doesn't cover on many occasions the additional costs that a proprietor has to wear, and there's a lot of issues in regard to ensuring bed occupancy when you've got

fixed costs for wages and salaries and running the building, and if you don't have those beds full that's an issue.

In terms of the fact that we - proposal number 8, state nursing homes in Victoria have had their SAM funding - sorry, get a discounting funding subsidy from the Commonwealth. So we really support that view that we should be on the same rate as everybody else, although I notice that that - what's that other, Jane, where they're talking about taking that off us? I'll get to that anyway, but - - -

MS GILCHRIST: The timing of the coalescence.

MR SALVIN: Yes, the timing of the coalescence being a fairly big issue for us and I'm sure all our colleagues in Victoria. We support the proposals regarding Commonwealth support for residential aged care in rural and remote areas. Certainly a number of our members run very small nursing homes attached to base hospitals and small country hospitals, and it's a huge issue. In many instances people have to travel long distances to get to those services.

The final thing is really proposal 13 where the idea was to - as I understand it - in Victoria or in the high-funded states that they be left on the current funding rate where the lower funded states would be caught up over a number of years. Obviously we've got pretty major concerns about that, and we feel that it's really coalescence by another term. That's basically all I wanted to say on that.

MR WOODS: Thank you very much. Does either of the other witnesses at this stage want to make any opening comments?

MS GILCHRIST: Can I just make some comments, please, about the items that the commission invited comment on? One of them was the alternatives to varying payments each time a new resident replaced a previous resident. It is a problem particularly in the smaller homes where a resident that's, say, category 2 with high funding is replaced, say, by a category 4 resident, particularly in the small homes where they don't have a large pool of people on the waiting list to draw from in smaller communities.

In the larger homes you could probably manage the cash flow over the year, but the sort of immediate changes in the funding by change of resident demand an immediate response in terms of staffing, perhaps reducing nursing staffing by 4 hours a day or something as a result of that, or 4 hours a week - and then you most times don't have the flexibility in terms of employment to reduce hours like that. It just isn't workable in terms of staff relationships, and doesn't perhaps necessarily reflect it in the staffing needs of the home overall.

So a more flexible way for homes to be able to respond to changes in classification mix would be valuable, and we did have some concern about the inflexibility of the funding overall. While we can appreciate the need for outcome-based funding, the way the funding operates is so tight there's very little

flexibility to put in place mechanisms which perhaps would age the aged care system as a whole, the effectiveness - for example, for homes to be able to keep one bed free for emergency admissions from the community, things like that which just make - some of the larger homes can do that, particularly the homes at perhaps the church voluntary homes in the public sector that have sort of a view of operating for the whole of the health or aged care sector, but in commercial terms it's really not possible.

The other issue we wanted to talk about was the two-tier concessional resident supplement. It does appear that by having to keep up the level of concessional residents to get the additional funding, this adds another sort of layer to the administration of the waiting lists in that homes would be encouraged to select a resident whose concessional status - it sort of has a perverse result that people who are able to afford accommodation charges would not be selected for admission to residential care, and again it just adds another level of administration and sort of complexity to the whole system.

In terms of another round of changes to the income and asset testing, we'd be strongly in favour of no changes at present in terms of the community acceptability and the demands on residential care staff and the people who assess people for residential care like aged care assessment services. To change the system again I think would be extremely difficult for them just when they're sort of getting it down, and I think our view is to wait until the outcome of the 2-year review.

We also supported the first proposal 3 about linking subsidy rates to the cost of actually providing the benchmark levels of care. That is obviously a very acceptable proposal. There are questions about what is an efficient size and average input mix and how would that be determined, and we would favour a panel drawn from the industry to form an expert panel to make those sort of arrangements. That's all.

MR KNOX: That covers most of what I'd like to say. Perhaps just to go back on the issue of extra support for rural services, that's a particular issue for a lot of our members as Bruce said. We'd be concerned that the special needs funding pool there recognises the needs of Victorian homes. We know that in some other health care areas where there has been special funding provided for rural facilities, it's perhaps been directed at very remote agencies which Victoria by the nature of its geography has missed out on some of that additional funding, but as we have stated there, our rural homes - particularly the smaller nursing homes - have some special needs in that regard that we would like to see taken account of.

MR WOODS: I'd like to pursue that in the course of your evidence a little further if I may. Can I pursue some of the matters that you raised in your first submission. I notice on page 1, the last dot point under item 1 where you talk about the much greater emphasis in effect on short-term pre-terminal care which is relatively costly. I understand that although the average length of stay had been decreasing over some years, that currently there is some trend marginally back up the other way. I don't know if you have got any statistics for your own homes on that, but could you also

describe for the commission the sorts of costs involved when you have shorter length of stay and therefore in any one year more residents?

MR SALVIN: Certainly. We haven't got sort of stats that could be generalised across the whole public sector nursing home industry in Victoria. I mean, it's primarily anecdotal I guess with several providers experiencing that. In my own experience we have had a number of residents with a sort of uncertain prognosis with a terminal disease in an acute hospital, been in there for, say, 40 or 50 days staying in an acute hospital and then referred for residential care, the costs really are associated with not only supporting the resident through that final phase, but also the family issues associated with it, the social issues around people coming to terms with their impending death, and certainly there's a lot of - particularly with the new residential agreements and the funding arrangements and all that, it's really quite complex to get families settled about the administrative issues associated with admission to a nursing home.

I operate a 120-bed hostel in Parkville, and we have a large turnover there. It's nothing for us to have at any one time 20 agreements that were currently out to people on the waiting list. So high turnover - not only that, it's the cost of the paper, producing it, getting people to understand the implications of it. There is a lot of time taken up for manager and administrative staff in that.

MR WOODS: Interestingly you refer to the time taken up by management and administrative staff. We've heard evidence from other witnesses that nurses, particularly the DON, is also heavily involved and therefore the greater the number of residents to admit and discharge in a year, the greater therefore the amount of work involved in the initial assessments and the settling-in procedures and the documentation required of the department and the like. Is that also a feature in your homes or do you see the burden mainly being on the managerial and administrative staff?

MR SALVIN: Well, no, I think it's really a big issue from the DON and it takes away from supervision of other clinical duties that I guess they would - whenever I go to recruit senior nurses like that, I sort of like to say to them, "Look, if I wanted you just to be a manager I'd be recruiting a manager. I want somebody who has got good clinical skills as well and can provide that clinical leadership." My experience is that it sort of can divert people away from a fairly core aspect of their role, that is, actually supervising the clinical activities in the home. It's all about good resident and family care, ensuring that everyone understands, and there are a lot of expectations around that, but it is complex.

MR WOODS: Thank you. On page 4 of that submission you refer to the fact that only 10 of more than 60 public nursing homes in Victoria are larger than 60 beds and then you add, "which is widely considered to be the economic minimum". In your rejoinder submission you refer to that other data suggests 45 to 60 beds may be efficient. Do you have a view from your own homes as to where on that spectrum if you were doing some form of benchmarking and devising a national uniform basic

subsidy what sort of facility size you would choose to structure a standardised set of inputs?

MR SALVIN: The reason we focus on multiples of 15 is because of the Nursing Award issues in Victoria. So that's why it tends to have gone, you know, 30, 45, 60. I think we've sort of got both extremes. There has been a large number of institutional nursing homes in Victoria, you know, very large size, but there's also a combination of 15 and 20-bedders. I guess from most of what I can garner from my public sector colleagues, I would say probably 60 would be our preferred, but certainly we do operate - I know I personally operate one 40-bed and one 45-bedder, and the 45-bedder does better financially; it's a more viable proposition.

MR WOODS: Of course structuring any subsidy based on a standardised set of inputs doesn't then dictate what the size of the home would be; it's just that you have to for the purpose of the exercise determine some level that - I draw from your considerations there that 60 is not an unreasonable figure to work on.

MR SALVIN: No.

MR WOODS: You talk about studies to the extent of rurality. Clearly this has been an issue that the commission has noted and has taken up in its position paper. I'd appreciate some elaboration of rurality as soon from the Victorian perspective so that I can then compare that with my understanding of it in some other jurisdictions.

MR KNOX: I don't know that we have done a lot of particular work in respect of teasing out, say, how far away from a major centre for nursing homes you would consider a facility to be rural. Really I suppose for our members they would be grouped into three groups: the metropolitan services; the provincial services in the large centres such as Ballarat, Bendigo and so forth; and the others would be rural. Out of those I suppose as a guide multi-purpose services would indicate that there are about four or five or perhaps half a dozen services that would be regarded as remote rural under the previous guideline.

But we'd probably have another 30 or 40 agencies, while they don't meet that criteria certainly they'd be perhaps more than three-quarters of an hour to an hour away from a major provincial centre. So therefore they need those type of services provided within easy reach of the residents in that particular area.

MR WOODS: I mean, distance or time travelled from a major centre is one factor, and certainly it shouldn't be the only factor taken into account, but we've heard and seen evidence of very contrasting situations where the three-quarter hour trip takes place totally within large metropolitan areas to get to the same distance travelled to the nursing home versus small towns outside of large provincial centres that are also 40 or 50 kilometres away, but in effect some of their patients are retiring from the provincial centre to the more rural aspects of a nursing home in a country town. In that particular instance it was located on the beach and looked over the river and did

all of those sorts of things. So distance itself is necessarily only one factor that was to be taken into account.

MR KNOX: I think the experience of our homes would be that they're for the local community, so it's not so much people retiring to a seaside home in some respects, but - - -

MS GILCHRIST: It's also the social aspect, too, of people living in a small community say for example Kaniva or some of those small - Dimboola, some of those smaller western Victoria towns, and as their cohort is also elderly and unwilling to drive, even though for a young person it's only 30 minutes in the car into the main centre, older people aren't able to do that if they no longer drive, and then if the person has to go into residential care in a large centre, they become cut off from their community. So although the distances aren't large, it depends on the target population that you are thinking about.

MR WOODS: And multi-purpose services, are they a way of providing greater flexibility and dealing with some of these issues or at the moment is that still administered on the basis of you may have an aggregation of funds, but you still have to apply each component of the funds to the source from which it was derived?

MR KNOX: No, those sorts of programs are expanding within Victoria. I think there are six multi-purpose facilities at the moment and they're looking at at the moment perhaps create another three. Then there's a particular state-based program called Healthstreams which also integrates funding or groups up funding from various sources, but that cannot touch the aged care component because that's as you realise a Commonwealth source, and that has about I think also half a dozen agencies.

So certainly that offers scope. They wouldn't just direct those funds to the original services; they would actually look to perhaps expand community-based or home-based primary care-type services.

MR WOODS: On page 5 of that submission you referred to many tasks in nursing homes and hostels could be undertaken by patient care attendants provided they have an appropriate TAFE qualification. Can you expand on that a little and in so doing advise on the extent to which training for patient care attendance is being upgraded and improved over time?

MR SALVIN: Basically I know I've had some personal experience in that in that same hostel that I mentioned before. We've actually organised with a TAFE college to do accredited training for some of our untrained previously classified as nursing attendants. We've upgraded their skills to personal careworker qualification, and entered into an enterprise bargaining or an Australian workplace agreement with those staff. It's worked out pretty well or very well indeed for those people I guess.

In our high care facilities we have tended to stick more towards both division 1 and division 2 nurses. So we've used the combination of registered nurses and

enrolled nurses. It's sort of something that we've had some difficulty with in the public sector. We've got, you know - there's big professional industrial relations issues with the nurses, the further role out of personal careworkers in public sector nursing homes. We tend to multiskill all our other tasks around the direct care so we have people who work laundry, kitchen, cleaning-type, handyman-type roles, but we haven't really - I'm not aware of a wide use of personal care attendants in public sector nursing homes, but it's certainly something that we continue to look at as we're more financially stretched.

One of the things that I didn't go into a lot of detail on, we currently have public sector pay rates for nurses in Victoria which has affected our aged residential businesses where we're paying the staff somewhere between 9 and 13 per cent more than private and voluntary sector at the moment, so we're stretched financially, so we're looking at other alternatives.

MR WOODS: Do you find that as the training opportunities for patient care attendants improves that there is any significant change in the quality of care as the mix of staff changes?

MR SALVIN: I think there's a direct relationship. I think it's an enabling-type process, and the course that I was personally involved in was a nationally accredited curriculum that came out of Tasmania, and it certainly gave these untrained staff - although they were experienced, they had had no formal training, and it's certainly I think improved their ability to work with residents, particularly where the residents had dementia and was a little bit more accepting of some of those difficult behaviours, so the staff were able to better handle the residents. I think it gives them a feeling of confidence in dealing with families and all that sort of thing as well.

MR WOODS: And in itself then leads to a better patient outcome.

MR SALVIN: Yes.

MR WOODS: Would you like to comment on that?

MS GILCHRIST: Nothing to add.

MR WOODS: You referred in opening comments - and it was Ms Gilchrist in particular who used the word flexibility. When I look to your substantive submission, I interpret it as supporting in fact greater reimbursement of costs - both on page 6 and 7 you're talking about it at a jurisdictional level, and then across on page 9 you talk about it at an intra-jurisdictional level saying the differences within states should also be recognised.

I can't immediately reconcile how tying the subsidies in some form of matrix closer and closer to your actual costs incurred then provides a subsidy funding model that generates some level of flexibility. If you pursue the ultimate of reimbursement, then you get funded what you spend, but you then get tied as to what you can spend it

on. How do you resolve those views, and what is on balance your preferred position? You may want to address that in any final comments you make before the 27th. I certainly invite you to explore the consequences of finer and finer grading of an in effect form of reimbursement which the obverse would be that then they're prescribing to you what it is you're going to do with those funds whereas I notice that your opening comment on your rejoinder notes is that you support the general thrust of the preliminary proposals 1 to 3 and particularly number 3. So if you could address that for me, that would be helpful. There's reference on page 13 of vacancies emerging. Now, is that in your sector in particular or is that across homes in general in Victoria, or does it relate to one of the other sectors? It's page 13, fourth-last paragraph in the middle. You talk about significant numbers of vacancies in many nursing homes for the first time in living memory.

MR SALVIN: I can certainly comment on my experience from the western metropolitan area. It certainly seemed that the Commonwealth changes that came into - you know, the whole uncertainty around nursing homes and accommodation bonds and charges had a big effect on nursing homes in our area in that there were a significant increase in the number of vacancies, that people were either staying at home longer or not going to homes. We were in the process of transferring large - 180 nursing homes beds for the private sector during the course of last year and I guess we expected that not all the residents would want to go to the new private homes, they would select other homes at that time, and the occupancy fell away. I think 50 of our residents were able to transfer to other homes of their choice within a sort of 5-month period and we would have expected that would have taken a lot longer.

So generally - I mean, we auspice aged care assessment services as well and the feeling I was getting from them was that there was a much higher number of vacancies within our sector. So I wouldn't say - I mean, I can't comment for the other sectors but certainly I felt that it was a more general regional thing than just in the public sector.

MR WOODS: I noted also that on page 10 of your submission you made the observation at the top that if coalescence proceeds, up to one-third of Victorian nursing homes beds would be forced to close and indicating that's sort of in the order of 5000 beds, and the effects on the acute hospital system would be catastrophic. I compare that with your comments where you support the general thrust of our preliminary proposals and whereas they're not of the coalescence variety currently proposed by government they do eventuate to a national uniform basic subsidy. Do the two views reflect a sort of further consideration by your organisation?

MS GILCHRIST: I think the comments about the support for the proposals was a different funding based on the input to achieve the desired outcomes, which was seen as substantially different to the current model.

MR WOODS: Rather than just being a mathematical conclusion of what exists now.

MR KNOX: We take account of the different costs in different sectors.

MR WOODS: Yes.

MS GILCHRIST: And also that I think the homes that would be most threatened under the coalescence would be the small rural homes too, which are probably the most vulnerable ones in our sector and again, given the comments in the position paper - - -

MR WOODS: So the totality of the package makes you more assured of where it's heading.

MS GILCHRIST: Yes.

MR WOODS: That's heartening. Certainly there is a viability supplement that currently relates to certain small rural and remote, but the question then is as to whether there are design problems with that supplement as distinct from just the quantum of funds applied to it. I don't know if you have a view as to whether the criteria that underlie the viability concept as it currently is, are appropriate or whether they also need re-examination versus whether the quantum applied to that area is sufficient.

MR KNOX: Certainly those changes have impacted on quite a number of our rural agencies or rural nursing homes. Whereas previously they were getting access to - I think it was 24-hour residential nurse top-up funding, under the new viability supplements they no longer have access to that and that reflects really I suppose the industrial situation for a large number of homes in Victoria, the awards that they have to meet with their staff. So we would like to take account I suppose in any viability supplements some of the local conditions that prevail for our homes.

MR WOODS: You refer in your second submission to some concerns with opening up the extra service areas and you talk about exploitation or potential for exploitation of residents. If the taking up of extra service places was an option pursued by those residents and/or their families who so wished, but that the standard level of care - and extra services is primarily the accommodation component, not in the care component anyway, that that was the default base, I don't fully understand how exploitation would occur under that scenario.

MS GILCHRIST: Our concerns were that people often don't have sufficient information. It's a stressful time when people decide, often after a crisis, to move into a nursing home, for example as opposed to a hotel where people might make the choice over a longer period of time. It's difficult for families often to check out the homes that are available, to assess them. If people have - - -

MR WOODS: To find one with a vacancy.

MS GILCHRIST: Yes, and don't have perhaps the knowledge. I think people who work in the industry when it comes time for their own relatives to find a home, they find it altogether a different ball game when they're involved themselves and it can be quite difficult. So provided there was sufficient information available to people in the community about what was the standard level, what was additional levels, I don't think we'd have problems with it. But we just were concerned that if people had insufficient information it would be very difficult to make those judgments, often when they're under time pressures and it's a stressful time.

MR WOODS: We note that over time many facilities offering the standard level of care are in fact moving to a single-bed ward with either a dedicated en-suite or maybe a shared facility with the room next door. If that trend continues is that potentially going to undermine what previously constituted some of the extra service market anyway? Is that not an area that you sort of have enough experience with to - - -

MR SALVIN: I mean, we provide in all our new facilities that level of accommodation and don't charge extra service for it. So I guess my observation has tended to be it's the type of cutlery on the table and the tablecloths or a glass of wine with meals and things like that. So I think the accommodation, really the standards for that have been really well established and we wouldn't be interested really in charging extra services for that, just for the standard of a building really.

MR WOODS: In your opening comments there was mention made of a point in your second submission about the difficulties when residents who were at, say, ones and twos - if several of them leave and you come back in with picking up threes and fours, particularly in rural areas where you're providing the community service so you're not picking and choosing between residents who match your staffing profile, you're actually just there meeting the needs of those in the community, I understand the concern you raise but I don't note an option. We've had certain discussions with other witnesses about the possibility of averaging over a period, whether it's a 3-month average or a 12-month average, and there are certain design concerns about that as to what behaviour that might then generate on the part of proprietors to maximise revenue and the like. But do you have a view on where you would like to see the preferred way of resolving this issue?

MR SALVIN: I think that sounds like an eminently good suggestion, you know, some sort of way of - that there be a transition. The difficulty, you know, the sort of experience we've had is like having to go back to the staff and saying, "Well, we've got to lose 4 hours a week," or something like that. Who's going to lose a half-hour a day really, particularly in a rural community? People sort of tend to live up to their income. So we don't have the flexibility of employment. What we tend to do in the metropolitan area is only sort of recruit up to a certain level and have casuals covering the rest, which is also not ideal.

MR WOODS: Yes, we've noticed the degree of casualisation in the labour force and I'm wondering if some improved way of predicting future income would reduce

that so that proprietors have greater certainty out over a period of time and could plan accordingly. I take your evidence would be in support of that.

MR SALVIN: It also can mean that you don't take the person in the greatest need off the waiting list as well. So it's particularly hard in a rural area, but even in a metropolitan context, you know, you may be taking the person to match the funding as opposed to the person who's in the greatest need and has been waiting the longest.

MR WOODS: You also refer to the two-tier concessional resident supplement and supported the view that everyone's at $12. But then you use the phrase of penalising those who drop below certain proportions in some way. One way of looking at the current arrangements is exactly that, that you get penalised because you drop to $7 if you haven't met your proportion. So I guess one could argue that the current system is designed to achieve that end. But do you have any alternate proposals?

MS GILCHRIST: We're thinking in terms of maybe a lower base rate and then additional sort of incremental ones for each additional person rather than - in some areas, because the proportions are set on a regional basis for individual areas within those regions. It can be difficult I guess because of socioeconomic-economic differences in the regions.

MR WOODS: Are you proposing some form of smoothing between the two?

MS GILCHRIST: More a sliding scale than a precise cut-off.

MR WOODS: Thank you for that. Are there any matters that I haven't raised that you'd like to draw to the attention of the commission or have we explored those submissions?

MR KNOX: I think we have explored those submissions, yes, thank you.

MR WOODS: I appreciate the time that you've obviously put into the submissions and coming along here today, and I'll have a short adjournment.

MR WOODS: I will recommence the hearings. The next scheduled witness is Dr Segal. Is Dr Segal available in the audience? That being not the case, I will then move to our next witnesses which are Mr Francis Sullivan and Mr Richard Gray from the Australian Catholic Health Care Association. Welcome, gentlemen. Could you please give your names and positions for the record?

MR SULLIVAN: Francis Sullivan, executive director of the Australian Catholic Health Care Association.

MR GRAY: Richard Gray, director aged care services, Australian Catholic Health Care Association.

MR WOODS: Thank you. Do you have an opening statement you wish to make?

MR SULLIVAN: Yes, thank you. Firstly through you, Commissioner Woods, we'd like to express the association's and its members' gratitude to the approachability and access of the Productivity Commission over this inquiry and the cooperation of its officers with our staff and members in giving us information in the early days about the scope of the inquiry and the type of submission you were looking for. From the outset it's important to state that the Catholic aged care sector accounts for over 500 services nationally, including up to 17,000 nursing home and hostel beds. In addition to residential aged care, these services encompass community and home care for the aged.

Catholic aged care service is not restricted to metropolitan areas, but are located throughout rural areas and in country townships. The federal government's aged care structural reforms need to be seen in the context of the wider community debate concerning aged care, health care and community care. Although residential aged care services are provided in both for-profit and church and charitable sectors, Catholic Health Care is totally committed to the concept of non-profit service provision. Our providers do not warmly embrace measures which can modify aged care services as if they are merely another product for purchase on the open market.

We contend that our services are more akin to social goods and integral to the social fabric of the community. Fundamentally the ethos of Catholic aged care does not sit comfortably with the for-profit modus operandi. Based on our own survey our sector, 55 per cent of Catholic aged care facilities provide over 50 per cent of their accommodation to financially disadvantaged people. Approximately 15 per cent of Catholic facilities cater almost exclusively for financially disadvantaged people. This ethos and tradition is fundamental to the providers of Catholic aged care. As a country we have developed a residential aged care system where the elderly are entitled to quality essential aged care and support particularly in their last years.

This access is based on clinical need. This entitlement is inextricably connected to our concept of community, our appreciation of social responsibility, and our respect for the dignity of all members of the community regardless of age, background or circumstance. This entitlement system is an obvious extension of those accrued

under Medicare for medical nursing care. Nursing home-type patients are under no obligation to pay entry fees or income tested charges if they are accommodated in public hospitals. To date the government still maintains a commitment to universal health coverage, however it is increasingly adopting a user-pays approach to the sick and frail members of our community who are in the last weeks or months of life.

Altering universal access to nursing home care will make the coordination and linkage between residential aged care and the acute and community care sectors more challenging. The adequacy of funding for residential aged care and the provision of resources for capital refurbishment of the sector are key issues that still require resolution. ACHCA welcomes the Productivity Commission's preliminary proposal that the coalescence of basic subsidies for high-care residents in nursing homes and hostels should not proceed in its current form. We also agree with the proposal that in combination with resident charges, government funding should be sufficient to support the level of care required to meet the accreditation and certification requirements.

Whilst basic subsidy rates should be linked to the cost of providing a benchmark level of care using an appropriate input mix, we do not agree that this should be based on an efficient-sized facility, whatever that means. Additional funding support for smaller nursing homes in rural and remote areas should be an automatic subsidy right and should not come from a special needs funding pool. Funding pools have a habit of contracting over time or being done away with by subsequent governments. An example of this was the contracting of the capital funding pool by the former Labor and now current government.

We contend that funding for services in rural and remote areas should be a priority, and we agree with the commission's proposal that the Commonwealth government should develop and cost new special needs funding arrangements in consultation with providers, residents' groups and state and territory governments. We also agree with the proposal that increases in basic subsidies should be based on an annual increase in the cost of the standardised input bundle necessary to deliver the benchmark level of care. However, we cannot agree that this should be subject to a productivity discount.

We also agree there should be periodic reviews of the industry's cost base and of the adequacy of subsidies in light of the changes and the care requirements. The commission's proposal there should be no requirement for providers to acquit subsidy payments under the proposed regime certainly accords with the current practice in operation since 1 October 97 which has removed the over-regulated acquittal system under the previous nursing home subsidy regime. The commission however did not comment on the fact that providers currently have to issue an annual signed statement regarding their prudential arrangements with respect to accommodation bonds, but do not have to provide any form of annual statement setting out that subsidies received had been spent in accordance with requirements under the act.

The commission also proposes that the regulation of extra service provision should be reduced, and that the controls on what constitutes an extra service wherein a facility and extra service places are provided and the price charged for such services should be abolished. ACHCA considers this will have an unintended consequence in terms of access and equity. As a technique for injecting additional income for capital regeneration, it will force those hostels with all single bedroom en suites to convert to either an all extra service facility or offering no extra service places. The proposal will produce visible inequities in the provision of hotel services with some residents in the same dining room being offered an a la carte silver service and alcohol with meals, whilst the non-extra service residents will be treated maybe as second-class citizens.

The Productivity Commission's position paper discusses allowing people to pay for a higher standard of care and that providing equity of care does not necessarily mean there should be one quality standard for all. This language suggests that the standard and quality of nursing and personal care provided to residents would vary according to their capacity to pay. ACHCA considers that a fundamental principle of access to aged care should be that the same standard and quality of care is provided to all regardless of capacity to pay.

The expansion of the user-pays principle should only apply to the additional hotel services and accommodation style and should not apply to short-stay nursing home residents. ACHCA is disappointed that the commission did not highlight that 66,000,000 of concessional supplement moneys was removed from the care subsidy pool. The intention of this supplement was as a capital income replacement in lieu of the loss of the accommodation bond or accommodation charge from financially disadvantaged residents. ACHCA considers it fundamental that providers separately identify capital income for capital regeneration purposes from recurrent subsidy and daily resident fees for the purpose of daily care.

Emerging of these two elements will lead to the sector subsidising care from capital income and failing to adequately regenerate their capital stock. ACHCA welcomes the opportunity to contribute to the Productivity Commission's further deliberations. Thank you.

MR WOODS: Thank you very much for both those introductory comments and for the submissions that you have put to this commission to date. I notice some of the matters that you raise both then and in the written material went into questions of quantum - and I'm sure you've read our terms of reference carefully and understand those matters that I will be addressing in my report to the treasurer. If I may pursue some of the matters that you put forward in your written material but also then pick up in relation to your opening statement.

In your first submission to us, you referred to over-award payments as not being particularly common in the sector, but are necessary to attract staff to more remote areas. Could you elaborate a little further for the commission on the extent of such over-award payments, both in terms of their quantum over the base award, but the extent to which it is becoming more common practice in those areas?

MR GRAY: We haven't actually conducted any formal study to ascertain the degree to which over-award payments are a common feature in the sector. However, we could certainly provide some further submission evidence on that for you.

MR WOODS: It would be helpful to assist us in understanding some of the dynamics. We have received evidence in terms of attracting and retaining staff in those localities and in the costs of providing short-term replacement staff where you need to provide accommodation, etcetera, as part of the - of ensuring that you can have staff to those centres, but that would be helpful. You then went on to say that:

> The current disparities in wage costs across and within jurisdictions is likely to remain whilst there are state awards.

A matter of concern to the commission in devising an ultimate recommendation in relation to a national uniform basic subsidy is to assess the significance of any variations between jurisdictions, and clearly wage costs goes to the heart of that. Is it your view that if we were to look out 5 to 10 years, that the current disparities between jurisdictions is likely to remain or are you of the view that the dynamics of the industry, the potential shortage of RNs at a national level and the like may cause some convergence in wage rates across jurisdictions? Where do you see those dynamics?

MR GRAY: There has certainly been a trend towards convergence, so there's no reason to believe that that convergence wouldn't continue, but of course it could actually plateau out, but certainly over the next - I would believe over the next 10 years, whilst the convergence may continue, we will still see a disparity.

MR WOODS: Would it be a disparity though, that locking in the current differentials would give equity over time. One concern I have is that some jurisdictions - clearly there will be wage outcomes as a result of industrial process which may cause relativities to change, not just the direction of movement, and that if you have a situation like we do under the current RCS scales, that could lead to inequity.

MR GRAY: It's also a question as to whether the current disparity in subsidies is leading to the disparity in wages. I mean, if for example all the subsidy levels were brought up to the same then that would lead to wage increases in the lower subsidy states and would hasten convergence at a greater rate than it is probably occurring. But there is clearly an inequity in the subsidy levels and obviously in the wage rates for the same amount of work performed by the same skill mix.

MR SULLIVAN: Just to add to that too, it's very difficult to crystal ball gaze, isn't it. I mean, at the end of the day what we're seeing also in wider government policy is a greater concentration on particular issues of regions in the country, and you can see scenarios playing out where there will be continued disparities - what appear to be inequities, even in wage levels, because of other matters. I think that's what we were

trying to say in the first place. The overall funding of aged services is caught up in a bigger issue about how we are approaching human services in general in the economy and how the Commonwealth in particular is trying to manage that set of outlays.

But on top of that, this is an example where other factors have come in that have created a history on wage increases or at least setting wage benchmarks in certain regions. I don't really believe that those factors will alter as fundamental forces over the next 5 to 10 years anyway, in our community. That's the hard part.

MR WOODS: You did make reference to the difficulty of crystal ball gazing. Nonetheless, I'm - - -

MR GRAY: Charged to do it.

MR WOODS: Well, very keen to ensure that any recommendations I make have relevance over time and not just address a snapshot of history as it currently stands. Therefore, this is a question I will continue to ply around the country as we hold our various hearings and garner as much evidence as I can on those matters. I must say, I don't have a clear view as yet from the evidence that I have. There are various views put to us. You then go on to say in page 4 of your first submission that:

> The introduction of national uniform subsidies will force efficiencies and savings in administrative costs -

but then you put the caveat -

> but will also lead to lower cost and quality of care, as well as reduced access.

Is there a form of design principle in constructing a subsidy that will lead to the efficiencies without detracting from the quality of care, or is the quality of care more an issue related to quantum of funds and less to the design of the subsidy principles?

MR GRAY: I think quantum of funds definitely is a driver in quality of care, because of the skill mix that the funding enables the provider to deliver in terms of the needs of the resident and the care that must flow from that and the achievement of good quality, although quality in itself isn't dependent totally on money. It's an attitude thing as well as a processing that is employed within an organisation. But in looking at how a funding model would be constructed, the challenge is in arriving at any form of uniform funding model based on an average of any sort is going to create disparities within the sector, because the sector, as you're aware - it's a very complex sector. I think of one of our three-bed approved hostels in Warrnambool and the capacity for an average or efficient-sized facility-based funding model to enable a three-bed facility or any facility that is of low bed numbers to be able to economically function.

So I think a model has to take into consideration a range of elements, which would include size, because size relates in many cases to location and therefore is a

feature of access and a fundamental access issue - location obviously is an issue in terms of cost differential - and obviously skill mix, which is dependent on the dependency levels and profile of the resident mix of the facility. I suppose the challenge in constructing any model is to take all of those elements and identify how they would combine in a reasonable approach to delivering a fair and equitable funding approach.

MR WOODS: I'll pick up the question of skill mix in a moment. But if you do start to chase each of those elements to its end, my fear again, as I was discussing with a previous witness, is that we end up with a cost reimbursement process and I don't have any confidence that that will produce the best outcomes for the industry, nor will it provide flexibility for the providers of homes, and you'll get the funding required according to what prescription there is as to the inputs you need to apply. Do you have a view on that?

MR GRAY: Well, I'm not sure that it would necessarily be a strict cost reimbursement approach, simply because the RCS now is a resource allocation tool that allocates resources according to relative care needs of each individual resident. Therefore, providing a funding system was basically that which had some supplemental additive to it, to compensate for those other variables, then that could be a possible approach.

The basic problem with the RCS at the moment, in terms of resident change, is the fact that a nursing home that would expect to have RCS1 to 4 and has an aged care assessment team provide a replacement resident which turns out to be somewhere between RCS5 to 8 - that's an issue of the way the funding works at the moment, rather than if it operated under the old system, the default was RCI5. At the moment the default is RCS8.

MR WOODS: Do you want to expand on that?

MR SULLIVAN: No, that's fine.

MR WOODS: I had noted that you had raised that particular point and I was curious, within the experience of your part of the church and charitable sector, whether that is a frequent issue or an occasional issue. I mean, what is the magnitude of the problem?

MR GRAY: We haven't surveyed the sector to identify the magnitude of the problem but it has been raised by a number of nursing homes with me, as a concern, in terms of the viability of the nursing home. So it is a viability issue for the smaller nursing homes. That's the issue - is that any nursing home that is of average size, which in our case, over 50 per cent of our nursing homes and hostels have 40 beds or less - that any facilities of that size, it is an issue.

MR WOODS: Thank you. You make reference in your submission to the importance of having a seamless and integrated approach between residential

community-based care and acute care. You explore in part the issue of some form of extension of funding that is acute care or palliative care based for short-term terminal residents in nursing homes. Can you expand on that view a little for the commission please?

MR SULLIVAN: Yes, it's probably more a - in the first instance it's a philosophical position we have taken in the overall reform debate, because we are increasingly seeing a high percentage of nursing home residents are staying in a nursing home - about 60 per cent of them for less than a year. Some would argue that figure goes down to less than 6 months. We're using the information from the Institute of Health and Welfare statistics on that. Primarily, people are saying that the basic service residents receive is a health, palliative care service.

Therefore, since some of the people who actually own our nursing homes actually own hospitals as well and the general thrust of our sector is to see more integrated services across the continuum of primary acute into community-based care, we're firstly saying there shouldn't be a financial disincentive between someone moving down that continuum. We're in particular saying why, in the first instance, if a person can receive a similar if not very similar service in a nursing home to that that they can receive in a public hospital - and in some cases public hospitals are acting as that function in country regions anyway - why have we got a different funding system in place, because clearly there will be a disincentive on the part of residents moving if they believe they're going to have to pay more. The debate about whether they should and shouldn't pay is separate to the fact that they are, and that there's a disincentive there.

Secondly, the general thrust of the aged care reforms have been about trying to merge a nursing home and a hostel into an aged care facility. So in effect it's trying to blur the services, one could argue to meet a financial agenda rather than particularly a service one, although there are benefits of course in ageing in one place and so on. So our general view has been that if the overall policy of government is to try and find sustainable links between acute care and the residential sector, then we need a consistent funding model.

Previously the government was pushing a casemix model based on ANDRGs for hospital care. They were also trying to use that for private hospital care. Most academics would say that that classification system is unsuitable for extended care consumers and cases. However, work has been done on that in the rehab, mental health field and the like. There is - you know, albeit tentative - work starting in the palliative care area.

So all we're saying - we're signalling the fact that at the moment there is an obvious incongruency between short stay nursing home residents and how we're funding it and how similar services are being provided in the public hospital sector and the fact that most governments are signalling that possibly nursing home type residents in public hospitals are being catered for in an inappropriate setting. So by implementation it must mean they would prefer them to be catered for in the

residential care setting or the home care setting. We're simply wanting to raise the issue that there's an area of reform needed.

MR WOODS: Are you experiencing, in your Catholic homes, pressures from neighbouring acute care facilities in hospitals for early discharge and - - -

MR SULLIVAN: Sure, yes. That would be across the board. It wouldn't just be Catholic homes.

MR WOODS: No, but it is in your sector as well. What we are seeing here are a set of pressures that, as you referred to the ageing in place approach where somebody changes the nature of their accommodation from separate living to hostel accommodation and that's a legitimate choice and activity that says they now want to move their capital and their accommodation from one to another but that ageing in place will lead to greater acuity over time of their requirements - and that brings with it one funding perspective. The alternate pressure is what is the most appropriate, and I add efficient, way of providing residential palliative care outside of the acute sector, other than in identified palliative care centres. Nursing homes clearly fit into that model as well but how do you at a practical level identify the boundaries and recognising as we have seen in fact instances where discharge from the hospital on the assumption of short-term palliative has led to longer term - - -

MR SULLIVAN: Longer term resident, yes.

MR WOODS: - - - residential, so it's not an easy matter to resolve, but clearly if you look from either spectrum, there follows a logical conclusion as to the funding model, but when you look at nursing homes there, the conjunction of the two - - -

MR SULLIVAN: It is the interface issue, and I suppose you're right. We recognise the difficulty of the demarcation issue, and obviously again without sort of waxing on lyrically about the philosophy here, but our primary focus of a residential aged care is increasingly becoming the safety net of the aged care services continuing. Sicker frailer people are ending up in residential aged care. The examples you have given are obviously still there, but one could see we are not going to have as many of those examples in years to come. So we're talking about an aspect of the aged care services continuing which is about the final if you like - last place of resort for a percentage of people who are frail and sick. We're not talking about everybody of course.

Now, that's the first point. So increasingly the nature of the service is more dependent, therefore needing more intensive care than previously; therefore tending to be more towards what health services are aimed to do. The demarcation on funding should have nothing to do with the sector, should have everything to do with the nature of the service, and we fund the service where it is, and I think that's a more appropriate way to look at it. I would suggest to you given the logistics that we're dealing with, it would make more sense to not charge short-stay nursing home residents anything extra till 1 year, and then some charges could come in.

People might say, "Hold on, someone might have been in palliative care for 13 months, not 12 months or 11." I understand that, but I think you need to say - at least put a point at which the literature might be able to justify some demarcation.

MR GRAY: I think there are two fundamental elements in determining the demarcation: one is clinical lead and the other is length of stay.

MR WOODS: Length of stay is not as certain.

MR GRAY: No, you can't determine that in advance; you can only determine that at a point in time.

MR WOODS: Yes.

MR SULLIVAN: It's definitive though.

MR WOODS: Absolutely. We won't pursue that further. I'm a little puzzled. In page 9 of your submission you talk about coalescent arrangements which sees the subsidy rates for high-care residents RCS1 to 4 moving towards national uniform subsidy rates. It clearly ignores the reality of the cost contribution system of funding and unrealistically assumes the cost of providing care services to high-care residents in above average cost states can be reduced to a national uniform level. Then you say at the same time:

> The process of coalescence denies the very real low base of funding currently applying in those states receiving funding levels below the national average -

and my conclusion from that - but I'll explore it with you in a minute - is that that was just - well, not just, but it was a plea for quantum, but then you say on page 14:

> There is no evidence to suggest a state-based regime tends to lock in quality relativities across jurisdictions. Any existing quality relativities are a product of the evolution of the sector and some state difference - eg significant number of private for-profit leasehold nursing homes in Victoria.

That paragraph suggests to me that there isn't a straight nexus between quality and quantum, and I see the merit of the point you're making, but that seems a little at odds with your earlier view which drew the disparities and drew a quantum conclusion from them. Can you assist me in understanding those points?

MR GRAY: The two fundamental problems with coalescence are obviously the states that have to coalesce down as we said, clearly that does not accord with reality in terms of the costs of the delivery of services in those states because the costs are not going to come down over time to match the reduction in subsidy, whereas the states that are currently under-funded in terms of the current subsidy, coalescence for them over a period of time would certainly bring them up, but it would not bring them

up as fast as the cost drivers are occurring in those jurisdictions. So coalescence over a period is not the resolution of that problem for those states.

MR WOODS: I understand that, but that's based on the premise that there is a close nexus between quantum and quality, but your further comment on page 14 suggests that quality is factor of many things.

MR GRAY: It is a factor of many things, but it is a factor of funding as well because one of the things I keep receiving a lot of calls about from our smaller facilities is the fact that they are just going to have to probably get out of aged care simply because they are not going to be able to meet the accreditation demands, and the quality changes, certification changes over time because they just are not of a size that can capital regenerate. In some cases of course they cater for retired religious who are 100 per cent financially disadvantaged, not able to provide any contribution to capital. So those particular services have no prospect of capital regeneration over time, and have no prospect of being able to meet the cost of accreditation.

So there will be some rationalisation within the Catholic sector of a number of those smaller facilities. So I think there is that link between the subsidy levels and accreditation, the cost of accreditation which is now an imposed cost on the industry which previously outcome standards and standards monitoring was a cost borne by government and is a cost that hasn't been reflected in the subsidy regime. There was no increase in the care subsidy pool to allow for the fact that facilities are going to have to pay X thousands of dollars to pay for the cost of accreditation in addition to the cost of working towards accreditation.

MR WOODS: Do I understand that you're saying the department didn't recognise the costs of the accreditation process when devising the current levels of subsidy.

MR GRAY: That's correct. The care subsidy pool was the care subsidy pool that existed before costs of accreditation were even determined.

MR WOODS: Thank you for that point. Has rationalisation within the Catholic sector been occurring to date particularly in that small home sector?

MR GRAY: There is some going on, and there's also some rationalisation where some of the larger facilities that need to capital regenerate are capital regenerating with lower bed numbers because of the need to construct with single bed rooms with either en suite, dedicated en suite or shared en suite, thus releasing a number of bed licences which are now being offered in the marketplace.

MR SULLIVAN: It's worth putting on the record though, commissioner, that there is an element of rationalisation in the Catholic sector which is to do with the fact that some of the religious congregations are small. Their actual personnel are declining in number, and therefore their longevity as an entity is questionable. So therefore one of the forces behind them rationalising or at least transferring their beds is simply the fact

that their ownership longevity is in question, and that's different - and I would put it to you it is different than say a commercial group saying our business cycle is worn out.

MR WOODS: Thank you. I understand that point, and in fact given that coalescence now has a life of only several months, the rationalisation that has been placed to date is unrelated to coalescence in effect, and therefore it's impossible to attribute coalescence as the only cause for that rationalisation. That's the important point. Do you have situations within the Catholic sector where two homes in a jurisdiction of roughly the same size have different financial outcomes?

MR GRAY: Yes, I think there are examples of that, and there would be a combination of factors leading to that result. One would be obviously the resident mix of the two different facilities.

MR WOODS: I presume that your staffing mix in part would reflect the resident - - -

MR GRAY: And the staffing mix also, and to some extent a different philosophy about the care provided in the facility because the various religious orders have their particular mission and are determined to serve a particular need, plus also the sector is a mix of facilities operated by religious orders, some are operated by diocese and a number are operated by lay Catholic organisations like Southern Cross Homes or St Vincent De Paul and so on. Consequently there is a little bit of a different ethos about the way some of those services are provided. Some will only cater for financially disadvantaged people; others will cater for the spectrum throughout the community.

MR WOODS: Is it possible to draw a conclusion from that outcome that in fact managerial expertise and ethos and approach to the delivery of care can in itself affect the financial outcomes and therefore again add to the argument that care isn't driven solely by quantum of funds?

MR SULLIVAN: I think we can answer that from a number of angles, the first being that if you take our private hospital sector as a case study about what happened to a sector that has become increasingly driven by price competition and therefore what effect did that have on the way an organisation manages its service, our private hospitals have become very commercially adept in their management, and much more sophisticated in dealing with that environment.

In the catholic aged care sector, which is still not in that type of milieu, we have seen the development in the lay organisations of the Catholic Church, a far greater degree of commercial acumen, as opposed to those that are still fundamentally managed by religious congregations, if not dioceses. Now, it is too bland a comparison to assume that one is bereft versus one is abundant in certain skills. But it is clear that over time there has been an adoption of stronger commercial principles in both settings.

MR GRAY: Another point too is that in the lay organisations there is, because of the nature of the management within those lay organisations - there is a belief in the continuity of the organisation as an entity. But within some of the religious orders they have a different philosophy and the approach may well be for some of the religious orders that whilst ever there was a religious person to run the service, the service will continue. When there are no longer any religious people to run the service, the service will no longer continue. The same as when the order believes it has fulfilled its function and its original mission for which it was formed is completed and there is no longer any way of fulfilling that mission, the religious order will cease to operate.

MR SULLIVAN: An important point here is about - just in general when we talk about viability I think it does go to the essence of why the services were there and some of the owners of our services do see themselves playing out a life mission and vocation to do a service, not necessarily to run the rigours of the business cycle, and they are not particularly focused on the prosperity of the service. They are quite keen on the viability of their services to see out what they believe is the longevity of that mission. But there is undoubtedly always a sort of tension and clash between what you would call maximising return on investment principles in commercial practice versus doing enough to make the service viable for medium to long-term planning, but not having to maximise a return, particularly for a disinterested set of shareholders. That is a debate that goes on across I think the non-profit sector, the church and charitable sector but in ours particularly, because we have so many different owners under the banner of catholic.

MR WOODS: Presumably there would be some though who would see that pursuing efficiency in a rigorous but caring manner would allow for reinvestment of that dividend back into the quality of the care provided.

MR SULLIVAN: Yes, and we just say that we believe in competence with compassion. Equity and efficiency can be said many ways.

MR WOODS: Thank you. In that respect I noted in your submission that you identified a number of areas where costs are higher for catholic nursing homes and I must admit I was surprised at the length of the list. But nonetheless is that again a further recognition of the different approaches to management that a number of your homes bring to delivering care?

MR GRAY: I think it's a reflection of size and facility, different management approaches and location. It's interesting that in the most recent Bentleys cost study, which we only received this week for 1996-97, when we split out the performance of Catholic sector facilities they actually performed better than the rest of the sector. In other words, they recorded a better surplus or less deficit.

MR WOODS: Thank you. In your supplementary submission you make a comment on page 6:

If the commission believes that subsidies should be based on the average cost of providing the benchmark level of care, why not base this on an average size facility rather than an efficient size facility?

First a little explanation and then a question of you. In writing that up we're trying to differentiate costs from mix of inputs that the cost is attributable to. Cost you can take - we proposed an average of the costs across jurisdictions, given that we were pursuing the significance of a national uniform basic subsidy, but recognised that when you then apply that to a mix of inputs you can take broadly three approaches: you can take a best practice approach, in which case both the size of facility and rosters and the like, you look for the lowest point on the curve, and that might in fact be 80 or 90 homes and a roster of a particular nature. You can take the average. The danger as we see the average is that at the moment the inputs reflect the funding the jurisdictions have received, not much more than that, so that if you look at bringing Queensland and maybe South Australia into the averaging process it's a consequence of what the subsidy currently allows them to do.

The alternative then is to develop a standardised bundle of inputs which would reflect in large part what is considered to be appropriate but not pursuing best practice to its nth degree. Then by applying average costs to that standardised bundle of inputs the attempt is to design a subsidy that will provide incentive for those who can achieve better, provide an encouragement to those who are operating outside of that - not being prescriptive as to what your actual bundle of inputs are but what it would constitute is a price set by government for purchasing RCS1 to 4, but the price must be based on an understanding of the underlying cost drivers but not be prescriptive in what they are.

So that was the underlying basis of our approach, but do you have a view that by looking at the average - and here you relate it to size of facility but I'm wondering if you'd extend it also to the average input mix. Is that a more appropriate model to pursue?

MR GRAY: Actually, further thinking while you were discussing that about efficiency, obviously efficiency is dependent on location, because an efficient size out the back of Bourke would be a different size to an efficient size in metropolitan Sydney or Melbourne. So again, if that's going to be the criterion on efficiency, depending on location, then that would probably be very much the same as an average for those same locations, I would imagine.

MR WOODS: That's if you keep subdividing. What we've attempted to is to see if there is a national uniform basic subsidy that can apply to the majority but to recognise the importance of size as well as other cost drivers, and they relate not only to transport costs and hiring costs and the local pool of labour but also in some of those areas to the totality of life experience that the nursing homes provide for residents. That's not to say that doesn't happen in metropolitan areas, because of

course it does, but in terms of the relative importance of that for the residents that they're catering for.

MR SULLIVAN: What you're suggesting isn't abhorrent or anything like this.

MR WOODS: Pleased to hear it.

MR SULLIVAN: A concession. But I think it's very difficult because, again, if we use the private hospital sector as an example, if you take private hospitals as they are reimbursed by a health fund, the health fund will reimburse - take Queensland - a particular acute hospital in Brisbane much higher that it will for the same type of hospital running the same service in Rockhampton. The arguments a health fund will always put back at a hospital will be, "At the end of the day the capital cost of the bed you just constructed in Brisbane is higher than the one you constructed in Rockhampton," yet the services that we're trying to provide in each case are identical to meet what are local community needs. Therefore the only way around that some hospitals have, of course, is competing with another health fund to get a better deal. But in this case, of course, the only funder is the Commonwealth.

MR WOODS: Of course also the capital costs may be higher in metropolitan areas, and indeed within metropolitan areas one location to another vary greatly, but the operating costs may provide the counter.

MR SULLIVAN: Yes, they may. I don't know.

MR GRAY: Average does represent the why the sector is at this point in time. Efficient size doesn't, and therefore I suppose the question is what is an efficient size and how representative is it of the sector and will it lead to rationalisation that would therefore reduce access?

MR WOODS: We understand rationalisation occurring anyway, so I don't attribute any future rationalisation only to whatever design principles come out of the subsidy, but it may either assist, be neutral to or be counter to that rationalisation, and my thinking at this stage is that the subsidy design should assist that process rather than be a countervailing force, but nonetheless.

MR GRAY: Providing that rationalisation doesn't lead to reduced access.

MR WOODS: Which is why we raise the question of the special needs particularly for rural and remote but also as to how that should apply to special groups in larger areas.

MR SULLIVAN: You note our comment on that. I think there is just a culture about that type of funding for this sector that there's great hesitancy about embracing it warmly.

MR WOODS: Thank you. Yes, I did note your views. That largely concludes the particular matters I wanted to raise out of your submission, but do you have any concluding comments you'd like to make?

MR GRAY: I just wanted to make one brief one, and that is that it is clear when you look at things like the Bentleys cost study that there is a difference in cost performance and therefore profit performance between the for-profit sectors and the not-for-profit sectors. I think there are many reasons for this. I mean, we know that generally the for-profit sector will construct at a lower cost because their time-frame of investment is a shorter cycle than what the charitable sector would view investment. Also generally speaking room sizes are smaller in the for-profit sector. They're larger in the church and charitable sector. Grounds are more spacious and greater and there's usually more staff. The dependency level tends to be higher, and consequently overall the cost of delivering and aged care service in the church and charitable sector is as a consequence of all of those elements, which I think are valuable elements in terms of quality of care for residents and what residents would expect and deserve. Clearly those are cost drivers that do result in a higher cost of operation for the church and charitable sector.

MR WOODS: Thank you, Mr Gray. Mr Sullivan?

MR SULLIVAN: I would be interested if the commission has the time or later to comment on the issue about the 66,000,000 that has gone to the concessional resident supplement, particularly because it is there specifically as a capital funding subsidy and, given the fact that your brief is to look at the care subsidies, it can't go in our view left unstated.

MR WOODS: I note you have raised it both in your written submissions and in your evidence today and we'll respond. Thank you.

MR SULLIVAN: Thank you very much.

MR WOODS: Thank you, gentlemen, for your evidence today.

MR WOODS: If I could call Dr Gerald Segal from the Australian Medical Association. Welcome, Dr Segal. Could you please for the record state your name and the position that you hold.

DR SEGAL: Dr Gerald Segal. I'm the chair of the Federal AMA's committee on care of older people. I'm also the president of AMA Victoria.

MR WOODS: Would you like to make an opening statement?

DR SEGAL: Only to say - and then I'll talk in detail - that we believe that the whole process should be about looking at quality of care, and quality is what we're concerned with. What funding that then attracts follows the quality. So quality is where we believe should be looking and that should be your primary concern. So that's the main thrust of our submission.

MR WOODS: Thank you. Do you want to take particular points in some detail?

DR SEGAL: Yes. You've received our submission and I'll just - - -

MR WOODS: I have and I've read it with interest, thank you.

DR SEGAL: I'll just go through them and there are some amplifying points that I might make about each one. Specifically, section 3, Nursing Home Costs, Wage and Wage-related Costs, and one of the questions was, "Are over-award payments common in the sector and what are the main reasons for them?" It seems to us that they are common, and one of the main reasons is there are just not enough nursing staff to go around, and that's the result of a number of things. (a) Australia changed to university-based nursing education some time ago, and that attracts a different type of people into nursing, people who are much more into technological-type things. Aged care is not that type of nursing. It tends to also be heavier nursing - and I mean physically heavier nursing - and also more demanding.

We have now the situation because of rationing in public hospitals where the actual standard of care, the level of care, required in nursing homes is often approaching that of hospitals and sometimes equal to exactly what was done in hospitals. Looking back 20 years ago, many of the people who are nursing and having things done for them would have been in hospital. But they're now in nursing homes, and that has quite a bearing on nurses deciding to either go into nursing homes or not. There's also another consideration, and that is that nursing homes tend to pay less than other places. They pay quite a deal less, therefore the nurses naturally choose places where they're remunerated better. In nursing homes, usually level 2 is the standard that they would like to get nurses at. That is in the federal award the minimum level that's mandated and that's what they go for.

If you can't have enough nurses, be they SRN or SEN, you then have to get agency staff. Agency staff are usually level 3, 4, and want to be paid at that and that really raises the costs that nursing homes have to pay. It is difficult. It is difficult to

get staff. That is a really big issue. I think probably that's the main bit that I would put about there. So there are definitely problems there. Of course what's happening from our point of view - the other thing that's happening is we're now getting less - sorry, we're getting more and more unqualified people. In other words, less qualified are actually coming into nursing homes and doing tasks in nursing homes and that's a very major concern from us. That's a funding issue and that would be affected by coalescence in a number of states.

MR WOODS: Perhaps if I can ask you questions on each of those then as we go through.

DR SEGAL: Yes.

MR WOODS: You make the statement that over-award payments are common. Two questions: one is that do you note that occurring primarily in either the private sector or the church and charitable sector or is it across both? Do you have a database or some underlying information that supports that view?

DR SEGAL: Firstly, the AMA doesn't have a database. It's done on what our members say to us and this is how we get our information. It's a member-based organisation.

MR WOODS: Yes, that's fine.

DR SEGAL: But the majority of us who work in nursing homes talk to the people who are there. We know what's going on. Let me say that I think it's the same across all sectors of the nursing homes. It seems to us, when you go there, and especially in the hours when people don't want to work which is usually the evening hours, that's when you find agency type people there but it does happen through the day too. On occasions you'll come and you'll say, "Gee, someone hasn't got" - they're there and they really don't know the residents, our patients, at all well and that's because a couple of people have got sick; it's impossible to fill the places.

MR WOODS: So the over-award payments are more related to bringing in temporary or casual staff rather than paying over-award payments to attract your permanent core of staff to the sector, because as you pointed out earlier, in fact wage rates in that sector are often less than the acute sector.

DR SEGAL: You picked up on an important point and that is that nurses are paid less and it's going to be an increasing problem. There's the catch 22. If you pay less you want less working there. If you have less working there then you've got to have more temporary staff. It goes around in a circle and we've got a huge problem. We certainly need to recognise the type of work that is done by nurses in nursing homes. It needs to be properly remunerated which would mean that there needs to be an increase in the amount of money paid to nursing homes so they can actually get people who at a higher level will attract people. Therefore we have permanent staff. If we have permanent staff we have better quality. It goes around in a circle all the

time. It is very tidy and that's why we're concerned with the whole idea of coalescence. Coalescence is looking at the dollar values. We're looking at the quality value.

MR WOODS: Yes, although the two must somehow - - -

DR SEGAL: Mate, yes.

MR WOODS: - - - come together. The question of other staff is one that you raised. There seems to be a trend over time to improve the training available to and made use of by personal care assistants or the related fields in different jurisdictions. Is that not a welcome move in the sense of improving their skill base so that their work is more meaningful in terms of improving the care outcomes and perhaps even as a consequence, if they are then, through training, able to take on a broader range of functions, may be improving the overall efficiency of homes.

DR SEGAL: My answer would be yes, but. The yes is it's obvious that to improve the standards of those people who are untrained would be an excellent thing and it would certainly make them enjoy the job that they're doing much more and that's fine.

MR WOODS: And it's happening.

DR SEGAL: And that's happening. However - and I stated at the beginning here that the level of care in nursing homes is now approaching that of hospitals and in many cases is equal to that that goes on in hospitals. That is the problem. You see, basically in nursing homes we only have the people in the higher classification scales. The others just aren't - they're not there. To expect people who haven't got the basic medical type training to do these jobs, it's just not going to happen and mistakes are going to happen and that's going to affect what happens to those residents. You really do need that higher level of training skill to know what it's about. The number of medications that people in nursing homes are on is usually higher than that of people who are not and that is a real issue. It's an issue for all of us in there. They've got more problems. That's why they're there, and to know what's happening, to understand if there's a problem, requires someone who is trained at a higher level. That's why I say it's all very well to have carers to do the basic jobs but if we don't have people who know what sterilisation is about and really know what it's about, to know what drug interactions, to recognise that there might be a drug interaction, we're going to have problems.

MR WOODS: Yes, and it's a matter of ensuring that the appropriately skilled level of people are providing the appropriate functions and that you're not having people with skills which are being remunerated appropriately but are performing inappropriate functions.

DR SEGAL: I would agree with that.

MR WOODS: Thank you. Do you want to move on to your other points?

DR SEGAL: Yes, the second one is do non-wage costs vary significantly within or across jurisdictions? How much control do providers have over their non-wage costs? There are obviously a number of things which others will raise but it's obvious to anyone that it depends on which city you're in in Australia; whereabouts in the city, whether it's in the centre, in the outer suburbs, whether it's in the country or not; the land costs, costs of buildings, costs of power, gas, electric - all of those will vary and that's pretty obvious but the point that we would like to make is about - again, it's a quality issue. RCSs, which are meant to be a casemix type way of working out what funding is, take time, lots of time.

Accreditation, which is another quality measure of nursing homes, also takes time. All these things were meant - I mean, those type of things are great in big institutions where you can employ extra people to do them and that's what really is needed. We know that hospitals have whole teams devoted to accreditation. They have people trained to do their funding, their casemix, to work out what it is. Here we have in nursing homes either (1), you're going to pay for such people and mostly that can't be afforded by smaller institutions or (2), you have to get your nursing staff to do it. That can be either done as subtracted from the time that they actually do face-to-face nursing or in addition to their normal. Whichever way you go it's going to significantly alter (1), the care that actual residents, our patients, get because if the nurses are there for a lot longer than they should be they're going to get tired; they're not going to be very happy and it's going to cause problems or if they do it in the time that's allocated then the actual face-to-face care is going to suffer.

So this is a very significant issue as far as we're concerned at the AMA. So there's a really significant problem in here about what's happening and we think that needs to be addressed because that's control of costs of which all the aged care facilities now have - well, they have no control. They have to do it and it's certainly causing a huge problem as far as the costs that they have to bear and therefore the quality of care that's being given to our residents, our patients.

MR WOODS: Thank you. Is there any scope, and I recognise it would only be at the margin for improved uptake of technology so that you could get more automatic translations of care plans into RCS scales and the like rather than relying on copious handwritten notes which are variations on themes and phrases and the like.

DR SEGAL: It would be nice if the RCSs were steady. We've had a number of changes already and I could see that they're going to have to changed again. Yes, I could see that it could be possible but they all require direct observation. They require someone actually looking, seeing, yes and knowing.

MR WOODS: It's not the knowledge. It's the transmission of that knowledge into a database and an information reporting process that I was referring to.

DR SEGAL: Yes, I understand that.

MR WOODS: Like doctors moving to greater use of automation in the IT area.

DR SEGAL: Yes. I can see that it will be used but again, that's going to provide a costing cost which is in itself another issue. I could see that it would be possible if the things were steady. I think we've got to learn a bit more about RCSs. We're in early days with those. Accreditation - again, you could imagine that technology would help. Accreditation in itself is also a problem with funding because as we know, the accreditation, the actual scores that places have got, they're going to have to improve their levels. That's another cost of course to be borne by the system.

MR WOODS: Thank you.

DR SEGAL: Merits of alternative - what impact would coalescence to national average subsidy rates have on access to and the quality of resident aged care services across Australia? We would actually ask you to start at the other direction. Look at the quality of care that's presently being delivered. Examine it by state. See what is actually being delivered and then decide what rate should be paid to ensure that that comes up to a level, a minimum level which we would like to see set as a very high level but we think that's the important point. The government, when they started out with coalescence, what were they saying - they wanted to see the appropriate funding for quality care and accommodation. That was the whole idea. We would like to see the quality care measured, approved, everyone understand what it is, and then the appropriate funding for that. So we think it's the other way around - look at the quality first and then decide what the appropriate funding is.

MR WOODS: I trust - and I appreciate when you wrote that but since then we've put forward our position paper and our preliminary proposal 3 in my view achieves exactly what you're arguing for which is to look at the cost of providing the benchmark level of care. So you determine what the benchmark level of care is, looking at an average input mix, or breaking that up into two bits, an average cost for a standardised input mix and then work out the subsidy from that. So I hope we've taken your point.

DR SEGAL: We're most pleased with that and we're most pleased with the consultation that we had with the department initially about this and I know that they actually rewrote some of their submission. I was most pleased with that and I was most pleased with that which you've just read out now.

MR WOODS: Thank you.

DR SEGAL: Alternative funding arrangements.

MR WOODS: I guess your key point there is a plea that the minimum must be set at a high level and we understand that.

DR SEGAL: Yes. There's one other point that I would like to make and that is that aged care facilities that do provide higher quality care are often penalised. How are

they penalised? Because the residents actually move down the RCS scale. So if you provide very good quality care then you make the patients better and therefore they're now at a level that's lower and you now get penalised and paid less. This is a rather perverse incentive that's built into the system. It's something that we think must be stopped.

MR WOODS: In my inspections I've come across many instances, particularly in the rural remote, where a regime of routine care and diet and health interventions has led to significant improvement in the residents and so yes, we do understand that and we ourselves have questioned where the incentive lies under the current subsidy arrangement for proprietors and staff trying to achieve exactly those outcomes.

DR SEGAL: Yes, places that are prepared to have, you know, more people around, more people to do things with the residents, whether they be carers or nurses or whomever, who provide a better environment; where the actual buildings are better, because that makes a difference. If you're in a place that's awful, you know, you feel psychologically awful. All that sort of thing is important and it must be taken into consideration with any funding arrangements that are made. We do need improvements in actual quality of buildings and arrangements. It seems to me that the generation that I represent, the baby boomers, are not going to be happy with being in two and four-bed wards. They're not going to be and they're going to want to be in single rooms, hotel type accommodation with their own facilities. That's the sort of thing that we need to be looking for. It's going to cost money. It's going to be difficult and I guess we're very worried in the short term that it may mean that a lot of places are going to close. We know the number of beds at the moment are barely adequate. Where does that leave everyone? All of this is all intermixed. There's no single point here but they're all about quality, as I keep bringing up.

MR WOODS: I would make the comment at that point that in designing a subsidy we're also conscious that if you try and achieve too many things with a fairly blunt instrument which ultimately comes to four payment levels across the nation, albeit with some supplementations or special needs funding but if you try and solve all of those problems with that one instrument you're not going to get the outcome you're looking for and so you've got to look for a range of incentive structures and motivations. Occ health and safety is a very good one but I don't at this stage consider it's possible to provide the right incentive structure necessarily just through the subsidy. I think you have to look at other ways of trying to improve the occ health and safety records in nursing homes.

DR SEGAL: I would agree with all of that. The actual RCSs themselves also need to be looked at, the way that they're actually done. You could have a patient who has got lots of problems in a medical sense, requiring lots of time input by highly trained nursing staff, yet their RCS level may be quite low. Because they haven't got dementia, they can actually tell you what they want and that is in itself a problem and a big problem.

MR WOODS: We have read the reviews of the RCS and understand where that particular issue is heading.

DR SEGAL: Shall I go onto the next question?

MR WOODS: Yes, please.

DR SEGAL: The next one was about paying subsidies direct to residents rather than homes increased the pressure on providers to deliver the right service at the right price or would it simply involve another additional administrative cost with little or no offsetting efficiency gain. The reality is that the residents usually aren't the ones who know what's going on. It's their family or if some of them haven't got family, their legally responsible person who is the one who can decide. I, as a doctor, know better than anyone. You get a snapshot and that's all you get and it's a very artificial snapshot when you come in because obviously people put on their best behaviour because that's what you should do to impress the visitor and who knows what's really happening at other times. You can only surmise it by things that you see and look at. So I think that that would not be a very good thing to do, and we would recommend that that not happen; strongly recommend that not happen.

MR WOODS: In our position paper, in fact, we've taken the same view as you have. Although it was a first inclination in the other direction, the reality is that once somebody has an ACAT classification then in effect where they become resident brings with it the subsidy so the system overall led us to make the same conclusion as yourself.

DR SEGAL: The last bit is basically about over what time should any proposed alternative funding arrangements be introduced. I would like to do this as a summing-up mostly. We believe that - and I say it again - the highest standard is what we should be aiming for. If that means that every state has to be brought up to the highest level of funding at the moment, that's what coalescence should be. If it means somewhere in between, then that's what it should be. We have no fixed idea on what the level should be, just about the quality. It's interesting, when the Commonwealth introduced coalescence they said they wanted to purchase consistent outputs rather than fund inputs. I have to tell you, I have not got a clue what they're talking about and I don't know if the person who wrote it also understood what the heck are the outputs? Is that the people going out the door dead? Or is it the people that get out of the place and get to an acute hospital? What are the inputs?

You know, we're talking about people here. We're talking about residents, patients, people who need care. Outputs and inputs - I just think this is a nonsense and something that someone wrote and thought up and I really don't think it has much meaning. They said there will be winners and losers from coalescence. There certainly will be. They will be our residents, our patients. The ones whose care will either be diminished, which I would hate to see; or whose care will go up. They would be the winners. But we must make sure that all of them are winners, that the care is highest everywhere. Remember, quality varies enormously in nursing homes

and if coalescence meant the closing of beds because - you know, things are very tight out there - then we would have a huge problem in this country. It might be good for the government in the short term with what they pay out in the budget for nursing homes but remember, it would just mean a cost shifting to hospitals.

I suppose that's okay for the Commonwealth because the states pay for that. But it would be a disaster for our patients because that's not the appropriate place for them to be cared for, in hospitals. There are a lot of people in hospitals today who should really be in nursing homes. So no matter what comes out of this, we must ensure that quality is consistently high, high, high and that we keep it that way.

MR WOODS: Thank you. Perhaps if I can respond to a couple of those points. The commission itself has put forward equity in terms of quality as well as access as its most important criteria by which it will be judging the subsidy design. You made the point that quality varies enormously between nursing homes and that occurs between similar size nursing homes in the same jurisdiction which suggests that it's not just a quantum question. It's a management and care delivery question. So that helps put quantum into some perspective in that respect. I can assure you the commission is independent of the department but I will take this opportunity to just clarify a little what is meant by inputs and outputs if I may for your assistance.

The inputs being referred to here are the resources applied to delivering care, they being nursing resources, personal care resources, food, accommodation and the like. So they're the range of inputs that are provided draws upon to provide care. Then there are a series of outputs which is the care actually delivered and that delivery of care consumes the resources that I've referred to. So the outcomes are in effect what it is the government is purchasing by way of levels of care for residents who have different levels of need. The outcome that the government then is wishing to achieve is embodied in their legislation which relates to quality and dignity and wellbeing of the residents. So it's a shorthand way of trying to differentiate between what it is that the nursing homes are providing - which is the outputs, the quality of care - from the range of resources that are used to generate or produce that level of care. And through our subsidy design proposals we wish to become less prescriptive on what the input should be so that it's a question of management, and as I have seen in many instances in very close partnership with the DONs and other nursing staff, to determine what is the best mix of staffing and other resources to produce the outcomes ultimately and the outputs that the government is purchasing. So if that assists - I hope it does.

DR SEGAL: Thank you. Could I just make one comment then on that because that actually clarifies for me - - -

MR WOODS: Yes.

DR SEGAL: I think you should continue to be prescriptive on the inputs because they are - without minimum inputs at set levels that really are important, we're not going to get quality outputs at all. So I would like to see that you really need to have

a balance between those inputs and outputs and I would be quite concerned if you didn't and the Commonwealth standards didn't actually prescribe inputs that are consistent. I think that's absolutely vital for standards so there's a balance here.

MR WOODS: Thank you very much. As I say, I didn't make that observation on behalf of the department. No doubt they can speak for themselves, but if it assists in the debate, we ought to make that contribution. Thank you very much for your evidence.

DR SEGAL: Thank you for your time.

MR WOODS: I propose a very short break and then we'll hear from the next witnesses.

MR WOODS: If we could resume the hearings, and I call as witness Mr Richard Hearn from Resthaven. Could you please give your name and position for the record.

MR HEARN: My name's Richard Hearn. I'm the executive director of Resthaven Incorporated. It's a Uniting Church agency in South Australia that provides services in nursing home, hostel and aged care packages.

MR WOODS: Thank you and welcome. Would you like to make an introductory statement?

MR HEARN: Thank you, commissioner. The first point I would like to say in relation to submissions I've written is that I've found the paper that the commission has provided challenging, and at a personal level challenging, to issues that I assumed positions on and has had me think more deeply about some matters. One of the comments I've made in my submission was over the Tricare submission initially and I was a little concerned that Resthaven was named as a contact for them, and I have noted in my written submission that they didn't use an award that Resthaven and the normal majority of providers in South Australia is using in their study. Hence, given the commission did rely to a degree on their study, I wish to bring it to their attention.

MR WOODS: Yes, I've noted your comments on that.

MR HEARN: Overall I suppose the view of a uniform basic subsidy and the need for special needs supplements - part of my positioning on that does reflect the history of a differential subsidy scheme that we've had for 10 years or so and the problems that have evolved over that time. I would like in an initial sense to make a comment about equity. I do refer to equity at times and I agree with the view of equity. At times in various debates in the last few years there have been concerns raised though about creating two levels of care. I believe that in a sense assumes that there is one level of care at this stage, but I don't believe that the sector as a whole reflects one level of care. I think there's quite significant divergence in both accommodation and care levels in various states and between states.

The other issue I'd generally like to make at the start is that as the government and the department encourage providers to take the journey to quality and ensure certain outcomes I believe that providers in their advocacy for their clients also expect a similar outcome at the bureaucracy level and government level.

MR WOODS: Thank you. Do you wish to go through your rejoinder submission point by point?

MR HEARN: Yes, I'd appreciate that.

MR WOODS: Thank you.

MR HEARN: I'll just emphasise certain matters in each point. Regarding proposal 1, I agree with the proposal but the key issue is what the basket of services will be and how that is costed and what variables may cut that basket.

MR WOODS: I think we can debate that also a little further on in your evidence.

MR HEARN: I'll keep on going unless you stop me.

MR WOODS: Yes, thank you.

MR HEARN: The proposal 2, again I agree and I do highlight the issue of - quoting from the paper, "Sufficient to support the level of care required to meet the accreditation and certification requirements." I sense there's a theme in the commission's paper that it sees the accreditation process as providing a benchmark from which you can base the basket of services. The concern I have may be incorrect, but I have a concern that the accreditation process is not necessarily going to be based on best practice and that I've had an impression initially in the last few months that some of the assessments will be based more on the improvement from the individual agency perspective. In that sense, if that is the outcome that they adopt, it may not provide that common approach.

MR WOODS: It's something that the commission itself has grappled with, that in designing a subsidy based on the level of care as distinct from the specific inputs you have to have some way of judging and assessing what that care is - and I'll be obviously pursuing that with a range of witnesses over the course of this inquiry. We also have looked closely at the accreditation process and note that a key element of it is this ongoing improvement component which in one perspective is commendable in suggesting that the level of care and the benchmark will rise over time.

But another interpretation is that accreditation may be given to facilities of very differing levels of care at the moment, provided they keep incrementing, and we need to understand that further before we conclude this inquiry, because if it's the latter then it doesn't provide the certainty and surety that the interpretation on the former basis would. You raise here the question also of whether commendable or satisfactory would then be the appropriate benchmark and I'd appreciate your views. You, I take it, favour commendable although that's not totally clear from the written word.

MR HEARN: I wasn't actually putting a view as such. I was just identifying that I was wrestling with the topic.

MR WOODS: Do you have a view, either now or in any final written evidence you might want to put before us by the 27th, of whether there are ways of assessing an acceptable base level of quality of care other than the accreditation process, through your experience?

MR HEARN: The dilemma I have in bringing this issue to you is I don't have an alternative option. I think it's a system in which it should be considered as to how it can be practically used in developing a funding system or have at parity to what a minimum level of standards are that is wished. So I haven't really been able to come up with alternatives.

MR WOODS: I encourage you to keep thinking.

MR HEARN: Moving on to proposal 3, again it reiterates the bench level of care issue. I have noted that the 60-bed size model that is discussed may not be the appropriate size model. I sense from some other submissions that similar issues have been raised. I have made the additional point - - -

MR WOODS: We do recognise that 60 beds is in fact - most beds are under 60, so we understand that point. Can I say on that one though that you make then the phrase "determined by government allocation models". Can you elaborate on that for me? Is that from your experience practice of government in the past to allocate new bed licences to achieve outcomes of facilities significantly smaller than 60?

MR HEARN: We have had the experience in South Australia where at a time when the department had a value of home-like environment as being an outcome in new facilities, they were also attaching to that a certain size. We were never sure where the science of the size came from but we had experiences where there were definite values that two-storey complexes were not acceptable. So in redevelopments of built-up areas there was significant pressure to downsize because the provision of a two-storey or a three-storey option wouldn't be encouraged.

MR WOODS: Yes, we've had evidence from a range of witnesses which we do need to pursue with the department as to just what their model was and what's the basis of it, underlying it - thank you for your comments on that.

MR HEARN: I note in some length the discussion about enterprise bargaining and differential rates between the acute sector and the aged care sector. I tried to do an analysis which was an attachment to this paper, comparing the Tricare outcomes, which seemed to be very commendable in their enterprise bargain, and the state government outcomes in South Australia that were being applied to the acute sector, which would appear to be in similar times when they were established. There are quite significant differences that I've emphasised and I think based on that evidence I'm disagreeing with the issue that there won't be a further widening of the gap.

I think that evidence does suggest that there may well be a far greater widening of the gap, and the pressures obviously in Queensland in terms of funding have had them come up with very significant outcomes. But those sort of outcomes in Tricare couldn't occur every time they have an EB negotiation. There would be a limit to the significance of such outcomes.

MR WOODS: But if those outcomes were replicated by other providers in other jurisdictions would that not lead to some level of convergence rather than divergence of wage outcomes?

MR HEARN: Within the aged care sector?

MR WOODS: Yes.

MR HEARN: Yes, I think they're similar in each award in each stage. There would be similar conditions that could be considered, that they are considered, and in South Australia when we've considered those issues they would be the areas. They seemingly were able to achieve all the areas that we've seen as potential, not saying that we would be going down that track at this stage but would be areas we would focus on initially. The issue there though, I think, is the competition for staff between the acute sector and the aged care sector. The experience we've had is that in the last 12 months we had approximately 1.5 per cent indexation that related to indexation that we would apply to wages outside the superannuation supplement. In our state the first year of their 3-year instalment was 3.2 per cent, so with less outcomes in changes and conditions.

MR WOODS: Yes. If I could comment at that point in time that the position paper on that point says that the industry cost base should reflect nursing wage rates and conditions applicable in the aged care sector rather than in the acute care sector, that has been variously interpreted. But if I could clarify that what that is focusing on is to say that the indexation should pick up over time what is happening in that sector, in the aged care sector, but doesn't impose a view or presume a view as to whether the aged care sector should be at parity or not at parity with the acute care sector. So we don't have a view through those words on that outcome, merely that the subsidy should be designed to reflect movements in the aged care sector.

MR HEARN: And that would be an improvement to the current situation.

MR WOODS: We understand the current - - -

MR HEARN: I wish to acknowledge that.

MR WOODS: - - - indexation and have come up with what we consider one base closer to the actual cost pressures in the industry with a productivity discount.

MR HEARN: I had read into the lack of comment about the acute sector that that had implied that you were saying more possibly.

MR WOODS: No.

MR HEARN: The other issue that we're facing I think nationally - but there are issues about supply of staff, professional nursing staff, and I was aware without any - I wasn't present at the meeting but I've heard a report from a meeting on Friday in

South Australia where it's quite a key issue that has been shared, both in the acute sector and in our sector, and also the training. The tertiary institutions are concerned about the drop in numbers of intake.

MR WOODS: We've also received evidence about progressive shortage, particularly at the RN level, nationally. Do you have a view as to whether that in itself may cause to develop a national labour pool with RNs and therefore some convergence of wage outcomes or do you see that not having any impact?

MR HEARN: Sorry, could you repeat - - -

MR WOODS: If a shortage is emerging in a number of jurisdictions what will happen is that nurses would be in a greater position to negotiate outcomes across those jurisdiction that may lead to some levelling of wage outcomes, because if one jurisdiction is clearly significantly different from the others, if it's ahead, it will attract the majority. But then there will be a competitive process for the other jurisdictions to catch up or if it is significantly behind it will need to address that to attract a quantum of nurses to meet its needs.

MR HEARN: I think, based on the indexation process as it currently has surfaced just recently, we're clearly challenged by any differential that's now emerging and there's clearly one in South Australia that has emerged. I'm challenged, as an individual provider or within an individual organisation, about issues of equity that we will be faced with whereby if we have only got a certain amount of money, that we can apply for an EB outcome and we have limited efficiencies; that we will have to consider outcomes may be different for professional staff than non-professional staff. Those sorts of challenges in an organisation that I'm associated with philosophically have problems with it as well, so it does create tensions that we wouldn't normally want to have to deal with, particularly in South Australia because there's a large proportion of carers or non-qualified nursing staff compared to some other states.

MR WOODS: Are there differences in the nature of the labour markets for say RNs versus personal carers? Are the personal carers a much more localised market and therefore between jurisdictions like that have different dynamics compared to nursing staff?

MR HEARN: My perception in South Australia is the supply is the key issue. There has been also a probably historic view that only certain numbers of the qualified nursing staff see aged care as a desirable work environment. They tend to be older more experienced nurses who have come back into the workforce following child-bearing. They're not nurses at an intake level.

MR WOODS: So you're benefiting from their experience and their skill base?

MR HEARN: We are.

MR WOODS: That's very good.

MR HEARN: But it means we have an older workforce as well and so we have greater risks of workers compensation and in our state current levels of workers compensation in the acute sector is 3.2 per cent and in the aged care area it's 6.9 per cent.

MR WOODS: Yes, we have seen your figures. To the extent that it is possible to address workers compensation premiums, at this stage in our position paper we've come to the view that because there is a level of discretion exercisable by proprietors in this field, that it is a different entity to payroll tax which is totally non-discretionary and have therefore proposed the payroll tax be reimbursed based on the actual costs incurred versus workers compensation which would be embedded into the national uniform basic subsidy. Do you have a view on the treating of those separately and I notice you come to it later but do you want to comment at this point?

MR HEARN: Yes, I believe that's an inconsistent approach and I would be challenging the commission to have a more consistent approach to those types of additional costs. I don't probably see the discretionary option that a provider has in the WorkCover environment, particularly say small agencies. The impact of one serious injury on a small facility - and again, other submissions have commented about the average size of facilities being on the smaller side.

MR WOODS: Yes.

MR HEARN: One significant injury in that area can have a huge impact on WorkCover costs and premiums.

MR WOODS: We note that you refer to some contradictions in arguments in the paper, I think is a phrase you use in your submission, but my concern is that if you merely reimburse on actual costs, that you're not providing any incentive to providers. I mean, I don't hold the view that it is a non-discretionary expenditure but I do recognise that for one reason or another at times you can incur a very significant claim. I've run a large public sector organisation and had - closely monitored the premiums and the cost drivers to it and the occ health and safety issues and practices to reduce it so I'm very conversant with it.

But I'm not yet convinced that there isn't a significant element of proprietorial discretion in practice which can lead to improved premiums but on the other hand I recognise that there can be circumstances which will generate a very large cost penalty. So maybe there's an area to be explored where there is some form of uniform basic recognition which allows the better operator to benefit with some capping of some exposures. Again, you're then starting to complicate your subsidy for a whole range of issues but I would welcome your thoughts either now or in any follow-up point.

MR HEARN: I don't think that the response from where I'm sitting is simple in the context that the issues you present are clearly there and I think there are dangers, that

a fully cost reimbursed system does have the potential to not encourage efficiency in some contexts. So I see the dilemmas there. Part of the issue of the contradiction was that I'm not necessarily - I think as we've said, I'm not sure that there's a difference between the payroll and the different state approaches to payroll tax. I'm not sure if there's a difference in that context.

MR WOODS: Only in that they're totally non-discretionary and that they hit differentially between sectors as well and therefore if you reimburse the actual cost - you can't change the behaviour of the recipient of the subsidy by reimbursement because it's a legislated payment that's required to be made.

MR HEARN: Yes, and those discretionary issues in WorkCover do exist but there's also another element of that you've referred to.

MR WOODS: So there's a judgment to be made. Please proceed.

MR HEARN: I think one of the issues I've raised - and I haven't studied it and it may be straightforward - that because of the challenge, I guess, from South Australia we've seen in the lack of significance between the current RCS subsidy rates and cost issues that have been discussed in the paper, that has been a concern to us and I guess we wonder whether there are issues in the payroll rates as well. Do we know that they accurately reflect what is happening in each state? That's a general issue, I think, about rigor and transference.

MR WOODS: Yes, one would hope that any subsidy would be based on what's actually being incurred and not behaviours that generate a larger return than is appropriate.

MR HEARN: Unfortunately, we all assumed that when they establish the RCI.

MR WOODS: Yes.

MR HEARN: So I do make a point about asking the commission to draw a bit more on the issue that there has been an unexplained breakdown in the RCI system that was there for 10 years that was in transport and the RCS system. I think I'm dwelling on that because there's a history issue here that I think all of us have to be careful that whatever system follows, that there is more rigor and transparency to avoid similar problems.

MR WOODS: I note your use of the phrase "rigor and transparency" to which I annotated that the PC itself, in our position paper, is advocating transparency as one of our important criteria in establishing the subsidy. Whereas there needs to be a separation between prescribing in detail the actual inputs from the price paid by government. The translation between the two in itself needs to be transparent so that you understand what is the data and what is the basis upon which government is making judgment and provided you have that transparency then government's decision is available for all to scrutinise.

MR HEARN: I touch on the issue of productivity discount and I raise the issue that based on the comparison I did with the acute sector that it would be unfair, I think, that the aged care sector, as we have heard earlier, dealing in some situations with much less finance, expected to have a productivity discount that's not going to be expected elsewhere in the community.

MR WOODS: I'm not sure I'd agree that productivity discounts aren't sought elsewhere. It's a question of identifying who should benefit from productivity and in this particular sector there seem to be three broad parties, one being the proprietors, one being the workforce who are implementing the productivity and one being the taxpayers who are funding the subsidy. It's a matter of determining what is the balance of sharing that productivity dividend to achieve good quality care with the right incentives but recognising the interests of all parties.

MR HEARN: That's all - are there any other questions?

MR WOODS: We've dealt then with your payroll.

MR HEARN: Dealt with most things. I've commented about the issue of government nursing homes and I have empathy that there should be equitable rates but there should be additional funds for them, straightforward from how I've argued the point.

MR WOODS: Yes, I notice your point of agreeing in principle with certain caveats. The question we need to grapple with is how do you have a transition period to avoid unintended windfall gains for those who may have purchased government homes at a discount price to recognise a reduced subsidy. That's a design issue that we need to grapple with.

MR HEARN: The response to proposal 13 generally talks about being sympathetic to the issues discussed in the paper, like clearly identifying the differential between states is of particular interest to us and the broad focus of the commission's inquiry on these other matters, as important as they are, we wouldn't want that to delay a response to states such as Queensland and South Australia having response to the differentials that they feel are currently not justified.

MR WOODS: I understand that point. Can I just go back one. On proposal 12, I'd be interested in Resthaven's own views on the opportunity for extra service places. You run, what, 225 beds, six facilities and they're all co-located with other facilities. What is your thinking in terms of extra service?

MR HEARN: With the history of the debate about bonds and nursing homes, we were in the midst of building a facility and stopped the program due to our - - -

MR WOODS: So this was to be an extra service.

MR HEARN: An extra service.

MR WOODS: A dedicated extra service facility?

MR HEARN: No, initially it was not going to be.

MR WOODS: A wing or something.

MR HEARN: It was going to be a wing funded by bonds that were going to attract - we were able to charge incoming residents.

MR WOODS: How many beds for this?

MR HEARN: It was going to be 30. It was going to be a 19 extra service wing but the history of the issue was that the way we worked through the change from accommodation bonds to accommodation charges and our concerns about the viability of the project was that we saw the extra service wing option as a way of maintaining the use of a 50 per cent proportion of resident contributions towards the building approach. So I share the concerns that if the level of extra service was significantly increased we would have to be giving our minds to the impact on concessional residents. So in essence I'm supporting the commission's view that I think there is an opening here for consideration that avoids the emotive arguments that were surrounding the selling of the family home and give people an option or a choice. However, if you did extend it, I think there would need to be some serious consideration to the impact on concessional residents.

MR WOODS: But provided the subsidy design protected their interests, then you have a more open mind on the opportunity for extra service?

MR HEARN: Yes, definitely.

MR WOODS: Is there a market, in your view, for extra service places? I mean, I notice - - -

MR HEARN: Yes, there is.

MR WOODS: - - - that the national uptake is in the order of about 1 and a half per cent or some similar figure so it's well below the 12 per cent cap at the national level.

MR HEARN: We've only considered it because we feel we've had to in the scheme - what's happened the last few years. When my board considered the concept of extra service it was a matter that they contemplated for some months. They were struggling with issues of, does this mean differential service levels? Does this cause other cultural problems within the facility? They are real issues that we need to consider. Our best understanding of that won't be until we've managed an extra service facility and then we'll have a different view, I'm sure, as to whether they were

real concerns or they are not real concerns. So we may have a changing view on where it fits in the scheme of things once we've had an opportunity to manage such a facility. It's interesting that - - -

MR WOODS: It would be very interesting to follow that through and see what your thinking is some way down the track.

MR HEARN: We're actually looking for potential interested people at this stage and we are having some people raise issues about differential service and comparing what they may be able to receive in a similar facility of ours. But I think in part that reflects that generally we provide a fairly high level of service. I would hope and I believe it would be beyond what will be the minimum satisfactory level. So that creates our own benchmarks that cause dilemmas.

MR WOODS: Then to create a differential that warrants the additional funding contribution for extra service, in fact you may be reducing that by improving your own base quality.

MR HEARN: I'm exploring other ways that we can maintain the impact of using bonds but not necessarily levying the minimum fee that's required in the system. As I understand, the minimum fee is 12.50 per day extra but that's the published fee. I don't believe there's a requirement to actually levy that to each resident. It's more the way you implement the system.

MR WOODS: I'm sure you could have fruitful discussions with the department on that particular - and no doubt there are others who have given similar thought but - - -

MR HEARN: I have already had those discussions and I then realised there is possibly some flexibility for organisations who were concerned about the equity issue, particularly in our environment because we use variable fees in hostels and so the leap from a variable fee culture that we were using to what we will be using in our extra service facility is not as significant as some agencies would find.

MR WOODS: Right. We challenged organisations and individuals to reflect on alternatives to the payment process and you've written at length about the payment process but it seems to be directed more to the first priority being for the payment system to be accurate and have gone into some chapter and verse on that and recognising that has obviously having caused some vexation do you have a view beyond that though as to whether the payment according to the daily profile is still the best way to go?

MR HEARN: I haven't identified an alternative that would improve outcomes at this stage in the method of payment.

MR WOODS: Thank you. We do note your points on those related matters.

MR HEARN: I can, without wanting to be too political, commissioner, question the impact of the 6000 retrenched staff in Centrelink on the income testing process, given the problems we're already experiencing.

MR WOODS: Moving on - - -

MR HEARN: I have dared to enter the discussion on input taxes.

MR WOODS: Yes, I noted that. I was actually quite pleased that you had pursued what some of the effects may be of different forms of input tax so I was grateful for your contributions to that and we will be taking them on board in the final report. I've got no other specific questions to ask of you. Are there any concluding comments you wish to make?

MR HEARN: I was listening to some of the other speakers earlier and I would support a view that Dr Segal did put regarding the role of registered nurses and we are just - and I think it is a longer term issue that clearly the 2-year review will be monitoring but I had a discussion with one of our hostel registered nurses the other day and she was comparing the PCAI review process, which we're currently in at the moment because of the year following its first inception, and the RCS and she was saying, a PCAI environment as a registered nurse, she was spending approximately 45 minutes to an hour reviewing a PCAI at the review period and she's spending 3 hours to 4 hours per RCS review. That alarmed me in terms of that's not being talked about widely so I think there is potential for issues in that area to evolve in the next year or so as we learn more about these new systems.

Other than that, commissioner, I would just emphasise what I already have about the pressing need for South Australia and our empathy for Queensland and that we trust that the theme of empathy for the challenge which I am significantly emphatic towards with Victoria and New South Wales, if there is an outcome that means, in a costed basket of services that some states that are higher paid have to be considering how they respond to a different outcome in their current subsidy, I think are real issues they do face. However, equally, I do not believe those issues should allow a disadvantage to be prolonged.

MR WOODS: Thank you for your evidence. At this stage I will adjourn until 1.45. Thank you.

(Luncheon adjournment)

MR WOODS: I'd like to recommence the hearings and welcome as a witness Ms Mary Lyttle from Residential Care Rights. Could you please give your name and position for the record.

MS LYTTLE: My name is Mary Lyttle. I'm chief executive officer of Residential Care Rights Advocacy Service.

MR WOODS: Welcome to the inquiry. Have you an opening statement you wish to make?

MS LYTTLE: Yes, I'm just going to make a brief point or two. Given that our perspective, if you like - and I've admitted that it's not as broad as some of the participants here - is coming from the point of view of what comes across the table to us from consumers, I guess the quality issue in relation to funding and staffing is the issue that I'm going to be looking at. The sorts of things that lead into that for us are the stories that we hear, and I've heard a lot recently as I've gone around the country, of relatives being concerned their residents weren't being fed properly because there weren't enough staff at those times of day. They were also concerned about the kind of staff that are on the floor and whether they have the skills to carry out the work, and the impact of all of that can be things like people being left wet when they shouldn't be and perhaps at lunchtimes again or something like that.

So those are the practical issues that raise the quality in terms of consumers. Therefore in looking at the review I would say it does need to consider is the funding sufficient for quality. Is it sufficient for the right sort of people, for the right sort of process and for the right sort of outcome? That also leads across to accountability. For me that's the test of not only the efficient use of public money but the effective use of public money. We look at requirements for service industries under the Trade Practices Act. We're looking at things that are fit for the purpose. So is there funding provided that means that these services are fit for the purpose?

I think given that this is a very imperfect marketplace for consumers one of the things we do notice, that the Canadian health economist Evans talks about in this environment is that people have a couple of choices. There's a lot of talk about choice in this area at the moment. But in actuality they may only have the choice of exit or a voice, so they either make their wishes known and the system changes or they exit. This is an area which is very tricky to exit for all sorts of reasons. It's a regulated area. You don't have that absolute choice again.

I believe at the moment - and it goes to some of what we've talked about, but certainly given the scope of the changes in all sorts of ways including the funding - that older people and the existing residents might be bearing what is called the sheer process of the system turning, that the people who are now in the system seeing it turn around are getting the fallout from that. That's what we would like to guard against. That's what we think the funding issues need to look at. In considering those issues then about, is it sufficient for the quality, I think then it moves to a policy issue

about how much you look at in terms of user pays, how much from government etcetera and what the mix of that is.

Government I believe, as the regulator in a capped sort of market, does have the responsibility and is accountable to the older people who are living there. They, we believe, have several interests in quality, in the issues of funding. That's the citizens who plan and pay for this, as consumers who sometimes receive that and as members of the community who want to see good quality care delivered. So from what I will admit is our somewhat limited perspective - and yet it is at the coalface we believe - I'm happy to answer questions on the issues we've raised, thank you.

MR WOODS: Thank you very much for making your time available to come before this inquiry. In your experience within the one jurisdiction of Victoria do you find that there are variations in the quality of care between facilities, even facilities that may be of sort of similar size?

MS LYTTLE: Yes, that can be true, yes, that there are people who appear to be able to carry out a quality job and achieve quality outcomes, presumably with the same money, and others who can't. You can also perceive that there are a range of mixes that go into that and certainly skilled staff supervision, planning, training, all of those things would appear to make the difference and the research certainly shows that that's the issue.

MR WOODS: So there are many factors that affect the final output of quality care in a home which are broader than the question of funding in itself, the managerial capacity and training and all of that.

MS LYTTLE: Yes, certainly, although obviously the resources to enable it to happen is a basic underpinning.

MR WOODS: But in facilities of similar size with similar resident profiles in the one jurisdiction the funding would be approximately the same, yet different outcomes of quality are achieved between homes.

MS LYTTLE: Yes.

MR WOODS: Thank you. You raise the phrasing, "The kind of staff who are delivering care." Is that a reflection of the mix of staff at particular skilled levels or the skills of the individual staff at those levels? So is it a factor of the individual training of workers or is it whether there are too few, too many nurses versus personal carers etcetera?

MS LYTTLE: Again I think it's somewhat complicated in that I'm told by facilities that they can't always get staff skilled at the level they wish. So grade 2 nurses etcetera, are there enough of those to actually employ if that's what they wanted. It's then a matter of saying what basic training do other people have who are coming into the area and how do we then add to that? So there appears to be a couple of things

going, that are there sufficient properly skilled people to be hired in, in the first place, and then how do they deal with that and what's the base level of training and how are people then skilled up? As I understand it, the base level of training, if you want to say, has opened up with deregulation in terms of not too many controls on that.

We then have people that we hear about who are able to only get nurse assistance who may be sent to them from agencies and who were working for Australia Post yesterday and now see they can get a job in aged care. There's no requirement for minimum training levels. I believe that's a great weakness amounting to the potential for abuse in some instances, I would believe. You can't go into the casino in this state to work or drive a forklift without a basic level of training. I don't see why you should be allowed to work in aged care without the same thing.

MR WOODS: Have you noticed any change over the years in the level of competency and training received by staff, particularly at those levels?

MS LYTTLE: Yes, I would think so, again because people are now able to employ basically untrained carers and so it's a matter then of management in their capacity and what they wish to do about that; whether they say, "We will or won't." I know some organisations say, "We won't take on people who haven't done a personal carers training and we will then skill them further." But the dearth of people out there seems to be one issue for them, as to who they can attract.

MR WOODS: What are the more common areas of complaint in delivery of care that you experience and deal with?

MS LYTTLE: I guess one of the basic issues we're dealing with all the time is about care and care planning and then how care is delivered. So you get back to the issue of, "I thought that I could expect to have this kind of care for my mother to meet her needs with dementia, to be looking at keeping her dry and comfortable for instance, and I'm finding that that's not happening," or, "I'm not being involved in the care." Sometimes that's an issue, that they haven't been involved in what's happening and so again things go on and they think, "Hang on, I didn't know that was going to occur." So certainly care and care issues and then also how the industry deals with complaints is another big issue for us. When you raise a query or when a relative raises a query, what happens? That's something I think is better able to be addressed in the new accreditation process.

MR WOODS: So do you feel, following on from that, that the resolution process will improve with the new accreditation?

MS LYTTLE: The potential is there for that, I think. It's a matter of the industry grasping that ability to deal with complaints, seeing that as a positive part of improving the quality, turning that around, because I suppose it's an issue that's hitting everyone in other areas of the health sector. We're all becoming much more conscious of taking part in our health care, participating, interacting. We're much

more prepared to challenge health professionals perhaps in the general community. So those sort of issues is now hitting aged care.

MR WOODS: In our position paper we grapple with the question of whether the subsidies should be paid to the resident or the provider and come down ultimately in terms of it paid to the provider, in part on the realisation that a resident will pass on to the provider the subsidy by the fact of their existence and choosing that particular facility. Does that in your view lead to a restriction of choice? Does it reduce the bargaining power of the resident or is this issue fairly neutral to the question of resident choice?

MS LYTTLE: I've actually come down to saying I wasn't sure whether that would shift the balance of consumer sovereignty. It could at one level. But then again we've got this imperfect marketplace. So if you said, "I can go out and take that wherever," as you might in some other settings, a school for instance or whatever, because you may have a choice of some within a range of areas close to home, I think the restriction of absolute choice here about what you can get into wouldn't necessarily shift that. I think there's perhaps some other ways to deal with it and I think in my paper I was just saying that I thought the - interestingly enough, although I'm saying it's an imperfect marketplace the government's user-pays changes have actually produced a marketplace of sorts. It has raised people's consciousness. For the first time they're realising that they're paying, although they've always been paying, but it's more directly not just a capped fee. They're being asked about their income and assets etcetera in a different way. So I think that's shifting some things.

MR WOODS: Is the imperfect market in part related to the limitation on the number of bed licences made available, in which case for greater consumer sovereignty would you be advocating some relaxation of that limit and rely on capping the total through the ACAT assessment or vice versa? Where is the mix of control to be? At the moment we seem to control up, down and around the middle.

MS LYTTLE: Sideways, yes.

MR WOODS: How do you see that?

MS LYTTLE: I mean, that would certainly, in line with other marketplaces, free it up, wouldn't it, in that again you have a bit more sense of choice. I mean, that's certainly the situation partly when it comes to, say, supported residential services, places like that, that as long as you satisfy the criteria you can open up something like that in Victoria. So they go where the market is and look at the market through the model with some regulation around how you run it. As I understand it, in looking back at some of the policy stuff, granted before the assessment process came in so tightly we're looking at if you build the facility people will fill it. Do you blow out at that end? But given that the assessment process is very clearly in place now, that's a cap on simply filling the beds - for inappropriate reasons, I mean.

MR WOODS: Is a consequence though of loosening, if not in fact overall lifting, the restriction on the number of beds that the competition will lead to some facilities having reduced occupancy levels and ultimately becoming unviable, which in itself would then lead to disruption for the residents who are there and associated issues. I mean, to what extent do you need to regulate the market to have continuity of care whilst still having sufficient caveats to ensure the care is at an appropriate level?

MS LYTTLE: I think you need more data than I have to say that, I have to say, but perhaps some loosening in the tension around that. I mean, the industry will only take it up again if they believe they can do it presumably.

MR WOODS: But some would take it up because they believe they can do it, which would then cause failure for others.

MS LYTTLE: Yes, it won't necessarily happen. I would think you need to think it through carefully and look at stages and whether that's what happens. As I understand it, that has somewhat happened with the extra service places and looking at, "Do we open up more of those?" Is there a sense that there's a market out there to provide that choice at that level of payment etcetera?

MR WOODS: I'd like to pursue that bit in the middle in a moment. But at this stage from your particular perspective of residential care rights what are the consequences for residents of homes becoming unviable and going out of business?

MS LYTTLE: Fairly drastic really. If you say this is the resident's home - and for better or worse it is - and that's the standard, then a bit depends on what happens. Does someone else take over the licence and continue the care? Does the resident have to be transferred? You know, we've had a lot of that happening and I guess it will continue to happen in the Victorian situation and people then are kind of transferred or not with the bed licence, you know, offered some choice again but not necessarily the one they would have wanted. Some people do then have a consequence of being able to be charged as if they were a new resident because the provider has changed, you know. So there can be quite a lot of impacts where you thought you were settled and I guess in this environment the really difficult part is that if there's a time in your life when you thought you had made a last decision, a nursing home might be it and suddenly that's up for grabs again and you're starting all over. So it's very difficult to make changes in that way.

MR WOODS: Moving on to the question of extra services, what future do you see there being? We note that at a national level there's very low take-up of extra service places at this stage. Does that reflect the fundamental nature of the sector, that it is providing a standard of care for all who are in their frail age circumstance or does it reflect the industry hasn't yet come to grips with the opportunities that may be available through extra service places? From the consumer perspective, is there an unmet demand or potential?

MS LYTTLE: I suspect - and again, I don't have enough actual data on this but I suspect that the unmet demand might be building, put it that way. If people are now being charged differently and things are changing, and again the market looks attractive. If you go and look at that and say, "That's a very attractive option. We've got more choices in there, mum," or "Dad can afford that," at the time and you say, "Well, we would already be paying this," which is over the basic 87 and a half per cent as it was, adding in some extra may seem more attractive. So I guess it's changing the culture as much as anything.

MR WOODS: Do you foresee problems if there is a greater level of extra service places of conflict, concern amongst residents that some are getting the better meal and the haircut more often or those additional services. Is that something that, for an organisation such as yours, is a concern or not?

MS LYTTLE: I think in terms of having people feel that they're getting a reasonable quality in the first place you'd have to look at how it was structured, you know. You don't necessarily want to be saying, "They're all sitting at the captain's table and I'm here in the second class steerage." So not that concept, but if you say, as I understand it, mostly people are either doing a wing that is extra service which would be like a separate area or the entire facility is extra service. So I guess the most invidious thing would appear to be if someone is actually sitting there saying, "You're getting that food and I'm getting this," and "you get more attention than I do" etcetera. Any sense of that would obviously be not a good way to run things and highly inequitable.

MR WOODS: Are you finding any experience with that at this stage though or not?

MS LYTTLE: Not at the moment, no. That's not an issue that has been brought up.

MR WOODS: That either reflects the low take-up or where it is being done, it's being done in a satisfactory manner.

MS LYTTLE: Yes, and that mostly it's facilities that are all extra service places, not the wings or anything.

MR WOODS: You put great emphasis - and rightly so - on the question of quality and its assessment. Is the accreditation process going to delivery quality benchmarks in your view?

MS LYTTLE: I think it has the capacity to do that. I think it's going to take a while. We just reflected on this with our staff this morning, that there's certainly two things that are happening - two responsibilities of the Aged Care Standards Agency - and that is bringing people towards and educating and supporting them towards accreditation and the achievement of poverty outcomes and at the same time continuing the ongoing assessment of those facilities until they're ready for accreditation through the standards. I think it's that second process that is the one

that we're still concerned about. If you said many people are moving towards accreditation and meeting standards, improving as they go, ready to put their name down to be assessed, there are others who have been more than recalcitrant in the previous system who frankly, I think, need to be managed out of the industry in many cases because they won't make it through the process. I'm just a bit doubtful about the capacity of the agency and its process to bring those people to the point where they either meet the standard and see themselves entering accreditation or they decide that they can no longer run this kind of business.

MR WOODS: So you think the next 3 years will be a fairly crucial period in the industry in Victoria?

MS LYTTLE: Absolutely, yes, and certainly as I've noted, there are people who are paying for the extra quality, paying for the promise and they won't live to see it. They may in fact suffer quite a deal from the changes in the meantime from some providers who are a small minority but who are key to a large number of residents' quality of life who will simply continue in the system, and as I understand the industry itself has reflected on this aspect - they will continue in the system for as long as they can and they will get out at the last minute before they have to face accreditation. I have people I'm working with right now like that and their residents are getting bad care.

MR WOODS: Are there any other matters that you'd like to bring before the commission in this inquiry?

MS LYTTLE: I don't think so. I guess I just reflected briefly at the end of it on some of the issues around the wage parity, certainly as I can see in terms of the kind of staff that are employed and the career track for nurses in this area. That should be encouraged, I believe, rather than saying, you know, you only work in aged care if you can't get into acute care where the pay is better. This area needs to be brought up, skilled up, and it needs to be a good career path to really foster that. I think the government needs to carefully consider the issue of who pays in terms of the mix of user pays. At the moment my belief, my sense is from talking to people around the country and from consumers that ring us, that they probably won't wear much more in the way of charges, given what they're seeing at the moment in relation to what's being delivered for money.

That's not to denigrate the staff who are working there trying to do their best, but in the conditions that people are saying, "There's less staff, we're more rushed," they're not seeing the quality promise. I suspect if you ask them for more money at this point, that is not a politically viable option. That's only my hunch but we had some hunches before we shared with the government and we were right. So if you want to take that on board for what it is worth.

MR WOODS: Thank you for your evidence today. I appreciate that.

MS LYTTLE: Thank you.

MR WOODS: I'll be calling next witnesses from the Australian Nursing Federation. Thank you. I welcome Ms Julie Ligeti, Ms Jill Clutterbuck and Ms Sue Koch. Could you please give your names and positions that you hold for the purpose of the inquiry.

MS LIGETI: I'm Julie Ligeti and I'm industrial officer for the Australian Nursing Federation with primary responsibility in the residential aged care area for the branch.

MR WOODS: Thank you.

MS CLUTTERBUCK: My name is Jill Clutterbuck. I'm a professional officer with the Australian Nursing Federation (Vic branch) with the portfolio of aged care.

MR WOODS: Thank you.

MS KOCH: Susan Koch from Latrobe University School of Nursing and I'm director of postgraduate studies.

MR WOODS: Thank you and welcome. Do you have an opening statement that you wish to make?

MS CLUTTERBUCK: Yes, we do, thank you, commissioner. The Australian Nursing Federation is very pleased and thanks the commission for its time and attention today and what I would like to highlight in the opening statement are the issues that are of most concern to us in relation to this review. The coalescence to a national standard rate of funding for SAM in 1986-7 saw Victorian nursing homes lose an average of 19 per cent of recurrent infrastructure funding. This loss of funding had a marked effect on our industry which historically was mostly comprised of small, that is, less than 45-bed homes and has played no small part in the fact that some 30 per cent of our homes now today must either be refurbished or rebuilt to meet accreditation and certification standards. They must also now agglomerate to become efficient within years and months of our large state geriatric facilities being broken up into 30-bed homes in order to become more homelike and to conform with government policy which was established in the late 1980s.

For the Victorian industry to now be faced with further cuts to recurrent funding on the basis of a movement to a standard national rate for care funding at a time of such enormous change when there is a shortage of qualified nurses and a pay disparity of some 15 per cent for nurses, will indeed lead to a total crisis in our sector. The development of the standard hourly rate formula for CAM, which set the basis of the current state specific funding, and the proposed coalescence of which this report is all about, led in turn to economic pressures being placed on states such as Victoria through the departmental review of resident category claims.

In simple terms, it led to the interstate unreliability of the data related to resident categories between states. That is, what was accepted as a category 3 in Victoria may well be funded as a category 2 or even category 1 in another state. This was noted in research which was carried out for the Commonwealth by Braithwaite et al in

1992-93 and has been recorded anecdotally by nurses ever since. The outcome of this state specific economic pressure on funding is demonstrated when we look at the data published in the volume 2 report on government services of January 1998 which shows that currently the average cost of a nursing home bed in Victoria is $1310 per head of population aged over 70 years.

This is $87 below the national average for Australia. The Australian Nursing Federation (Vic Branch) therefore recommends that the commission in its final paper that this issue of actual funding to states be addressed in whatever solution is developed. Secondly, that recurrent nursing home funding is placed in the wider context of actual funding for all aged care services on a state by state basis, otherwise we may be in danger of simply replacing one set of funding inequities with another.

The Australian Nursing Federation (Vic branch) contends that with Victorian state deregulation of nursing homes in 94-95 and with the further removal of accountability of CAM funding as of 1 October 1997, there has been a serious erosion of skilled experienced nurses in the nursing home sector in Victoria. This is continuing today and has already led to a crisis of care, we believe, as nurses in our homes. In 1996 Victoria had some 40 homes of concern. With the dismantling of the departmental monitoring system and the transfer to the aged care standard agency and a reduction of resources in this area, the data collection has changed but the standards issues remain and are only now collected on a complaints basis.

I would like to draw the commission's attention to some nursing labour force figures that have recently been released for Victoria. The last two sets of data, that is, 95 and 97, have only been released in the last 2 weeks. These figures effectively show a loss of 904 registered nurses division 1 and 3285 enrolled nurses or division 2 nurses. This is a total of 4689 gerontic nurses lost from the industry over a 3-year period. These figures are even worse than appears because these losses have occurred in the majority, in the private for-profit and charitable sectors; that is, two-thirds of the sector - because one-third of our sector in Victoria is run by the public sector which have not had those losses.

Victoria has been blessed over the years with a comparably low wage cost, very high skilled nurse in the division 2 nurse. This is unlike any other state in Australia. This changed dramatically in 1993 at which time the state government embarked on a series of quite large funding cuts to our public health sector. And as part of those cuts they closed the Melbourne School for Enrolled Nurses which was the PTS training centre for the whole of the metropolitan area of Melbourne. We fell within 12 months from training some 800 division 2 nurses down to training 120 per annum and it's only in the last 12 months that those figures have climbed back up to that situation again.

The Australian Nursing Federation (Vic branch) will attempt to demonstrate the link today between quality inputs, that is, nursing staff and skills mix, and the maintenance of quality outcomes for residents of nursing homes - and Miss Koch will speak to this in a moment. This link is critical I believe to the success of the

government's reform process and it is becoming increasingly difficult to maintain in a deregulated environment we're finding in Victoria. The American aged care experience demonstrates that a market for-profit approach has failed miserably, causing untold pain and suffering for their elderly, and it has been stated publicly that that industry is a shame on their society today. In 1992 Prof Allan Pearson quotes a study by Ryan of 1986, which study was of untrained staff working in nursing homes, and the quote from that study is:

> The level of ignorance and misconception held of aged people amongst these untrained workers was alarmingly high and I believe this poses some serious questions for Commonwealth departments opposed to funding trained staff to provide care for nursing home residents.'

Again in 1993 Prof Gregory in the review of the structure of nursing home funding arrangements on page 78 stated, and I quote:

> If a non-acquitted funding system were adopted the other components of the regulatory framework would have to be examined and strengthened to try to safeguard delivery of care to residents and consideration might also be given to whether measures should be introduced to protect staff.

The Australian Nursing Federation (Vic branch) is now able to demonstrate - after some 2 years - that enterprise bargaining, CAM or not, has been an abject failure in this industry in this state. If it is demonstrable that maintenance of quality outcomes for nursing home residents depends on the input of experienced, skilled, knowledgeable, gerontic registered nurses, then the recommendations of this commission, we suggest, must be conducive to the maintenance of those nurses in the workforce. To keep this skilled workforce and to be able to recruit from the nursing profession, nurses in this sector must (1) have pay parity with the rest of the nursing workforce. They must have comparable working conditions that allow and enhance their ability to maintain their professional practice. This goes to the issue of skills mix, untrained workers and staffing levels.

The ANF (Vic branch) recommends to this commission that it recommend that the Commonwealth in conjunction with peak organisations, consumers and professional associations, develop quality outcome indicators for aged care services which are measurable and applicable, as they have done in the acute sector. I thank you for your time.

MR WOODS: Ms Koch, do you want to proceed?

MS KOCH: Thank you, commissioner. If I could just start by saying that until relatively recently long-term aged care was typically custodial in nature and there was a widely held view that as nothing could be done for these elderly people, they were only going to die anyway, that skills and knowledge were actually unnecessary, that really kindness and a strong back were seen to be the main requirements for working in nursing homes. However, it's now actually recognised that gerontic nursing is a

specialised field and that custodial care is entirely inappropriate and we actually see this now by the universities offering gerontic nursing as a specialty and gerontology as a specialty.

However, there is evidence that suggests that the numbers of qualified nurses in aged care are decreasing and at the same time as demands for care are actually increasing. What we're actually seeing with older people now in nursing homes, that they actually have a higher level of acuity than they did possibly 10 years ago. There has been some research. Two authors, Trex and Rodeski, actually contend that because of relative lack of technology in nursing homes and the lack of medical support and other paramedical support that there actually is a great need for qualified staff with appropriate clinical skills - and we would actually advocate that those qualified staff should be nurses.

The cost and benefit of qualified staff seems to be an area of contention and yet there are some studies that have supported a view that while employing unqualified staff may appear cheaper in the short term over time in fact it's actually more cost-effective to employ qualified staff, especially if quality is a consideration. For example sick leave, staff turnover and workers compensation may all be greater when unqualified staff are used. A study by Phillips and Carter showed that some 30 nursing homes in Melbourne, they actually reported that qualified staff tended to stay in employment situations for longer periods than less qualified staff.

However, this situation is not unique to Australia and if you actually look at American literature and their research we can actually see what's happening over there. They actually have turnover rates estimated to range between 40 per cent and 75 per cent with some reaching 500 per cent. Appropriately qualified staff may actually also prevent costly problems such as unnecessary acute hospital admissions, pressure sores, overuse of drugs, restraint both physical and chemical, incontinence, accelerated functional decline and all of the associated costs. Health Interlink in 1988 found that labour costs increased by 8 per cent with the higher proportion of RNs. However, productivity actually increased by 10 per cent, despite this increase in acuity. Improved quality was also associated with more RNs in the staff mix. In another major US study in 1983 it was reported that:

> Increasing the ratio of RNs to residents was related to higher patient care cost but also reduced total costs per day. The use of unqualified workers can increase costs through associated time required for supervision and training.

One significant 9-year study by Lyn in 1977 followed 1000 men transferred from a general hospital to 40 nursing homes again demonstrated that a higher ratio of RN hours per patient was consistently and significantly associated with all three outcomes measured. Those were patient survival, improved functional status and discharge. Pearson's study in 82, Manuel and Hosler, Zin, Munro, Gavin and Tilbury have all supported those findings. There has also been reports from the ANF that we've just heard and others which are located in the US newspapers and on the Internet that actually indicate there is a relationship and a cost analysis with litigation

and worker injury which may provide evidence needed to demonstrate the cost effectiveness of qualified staff.

Can I just add though, it's also problematic to equate having a qualification with being appropriately qualified. Having a qualification that is not valued may actually lead to frustration, resentment and poor care delivery and it may be that your qualification was one that was gained many years ago and never upgraded and predictably may not be related to high quality care as Pearson's study highlights. I would like to also add the aspect of actually experience is something else. We hear of nurses having 15, 20 years' experience in aged care but perhaps we should also reflect that that may be 1 or 2 years' experience repeated 10 or 15 times so they may not actually have a broad experience.

In relation to the image of aged care, the devalued status of elderly people and the associated ages in society generally and amongst health professionals is recognised by most authors as a primary factor in the low status of gerontic nursing. The low status reflects a status of ageing in elderly people in our society and I would also add if we're seeing that nurses working in aged care do not deserve the same salary as their colleagues in the acute care centre, we're actually reinforcing that. I think that's all I'd like to say at this moment.

MR WOODS: Thank you.

MS LIGETI: Yes, if I may just add one more comment to that.

MR WOODS: Please.

MS LIGETI: What the ANF believes is not being recognised by government is the expanded role that the residential aged care sector is now playing across the health community services and aged care system and by that we mean that because of, in the acute public health system, there have in the last 5 to 10 years been a significant downsizing, budget cuts, service closures, the advent of casemix funding, that the responsibility for the provision of services which 5 or 10 years ago would have been provided in a hospital setting are now being foisted upon the aged care industry and the complexity of care has increased significantly and we believe that that adds to a necessary conclusion that work must be done to improve the level of numbers of qualified nursing staff in residential aged care.

MR WOODS: Thank you very much. Can I at the outset thank ANF (Vic branch) for the extensive detail that you've provided in your submissions to us and for the time that you've made available to us on our earlier visit to this jurisdiction. It has been most helpful to the commission in its thinking. If I can also at the outset clarify a point that may have caused some comment - and I notice that you pick it up in your second submission, and that is where in our position paper we talk about the industry cost base should reflect nursing wage rates and conditions applicable in the aged care sector rather than in the acute care sector. I notice that you have commented on that. It is not a reflection by the commission on whether those two sectors should have

different wage rates as such but purely that for the purpose of indexation and subsidy determination you should rely on the wage rates that apply in the aged care sector separately from whether they are the same or different from that in the acute care sector. I notice that you draw that conclusion by saying the ANF does not believe that this is the Productivity Commission's intention, so just to clarify that point.

A couple of matters that you raise in your opening statements. If I can pursue those first. One is you have talked on several occasions about the importance of greater training and the quality of care that results from having appropriately trained staff in nursing homes. Does that relate also to improving the training available to the personal care sector, and what, from your experience has been the trend in that and if there has been an increase in training and in skills and abilities of personal carers is that improving the quality of care in the homes and also assisting the RNs in the delivery of their care to residents?

MS CLUTTERBUCK: Perhaps, commissioner, if I can answer that in two parts or from two perspectives. The first perspective is that in terms of education, with the changes resulting from the state government budget cuts and the closure of the MSEN in 1993, we started to move very rapidly away from an historical skills mix. There has been - and is not to this day in Victoria - an accredited course for what is called a nursing attendant in a nursing home in Victoria. So there has not been developed or made available a course that would replicate that of the historical training we had in hospital base for division 2 nurses.

Anecdotally I have been told by directors of nursing in nursing homes that where they have employed what may be called trained unregulated workers - these are personal care attendants - their training does not fit them to work in nursing homes where there is such a complexity and acuity of residents. They do work quite well, I understand, with less dependent residents in settings such as hostels and the community but directors of nursing tell me that the training they receive is not enough to replace a division 2 nurse that we historically had in nursing homes.

MR WOODS: Yes, I'm not suggesting it be to replace but that for the employment of personal care attendants presumably if they can receive training that is applicable to that particular industry area then that would assist in improving the overall quality of care and assist nurses in their delivery of their services.

MS CLUTTERBUCK: By the time you gave them the training that would fit them to carry out that work, we would believe that they may as well be a division 2 nurse. The division 2 nurse, in terms of wage cost to a personal care worker trained, is only a matter of some - I've actually got the figures somewhere. In terms of hourly wage rates it's very little. There's a marked difference between the cost in wages of a division 2 nurse and a registered nurse division 1.

MR WOODS: Yes, I understand that difference.

MS CLUTTERBUCK: So one would ask why wouldn't you train division 2 nurses. A personal care worker, year 3 and thereafter is $14.57 an hour. Pay point 5 for a division 2 nurse is actually $13.55 an hour.

MR WOODS: Thank you. That's useful information. You also made the point about quality outcome measures and clearly that's fundamental if we're to pursue a subsidy that relies on there being a benchmark level of care as an underpinning across the industry. In your view, will the accreditation process provide such a series of measures or are there alternatives that should be brought to the commission's attention?

MS CLUTTERBUCK: Perhaps I think Miss Koch would like to ask some questions about benchmarking and you do talk about it in your discussion paper or mention it.

MR WOODS: Yes.

MS CLUTTERBUCK: I think I would agree with Miss Lyttle who spoke before, that there's a possibility that this may occur with accreditation. We don't know. We would hope so and we would hope it would develop good outcomes or better outcomes. But in my mind there is a question mark over that and perhaps - would you like to say something about that, Sue?

MS KOCH: I think as well, if we think historically, when the outcome standards were first introduced the idea would be we would have quality outcomes in which to measure and now we've got accreditation coming forward. I can't say that I'm familiar with exactly what that process is going to be. I don't know if they have quality outcomes which are going to be measured. It almost looks as though it's processes that are going to be set up. I'm not sure about quality outcomes. I think we also have to be concerned or be aware of the fact that if we are going to benchmark, (1) what is meant by that and who are you going to benchmark against. The other thing is management will actually be reliant on the people on the floor to ensure that the quality outcomes are met and that they understand the processes of benchmarking and accreditation. So they are going to have to ensure that the staff they have also have some knowledge; some education in that process which doesn't seem to be happening a great deal. Yes, I mean, I think there is still some haziness about benchmarking and how it's going to be done.

MR WOODS: There are several options in devising a subsidy. One is to take what we have and perform some mathematical process which would lead to the coalescence as currently proposed but with all of the underlying anomalies and inconsistencies to some extent just being averaged out. The proposal put forward by the commission was to increase the transparency of the basis upon which the subsidy is developed so that you identify an average - sorry, you identify a standardised bundle of inputs for a profile that is generally agreed to be a useful benchmark in many respects, one being roughly its size, a second being the profile of residents, the third being the roster and other resources applied; another being to ensure that the funds are sufficient to meet

an acceptable minimum level of quality outputs. So it is necessary for those experts who will later grapple with implementing whatever the government finally decides in relation to our recommendations, to put that into hard and fast numeric form.

So I'm very interested in assessing whether there are such quality measures available either at present in industry as developing in industry or as could possibly be formed to be able to put forward such a recommendation, but I don't want to recommend a form of subsidy that is built up on a lack of substance. Hence, pursuing this question with many witnesses. The issue of accreditation, if it is pursued in a form that says you must achieve these levels in an absolute sense before you can be accredited, whether it be for 1, 2 or 3 years, but that forms a definitive floor under which quality cannot fall, then that is a useful base. However, if the emphasis in the accreditation process is ensuring that there is progressive improvement, that the floor is variable, then clearly there will be some concerns. It may not prove to be the appropriate instrument to draw upon.

From your research more broadly than just the accreditation process as it is currently envisaged, has that research produced methodology by which you can measure in some more definitive way the quality outcomes in nursing homes?

MS KOCH: I think if you're looking at aspects of care, if I can focus on that, then yes, there are ways in which that can be measured. Unfortunately you have the problem at the moment of a measuring quota that comes of funding. That's of research because it has not been done a great deal in the past. It can be done. There is now research into evidence - best practice - which is seen as best practice to model your care on. The other outcomes - I suppose I'm concerned that if we take it too far - if we're looking for improvements it may only be for a very short time for an individual that there is a marked improvement. However, the improvement might actually be a stabilisation but because of the community that we're looking after there is an inevitable deterioration and I'm concerned that may well be then interpreted as, "You are not achieving the outcomes that you were supposed to."

MR WOODS: I'm not aware of people having that particular perspective, given the nature of this industry.

MS KOCH: Well, anecdotally when it was the outcome standards it was almost seen that it was actually better not to attempt any rehabilitation because there was actually more funding by not doing that than by actually carrying out what would be seen as best practice.

MR WOODS: Certainly it is a matter that has exercised the commission's mind in terms of the incentives for achieving some level of rehabilitation and watching a person go down the scale in the RCS funding as to where the incentives lie in that process. You make a comment in your second submission on page 4 that:

The commission needs to acknowledge the relative efficiencies and cost structures across the whole of aged care service provision within a particular state and compare this to other states if true equity is to be achieved.

Ms Clutterbuck, you made reference in your opening comments, to understanding the totality of aged care funding. Can you elaborate on how you see that broader view of the aged care, as it impacts on the particular matters that are being addressed by this commission?

MS CLUTTERBUCK: Perhaps if I answer that and Julie may like to add to it. Victoria was the first state to introduce casemix funding into our acute health sector and within 6 to 8 months we started feeling the impact of that in our nursing home sector and then into both hostels and community care, HACC and community aged care packages. At the same time in this state over the last 3 or 4 years we have been closing nursing home beds. It's hard to tell whether you're closing them or just moving them. Relative to our aged population, we have decreased the number of available nursing home beds. At the same time our number of hostel beds have not been increasing markedly. They have increased but not to the same degree as the other offsets have occurred. I guess the Commonwealth department - and I've often heard them exhorting the aged care industry to particularly nursing homes, to see themselves in the light of a broader service sector.

So I would believe that the commission, when it's looking at recurrent funding for nursing homes, must also take that into account because it has an effect on the residents that that service is providing for, that is, I would say as a nurse - there may be others in other states that may shoot me down in flames - that our residents in nursing homes have a great acuity and complexity of care needs. They would need in some instances quite technical resources that are not as apparent in the provision of nursing home care in other states and I note that the commission does discuss the issue of extra subsidies, I think you call them, in relation to these issues and we would believe that that is something well worth pursuing.

But I think whatever formula is developed for funding, the commission must look at that aspect of the various jurisdictions and the effect that it's going to have on the nursing home care. I think it's very important, if we're going to look to the future, and the role that nursing homes in particular will play with our ageing population in the delivery of health services. Does that answer your point?

MR WOODS: Yes, thank you.

MS LIGETI: Just simply to add to that and to stress in Victoria we believe that the estimate is since the end of 1992 to date there has been a loss of approximately 1700 public sector acute hospital beds, a closure of quite a large number of rehabilitation services for the elderly and rehabilitation beds. We believe that many of these services that used to be provided elsewhere in the system are now being picked up by the residential aged care sector and this isn't being recognised through the funding system. The savings achieved to the overall system isn't being in fact recognised.

MR WOODS: Is some of the loss of acute care beds also related to increases in day surgery and reductions in average length of stay and other practices that have also assisted in deinstitutionalising a large part of the recovery process of patients?

MS LIGETI: Yes, it would be but insofar as the elderly are concerned, particularly if they are persons who are living in a nursing home or eligible for admission to a nursing home, their shorter lengths of stay in hospital due to casemix funding and the advent of day surgery and so forth means that their pre-acute care and their post-acute care is being provided in the nursing homes, not the hospitals. So it is that kind of work that is now being picked up in the residential aged care sector.

MR WOODS: Yes, I just wanted to put the totality of the reduction in context; that there are significant other forces.

MS LIGETI: Yes, I accept that, commissioner.

MS CLUTTERBUCK: I guess looking at it from the other perspective, if there are introduced into the new funding formula what may be termed disincentives to take the complex type care resident, that will impact very rapidly back into our acute sector.

MR WOODS: Yes, particularly in country areas.

MS CLUTTERBUCK: Particularly in country areas.

MR WOODS: Putting to one side the interjurisdictional comparisons - and I take them all on board and understand your point, but looking at the interplay between the acute care sector, nursing homes and what was previously known as the hostel sector, it seems that the nursing homes are in some form of interplay between the two; that people who may move through a continuum of own homes, retirement village, hostel, are making progressive choices about the accommodation they wish to have.

That leads to one type of view as to how the subsidy should be built up, particularly with ageing in place, therefore from hostel into RCS1 to 4 categories whereas if you take the perspective of looking at nursing homes in part being an extension of acute care and to some extent palliative care in effect, that leads to a different view as to how a subsidy should be constructed. How do you resolve those two very different perspectives when you're looking at trying to fund a thing called high level care RCS1 to 4, which seems to be meeting very divergent needs and comes from two different directions? Is there an easy solution?

MS LIGETI: Can I just make a preliminary comment before deferring to the nurses at the table, commissioner; that is, there are statistics released by the Institute of Health and Welfare, which documents that most residents of nursing homes are admitted directly from an acute care setting; that is, there are very many of them and I believe the statistics substantiate that the majority of residents in nursing homes don't have the opportunity to make that progressive choice. They suddenly find themselves

in the circumstances of needing nursing home care and the majority are admitted directly from an acute care setting with very limited time to make choices.

MR WOODS: Although with ageing in place there may be some change in that over time, even if they have a period in acute care as part of that continuum of moving from hostel into nursing home, that there may be a period in acute care and then back into nursing home. Thanks.

MS CLUTTERBUCK: Two issues. I think possibly our government is about two hops ahead of us on this anyway. One of the reasons that we've had developed a funding instrument which rewards ageing in place is that the view is that a lot of that continuum from retirement village, hostel to nursing home, will stay in the hostel.

MR WOODS: Yes.

MS CLUTTERBUCK: Increasingly over the last 5 years, I would suggest that our federal government views increasingly nursing homes being an adjunct to acute, that is, a sub-acute setting for elderly care and as Julie says, I think over 70 per cent of residents now admitted to a nursing home are admitted post-acute episode out of a hospital and that's growing markedly and I think it will continue to grow, given the way our health services are being provided now.

MR WOODS: But in part you then have to look at where they were before they went in and had the acute care episode and that pattern may also be changing over time.

MS CLUTTERBUCK: Yes, it has changed over time.

MR WOODS: They are not necessarily coming in from a house in suburbia; they may be coming from either a retirement village or a hostel.

MS CLUTTERBUCK: There is interesting data, I understand, collected by ACATs, the Aged Care Assessment people in relation to this issue and they're very interesting people to talk to.

MR WOODS: We have met some ACAT teams in our travels through this inquiry.

MS KOCH: Commissioner, can I just ask you - I don't know whether I'm on the right track or not but I think one of the other issues is if someone has been in a nursing home and gone into the acute sector there seems to be some anecdotal evidence to suggest that they're actually transferred out of the acute sector, which saves the acute sector money but transferred back into the nursing home area where there are insufficient qualified staff. The residents then have a higher level of acuity which burdens then the nursing home. So it might be, if there was more transparency of funds, in that if someone was discharged earlier from the hospital back into a nursing home that what the hospital then saved is transferred with them to the nursing home.

MR WOODS: Picking up your point, that's why I'm saying you can design a subsidy from one perspective or the other but it's very difficult to see how you actually marry those competing interests into one instrument.

MS CLUTTERBUCK: Yes, there is a system of funding developed by the state government in Victoria called Healthstreams, which is an outgrowth if you like of casemix funding, designed to allow that funding to follow patients from acute services out into the community. So there is already something there to look at in relation to having funding follow the client into another silo.

MR WOODS: Form of care. A final question from me. You advocate that workers compensation - and you also say superannuation and accrued entitlements of staff - should remain a discrete area of funding for which employers are required to account. I understand the importance of preserving superannuation funding but if we look at workers compensation, are you in those words advocating that you would reimburse the actual cost of premiums and if so, where are the incentives for providers to invest in the short term even more into occ health and safety to produce longer term savings in their premiums; produce a better work environment; improve the quality of life for staff etcetera?

MS LIGETI: Commissioner, I believe that the previous system of OCRE funding operated in a way that it funded the average workers compensation cost.

MR WOODS: Yes.

MS LIGETI: If I might first say that we believe that the previous OCRE items - that is, superannuation, workers compensation, long service leave - are important to be segregated to ensure that the premiums or entitlements or the superannuation contributions are there and able to be paid. The reason that we've put forward the view that it ought to be a discrete part of funding is that we are concerned about premiums not being paid. It's simply that. If the government, in its wisdom, decided that that ought not occur then we would be suggesting that there needs to be some transparent way of accounting by way of producing annual reports or quarterly reports to ensure that providers are making those payments. If the commissioner was considering workers compensation and other items as being a discrete area of funding, we would perhaps suggest that a way of providing the incentives for occupational health and safety initiatives and incentives for providers to bring costs down might be aligning the funding with an averaging in the way it was before.

MR WOODS: Okay, thank you. That's helpful. I understand the different perspectives that you bring and are seeking to ensure through the subsidy process. That's all I have in the way of particular questions on what I may say have been very lengthy and very detailed and useful submissions. Are there other matters that you wish to raise in this hearing?

MS LIGETI: Commissioner, may I make a brief comment about what has occurred in the process of enterprise bargaining for nurses in Victoria?

MR WOODS: Yes, please.

MS LIGETI: We will be putting in some more elaborate submissions on that but we did wish - - -

MR WOODS: On 27 November.

MS LIGETI: Yes, on time this time, commissioner. But we did wish the commission to be up to date on what has occurred. Commissioner, some 2 years ago the Australian Nursing Federation commenced the process of enterprise bargaining for the rates of pay of registered nurses division 1 and enrolled nurses division 2 and that was done at a peak level for the first 12 months and then formal notifications pursuant to the Workplace Relations Act were served to commence bargaining periods. That didn't reap any benefits via a process of negotiating with both individual providers or their peak organisations and at the beginning of this year an industrial campaign ensued where nurses in approximately 20 nursing homes commenced protected industrial action. Still at the end of a fairly protracted period of industrial action - I think in one home the lengthiest period of action was 2 months - what was transparent was that there were appearing to be no providers able to step forward and to pay a pay increase or offer terms and conditions which were even near comparable to the public aged care and acute sectors or the private acute sector.

So the ANF has made an application to the Industrial Relations Commission to test its powers to terminate the bargaining periods and to arbitrate a wage outcome. It will depend on the Australian Industrial Relations Commission's view of our award and as to whether or not it believes our award holds pay rates status which is an arguable legal point. Should the ANF be successful in its application, it is likely that there will be an arbitrated case in relation to rates of pay. Commissioner, if I can just make two points about that. One is that I think the demonstrable loss of registered qualified nurses across the system in the last few years has now I think led to a fairly - it will lead to very powerful evidence for the commission in relation to productivity. Particularly since 1 October last year when the boundaries around CAM were removed but in the 2 years preceding that the ANF has witnessed very, very significant reductions in care hours, increasing pressure on nurses to pick up a whole range of new duties.

MR WOODS: Yes, I noticed those.

MS LIGETI: And very significant hours of unpaid work being done. So we believe that there is a fair likelihood of our case being successful and the commission awarding a pay increase. What I would like to say in relation to that, and I believe that the industry organisations also may wish to comment - if that case is successful and we are awarded a pay increase and it is not funded by government, it could be catastrophic for the industry. To that end, we would like to suggest to the

commission - we understand that the current proposal in respect of indexation is that, with the exception possibly of Queensland and South Australia, for a time at least the current indexing arrangements continue.

The ANF believes that Victoria has its own set of unique and very serious problems and an arbitrated decision in respect of rates of pay or not, Victoria needs to be treated as a special case for the purposes of indexation because something must be done, in the ANF's contention, as a matter of urgency on the issue of rates of pay in Victoria and something must, in our view, go into the system in terms of funding to enable the problem to be addressed because by the year 2000, if it's not addressed, the disparity will be 18 to 20 per cent. Thank you for your indulgence, commissioner.

MR WOODS: I welcome your views on that. Do you have a copy of our - yes, you do. Could you turn to page 17 of our position paper and there's a table - 3.1 identifies qualified nursing hours compared to subsidy rates. These are drawn from submissions and the first column is looking at the RCS level 3 subsidy per day. You will see there Victoria being the second highest. Then the average hours per resident per week of nursing attention to residents and Victoria is also there - in fact it's equal highest with Tasmania. Does that suggest that there may be some relationship between the level of subsidy offered and the hours of nursing care made available between jurisdictions or is that a consequence of other factors that aren't explained by that table?

MS LIGETI: Can I just make a preliminary comment, commissioner. I believe two things about these statistics. One is that they are probably out of date. In terms of what has happened over the last 12 to 36 months, we have witnessed a very marked reduction in hours of care by registered nurses. Secondly, I would suggest that it is partially explainable by the numbers of enrolled nurses division 2 that we have working in Victoria. We believe, as we said earlier, that they are a cost-effective nurse; that their rates of pay are in fact lower than personal careworkers at the highest level of their pay rates but I would suggest that those figures were explainable in that way. First of all, I would believe that they wouldn't be current. They couldn't be current. But secondly, it's explainable by the numbers of enrolled nurses division 2 that we still have working in this state.

MR WOODS: Yes, and we recognise there are small numbers in the samples and also there may be some bias that clearly if you've got very much smaller facilities the structural inefficiencies lead to higher nurse hours anyway because of the way that you can design rosters and suchlike.

MS CLUTTERBUCK: Yes, that's right. Because the majority of our nursing homes are smaller they do have a higher component of registered nurse hours and I would support Julie's contention that because division 2 nurses would come up as qualified nursing hours, they will boost those hours quite markedly in comparison to other states.

MR WOODS: Nonetheless, I would appreciate if you did wish to jot down some reflections on that table for us. That would be helpful.

MS CLUTTERBUCK: We certainly will. I think the other thing that would come into play are the comments that we've made about the classifications of our residents and their relative dependency to other states. Victoria is very close to having category 1's, 2's and 3's that are similar, for instance, to New South Wales but those residents may indeed be consuming a lot more dollars. Because of the interstate unreliability of the comparisons of categories, we maintain that you can get a distortion.

MR WOODS: Thank you. All right. I would welcome your comments.

MS KOCH: Commissioner, may I be indulged just to finish.

MR WOODS: Please.

MS KOCH: Just in relation to the skills mix, I would hope that when this is being looked at it's not only a skills mix from RN down to the unregulated worker, the PCA, but actually upwards as well and especially when we're looking at areas where nurses are perhaps working alone and having to work as practitioners. In this text, which is nursing staff in hospitals and nursing home staffing and quality of care in nursing homes, there have actually been some demonstration projects which have convinced the hospitals and nursing homes that the gerontic nurse practitioner is actually extremely effective. If I can just read this:

> Evaluations confirmed that nurses with advanced preparation in care of the elderly decrease unnecessary hospitalisation, the use of emergency rooms and prove admission and ongoing patient assessments provide better illness prevention in case-finding, decrease incontinence, lower the use of psychotropic drugs and generally improve the overall management of chronic and acute health problems.

Based on the research evidence they have actually made a recommendation that:

> Nursing facilities use geriatric nurse specialists and geriatric nurse practitioners in both leadership and direct care positions.

Perhaps it's something that Australia should also consider.

MR WOODS: Thank you very much. I appreciate the time you have given us. I'll call a very short adjournment and then the next witnesses.

MR WOODS: I reopen the hearing at this stage and welcome Mr Kingsley Curtis from Aged Care Organisations Association, South Australia and NT. Could you please state for the record your name and the position you hold.

MR CURTIS: Kingsley Curtis. I'm the vice-chairman of the Aged Care Organisations Association of South Australia and the Northern Territory.

MR WOODS: Thank you and welcome. Have you got an opening statement you wish to make?

MR CURTIS: Yes, I'd like to just talk briefly to the response that we made and also to pick up some of the details from the preliminary proposals that the Productivity Commission put out, if I may. South Australia and Queensland have been disadvantaged in some way and we welcome the commission's view that there should be immediate relief in that area but we also recognise that other states that have been funded at a higher rate will have cost increases and so it's not just a simple exercise of shifting money from one state to another and we realise that this is one of the challenges that the finance people will need to address. So we are pleased about the recognition that the coalescence over a long period of time is one that should not go ahead.

We are also interested in the fact that the range of subsidies between the states is much greater than the range of costs and we recognise that and we'll need to look at the fact that there will be minor variations. There's no way that you could have a single rate but the variations do not need to be as much. We believe that we need a simple system and one that is not administratively complicated. It could be a weighted system and it could eventually work towards a common funding system with minor variations. So we recognise the fact that the commission has indicated that the subsidies and the range of costs - there are some variations there. Equity - we're very keen that there is consistency and that national service and care outcomes are taken into consideration.

We recognise that remote and isolated areas need special recognition because there are special details that need to be addressed in that area and I'll talk about those in a minute. We need some very clear criteria so that everyone can judge and feel confident in the system . Where people don't understand the system then when they're working in very tight financial constraints then there's a lot more complaint than is actually necessary. So where the system is clear and people understand it, even if they're working under tight constraints, they're much more accepting of that. The funding mechanism therefore must be transparent, objective and it must be regularly reviewed. One of the problems is that some of these things have gone on too long and people haven't been content with those and they haven't seen any changes that are coming.

Wage Parity: one of the things that concerns us is the fact that we and the acute care people work in the same environment. We take our staff from the same pool and the staff in aged care in many cases need to be able to work more independently than

those in the acute care area because we haven't got that hierarchy of nurse supervision. One of the problems that we have had in the past and we still have now is that registered nurses who are first out of training are not able to perform the tasks that are required in aged care because they will be working on their own at nights and without the close supervision that they have in the acute care area. The other issue that's important from our point of view is the fact that our work is becoming more technical due to the increased frailty and many of the procedures and things that are carried out in acute care are also carried out in the aged car. So we believe that if there's a bit separation in the wage levels there, that disadvantages us.

Payroll tax and WorkCover seem to need to be treated in a similar manner and I don't think that we can treat one in one way and WorkCover treated in a different way because there are variations across the states. Basically, ACOA, Aged Care Organisation in South Australia, supports the Aged Care Australia submission and what I'd like to do now is just run through some of the things from the Productivity Preliminary proposals. In relation to coalescence, uniform and clear funding details need to be set out. We need to have equity in funding but that doesn't mean that every state needs to have exactly the same level. That's the key to the whole issue and we mustn't lose that in all of the other issues that we raise. The funding must be sufficient to meet the accreditation and certification and there are many areas where accreditation and certification come together, particularly in the building side of it where certain building configuration will also have an impact on the staffing and part of the review of building codes and things.

We've been looking very closely at what is certification and what is accreditation. When you're looking at fire and all of those issues where people have to get out of the buildings, is it staff training that's important or is it the configuration of the building? All of those sort of things bring accreditation and certification very close together. So the funding needs to be sufficient to meet both of those, even though we don't know what the cost of accreditation is at this stage. There needs to be some benchmarking and we were looking at the size and the mix and the location and particularly in relation to developing some basket of services and that will need to include goods and services, not just the service side and we need to have some flexibility. So once the basket of services is organised, then there needs to be flexibility for the organisations to use those to achieve the goals that they have in line with the requirements.

Wages Rates: as I said before, we compete in the same marketplace and so we need to make sure that we have comparable wage rates there. Productivity index that's mentioned - that must be appropriate and we must make sure that there is a fairly quick movement towards something that we can feel confident about. If we're looking at the things like pensions and pensioner supplements and oxygen and central feeding and respite and hardship things, we'll need to keep identifying those because the distribution across the system is not even and we need to make sure that we recognise that factor. Payroll Tax: we agree that people who don't pay payroll tax certainly shouldn't have the opportunity to collect that supplement.

Workers Compensation: there are state variations and there are all sorts of problems associated with that that must be recognised. In government homes and not-for-profit homes we believe that there should be a basic subsidy and they should be comparable there. In rural and remote areas, the difficulties in the rural and remote areas are (1) particularly the balance of services. How do you get that balance right between high and low care with the very limited facilities; between Aboriginal and the white population because of the different needs; the staffing difficulties because of the on-costs associated with that. When you get into the Northern Territory - and you've probably been talking to people there - you have the airfares, you have the accommodation, you have the loading for agency staff and then you have the actual wages. So all of those things need to be looked at and then the cost of supplies and services and servicing those supplies. We need to recognise the needs of those people in that area. We can't always expect those facilities to be viable. There needs to be some government conscience in this whole process when you're looking at the very small organisations.

We're happy with the idea of no acquittal. We believe that people can use their funds in a responsible way and we believe that the funds should be paid to providers. Over many years there have been long discussions in human services areas about education vouchers and voucher systems and things of that kind but we believe that payment to providers is important and as far as reduction of controls and extra services, I think that that could be managed carefully and people would manage that responsibly. There are a whole lot of other issues that come out of that but basically what I want to do is just to emphasise the things that we think are important and to just look at the areas where we are comfortable with the preliminary paper that you put forward.

MR WOODS: Thank you very much for a very comprehensive opening statement that just travelled the gambit of the issues. A couple of things arising from those comments. One is in terms of special needs that you indicated your support for the general proposition. The question then is: is the current viability supplement constructed in a reasonable manner and the problem being the quantum of funds applied to it, or is it that the viability supplement as it currently stands isn't sufficiently embracing of the needs that are in those rural and remote areas?

MR CURTIS: Having spent some time talking to our members in the Northern Territory, their concern is that there aren't sufficient funds for the variety of services that they need to provide. In a small remote area they will still require the same range of service that we provide in our larger metropolitan areas because of the mix of residents and it may be that the way the system is constructed doesn't address all of those issues but I think that there needs to be a better collection of data about that. In talking with the people in Katherine and the other Northern Territory places, they have difficulty really in identifying what their detailed needs are because they change from one group of residents that come in, to the next group. They may get it set up very beautifully for 1 month and the next month the mix will be totally different.

So I think there needs to be a careful study of that and some flexibility in that. The flexibility needs to be fairly immediate flexibility, not "We will adjust it in the next 12 months or in the next 3 months," because their needs change very quickly and one of the things they emphasise to me is the fact that they can't really predict what kind of client they're going to have and they can't predict the client mix so the fact that funding follows after the fact is a difficult process for them to cope with. So that needs to be - - -

MR WOODS: Yes, that's interesting, the perspective on the rate of change because in some instances also the average length of stay can be 10 or more years by some residents who come in at say RCS4 and over that time will stay at or about that same level for a very long time which in itself generates different needs and pressures and you're playing a different role for them than you are for others who are there for a much shorter period.

MR CURTIS: That's right. The building requirements is a difficult one too because of the requirements for Aboriginal people to have community rooms and the white people to have single rooms and you can't get that mix right.

MR WOODS: Yes, and access to outdoors and sleeping arrangements and all sorts of things.

MR CURTIS: And meal provisions and the way even - - -

MR WOODS: We have been to Katherine and Darwin and various other places and discussed those on site with the relevant people. The thrust of your submission is to recognise that a subsidy could still lead to a differentiated state basis so that each jurisdiction would have a different subsidy. Is such an outcome adding a level of complexity to the subsidy arrangement or is it recognising the reality that the differences between jurisdictions on balance, that is, taking the ons and offs of wage rates and land costs and building costs and other operating costs etcetera, is such that the differences are more significant and therefore affect the fundamental viability of facilities than a national uniform basic subsidy could achieve?

MR CURTIS: In coming to the conclusion that there should be some variation, we picked up those issues that you mentioned, that there are different costs in relation to land and buildings and things of that kind. What we would be looking at is something which doesn't make the thing more complex, and I don't know exactly how that would work at this stage, but it would be something that does have a clear statement of why there is a slight variation from state to state. It would be difficult to come up with, I think, a straight per capita rate right across the whole process without somebody saying, "What if - we have this cost and we have that cost." So what we were thinking of is that there should be some variation but the variation shouldn't be anywhere near what it is at this stage because the variation in input is much greater than the variation in costs.

MR WOODS: Yes, and you make that point and so did Queensland, quite strongly. In which case, I then also refer to page 8 of your first submission, which talks about an option to consider block funding states on an equal share basis, using the level of elderly in the population aged 80 plus and thus allowing each state to be accountable for the variations it particularly focuses on to resolve different cost issues within the state. Is that a model that you're supporting? I know you put it forward in discussion.

MR CURTIS: What we've done is listed a number of options there.

MR WOODS: I'm just not quite sure where you fall out in terms of that one though.

MR CURTIS: What we were looking at there is just putting together a range of options, I suppose.

MR WOODS: Which I read with interest, thank you.

MR CURTIS: We could look at various options from, I suppose, a base per capita and blocks for states based on historical data as far as the resident mix and things of that kind and what we're looking at is a range of options that may be considered to improve the system that we have at this stage, without coming down very hard on any particular one of those.

MR WOODS: Yes, I was just wondering whether that one was still within your ambit of possible or whether it was outside of that.

MR CURTIS: I think it could be possible. It could be - yes, I think it could be a possibility because what we are looking at there is trying to come up with a distribution which is clear, is set out so that one state can understand what another state gets, knowing the basis and I suppose it's a bit like the system that was set out in one of your papers that says we would base it on the figures at a certain period of a month and use those periods. There could be, I suppose - one of the other things we talked about was whether we ought to have everybody in the high care funded at a level 3 and everybody in the low care funded at a level 6 and average that out, reduce our administrative costs, put our staff into the care, reduce the administrative costs of the department, simplify the system like that.

Or you could go to - another option that we talked about was a base per capita and the base would have a greater impact on the funding for the smaller organisations and so pick up the sort of problems that they have in limited funding. So there are all sorts of options that we have canvassed and just wanted to help people think through those issues.

MR WOODS: Thank you. I was just trying to assess which ones you sort of gave a tick, albeit conditional, to; and which ones you put a cross against.

MR CURTIS: Whichever one worked the best and was the simplest we would put a tick against but we wouldn't come up, I don't think, with the ideal funding system but we would like to raise issues and options that ought to be considered. We've talked about the whole range of them but what we didn't want to - - -

MR WOODS: They are potential design options. It's then a matter of sorting through - - -

MR CURTIS: That's right, that we believe could be set out clearly and people could understand and that's the key to it. People need to understand how it has been worked out.

MR WOODS: Transparency - it's a feature that we've put forward strongly in our paper but many witnesses have also raised as being a matter of current concern. You on page 3 of your submission, towards the bottom of the page, make a number of comments about technological improvement but I must confess you appear fairly dismissive of the scope and potential of that. I mean, for one, you talk about lifting technology, aim to reduce incidence of injury rather than staff costs as such, but presumably if you reduce injury you reduce workers compensation premiums, you reduce the time spent on training new staff, you improve morale, productivity and the like which all feed back then into reducing staff costs. I'm not quite sure why you have taken the particular view you have in relation to it or are you just trying to demonstrate a broader point?

MR CURTIS: What we're trying to demonstrate there is the fact that there are options to improve work conditions and the fact that they do cost - the training, the equipment and things of that kind - and it's a matter of each organisation having to work out that balance within the funds that are available so that they get a good balance which protects staff, protects the residents and provides the best level of services that people can receive. What we need to do is to recognise that if we improve the staff operational side of it then we also improve the WorkCover, we improve the absenteeism - all of things that add to cost, because absenteeism adds to costs in staffing because we employ agency staff which cost one and a half times ordinary staff and things of that kind. So what we're saying is we ought to be in a situation where we are funded in a way that we can maximise those services and those modern appliances and things of that kind.

MR WOODS: But you don't have a fundamental concern that they're not going to generate or have the potential to generate some efficiencies?

MR CURTIS: They certainly will and then those efficiencies ought to be put back into care, not losing them in WorkCover and other sorts of things like that.

MR WOODS: Yes. Page 5, you talk about equity of resource availability and you talk about equity of course implies not only access to services but to services of a common minimum standard. Do you have a view on how best to assess common minimum standards and what instruments there may be available for assessing those?

MR CURTIS: In the past we've had the standard monitoring system that we've used and having had many of those standard monitoring things in our organisation, one of the concerns that I've always had was the fact that people can be 98 per cent correct but still fail the system because there's one thing that's not met and the problem that we had with that is that people felt very bad about missing out on one thing when they ought to be feeling very good about getting 98 per cent of the things right and being able to correct that process. I hope that the accreditation system works in a way that is positive and says, "These are the things that you are doing very well. Here is where you can improve," and not in the negative way like the standard monitoring system did where it said, "These are the things you haven't got right," and forgot about the 98 per cent of the things you've got right.

I think that our staff and staff across the state are looking in a positive way at the change and looking at developing that positive approach to continual improvement. I think that way is the way to go because the other one didn't really provide the controls that you would want to know your standards.

MR WOODS: Would you also propose that there be a minimum against which those who fail to achieve that after due warning and notice should be closed down and exited from the industry or "managed out" I think is the phrase that is used.

MR CURTIS: Yes, that's right. I've worked with groups that have been very close to that from the industry's point of view, when the industry have been asked to go in and work with people who are very close to that on the third rung of being out. What we've found there is that we need to look very carefully and give them some examples to compare, to work with, and sometimes people don't realise in some of the smaller ones that we've had to deal with, exactly what is achievable in the level of standard. So I believe there ought to be some clear guidelines. The whole industry ought to be fairly open and I believe that it is where we share ideas, share standards, have a look at what's happening in the next organisation, compare our own sites where we've got half a dozen or so sites and I think that process of your own management team getting together and working, comparing and doing it - I work closely with Richard's people and we compare. Our directors get together and things of that kind.

That is very important because that peer assessment, comparison, and all of those things, set some very clear levels and guidelines. That's one of the things that ACOA is on about in our organisation in South Australia, is this business of cooperatively working together to improve and sharing ideas and not being a closed shop where, if we develop something that we think is good, we don't sort of hide that from somebody else, we share that. I think that's how things improve.

MR WOODS: Thank you. Under the banner of social equity, you refer to the sensitivity associated with models that imply double standards for the wealthy and disadvantaged. You're raising that in the context of ensuring common accreditation outcomes, but extending that as a natural consequence into extra services, is that a view that you would apply there, that extra services may differentiate between the

wealthy and disadvantaged and that that's a sensitive and perhaps inappropriate direction to follow.

MR CURTIS: One of the concerns that some of our boards have had about the extra services is that it may do that - that it may separate one part of a facility from another and I know in our board, when we discussed this about 6 or 7 years ago when it first came up, they weren't very keen on the idea because we believed that we provided most of the things that were in the extra services to everybody and their aim was to work to provide all of those things to everybody on site and not differentiate. What we're concerned about is that we don't want organisations to pick up the people who can pay and work at the very bottom end of the concessional resident percentages because there are a lot of people out there who are hurting and a lot of people in need.

MR WOODS: Thank you. I think that concludes the specific issues I wished to raise with you. Are there other matters that you wish to bring before the commission in our inquiry?

MR CURTIS: If I can, just a couple of things. One of the issues that concerns many of our organisations is the complexity of the current system and the distribution of funds and the problems associated with that and the additional staff that are required because of the errors and late payments and things of that kind. We need to tidy that up. The reconciliation process is long and complex and slow and many of our smaller organisations are having real trouble in meeting costs because things are so far behind. The other one that is of great concern is the fact that Centrelink is involved in the whole process and many organisations have had real problems with that because of the confusion to residents, the slowness of letters coming out and the fact that most of our accounts go out a fortnight before. The letters come to residents and there are so many variations on the accounts and one that needs to be tidied up very quickly - and people have talked to us about it - is the business of people who have overseas pensions and the fact that their payments can change on a monthly basis and it means that there are just so many variations.

What we're trying to do is to make the thing user friendly for our residents and elderly people don't like changes on their accounts and all of these sort of things. So somewhere along the line in looking at all this, we need to look very carefully at that distribution of funds, the mistake level, the Centrelink involvement which has slowed the system down and to make sure that we get it user friendly. The other things that concern us - we don't know what's going to happen with the GST in relation to the 10 per cent and the sales tax business and the FBT is another thing that is of concern to our members. So we need to look at those things, simplify some of those. We have no problems with the principles in relation to the changes. It's only the operational factors which cause us a lot of trouble. We also need to recognise the fact that people do move from low care to high care and make that as simple as possible. They're the things that are of concern to us and I think that's probably all.

MR WOODS: Certainly the principles have got to be sufficiently clear that the implementation of them can be appropriately clear and simple.

MR CURTIS: Yes.

MR WOODS: We understand that.

MR CURTIS: Thank you.

MR WOODS: Thank you and thank you for your time.

MR WOODS: If I can then call our final witnesses for today from the Uniting Church in Australia Synod of Victoria. I understand are we having five witnesses at the front - four. Mr Moss, Mr Donohue, Mr Paterson and Ms Edmiston. Is that correct? Could you please state for the record your names and the positions you hold.

MR MOSS: Yes, commissioner, Brian Moss is my name. I'm the chief executive officer of Bodalla Aged Care Services, an agency of the Uniting Church.

MR DONOHUE: My name is Michael Donohue. I have a background in aged care with the Commonwealth Department of Health and Aged Care, following 5 years with Aged Care Victoria, and I now work as a consultant.

MS EDMISTON: I'm June Edmiston, director of residential services and care at Strathdon Community which is an agency of the Uniting Church.

MR PATERSON: Austin Paterson, chief executive officer of Strathdon Community, an aged care agency of the Uniting Church.

MR WOODS: Thank you. Do you have an opening statement you wish to make?

MR MOSS: Yes, commissioner, I'd like to make that statement. As I say, my name is Brian Moss. Firstly, may I say thank you for the opportunity of presenting this response to the position paper. We're very grateful for the opportunity of being here this afternoon. I have over 30 years' experience in aged care, 17 years as the chief executive of Moorefields Community, which is another large Uniting Church facility in Melbourne. After 12 months running my own business as a specialist book distributor I accepted an invitation to take on the task as the chief executive of Bodalla just 12 months ago. The delegation here today represents the Victorian Synod of the Uniting Church which works under a devolved model of management.

The initial submission from the Uniting Church was made by our national office of community services Australia in Canberra which is in effect an affiliation of state synods. It had little input from Victoria and I myself unfortunately was out of the country when that was prepared and submitted. After reading the position paper, we in Victoria felt bound to make a response on behalf of the Victorian homes, hence we're here today. We have submitted a draft response which will be completed by the end of the month. The Uniting Church in Australia is one of the largest, if not the largest, provider of aged care services outside of government. The Victorian Synod is no exception. Our services start with home-based services such as the Inner East Community Options program and also many of our providers have community aged care packages.

We also have day care programs including dementia specific care, day therapy centres, independent living units, hostels or low care residential care and nursing homes or high care. Many of the hostels and nursing homes provide dementia specific services. Indeed, we pioneers such services in this country. For example, the Uniting Church Lodge program which started in the seventies and Overton Special Care Unit,

Carnsworth and others. These services are provided in both rural and metropolitan area, although we will acknowledge in Victoria the majority of our services are metropolitan based, particularly the nursing homes. Some of our services are multi-faceted, in other words, independent living units right through to nursing home care on the one site. Some are multi-faceted but on separate campuses. Others are stand alone.

The Uniting Church is committed to the equity of access principle. We do have a policy of charging accommodation bonds and accommodation charges in an endeavour to maintain viability but we do make admissions on the basis of need. The Uniting Church embraces the concept of ageing in place and indeed, many of its facilities have been practising this for a number of years and in our hostels in the past it would not be unusual to nurse a person till the end of life, even if they might have been a category 1 nursing home resident. The Uniting Church in Victoria initiated respite care. I can recall contacting a Commonwealth departmental officer during the mid-1970s to say we wanted to utilise unoccupied staffrooms, which they had provided capital funding for, and we wanted to use them as holiday beds because we receive so many requests from families or carers who needed to have a break but we didn't have many live-in staff. The departmental officer's response was, "Do it, but don't tell us about it." We can see now that there's a heavy emphasis by the Commonwealth to provide such care but we believe we've been pioneering it.

Let me now respond to the position paper. The Uniting Church Victorian Synod supports the opinion expressed by the commission, particularly (1) that equity of access to quality - and the emphasis on quality - aged care must be the main criterion for assessing alternative subsidy regimes; (2) that government funds should be used to support uniform quality of care across Australia; (3) we accept that there is a need to address inefficiencies and differences in quality of services; (4) we endorse the view of the commission that there is a need for an explicit and transparent link between funding and the cost of providing care to meet accreditation and certification requirements.

Whilst we have no desire to return to a CAM-SAM funding regime, we do have a concern of how we measure productivity or efficiency in the nursing and personal care area. Non-nursing areas such as catering, cleaning, laundry, maintenance, administration - yes; but nursing and personal care, what is productive or efficient. Reliance on outcome standards and accreditation do not always help a great deal when it comes to determining adequate funding and its relationship to efficiency or productivity. In Victoria we are currently in crisis in respect of nursing and personal care. Despite budget rosters aimed at achieving the required staff resident ratio, it is extremely difficult to recruit trained staff. I would ask who would want to work in a long-term care in the private sector, including the voluntary sector, when conditions in the public sector are much more attractive?

Already reduction in funding in Victoria through the first tranche of coalescence has created additional pressure. Nursing and personal care staff are already under stress and it is our contention that reduced funding will lead to further reduction in

staff levels which will lead to reduced quality of resident care. The inevitable increase in wages for nursing staff in Victoria, as they seek parity with the public sector, will undoubtedly exacerbate our problems. We emphasise that we are not arguing how the cake should be divided but rather that the cake should be bigger. We're very concerned that decisions about funding levels are made on economic grounds, on the amount of funding the Commonwealth will make available in the budgetary process, rather than on what is needed to provide quality care. We are required to meet outcome standards and achieve accreditation but as far as income is concerned, both hands are tied behind our backs. Commissioner, I would now ask Mick Donohue to speak further to some of our points in our submission.

MR WOODS: Thank you very much.

MR DONOHUE: We just don't really want to go through the submission point by point but rather emphasise what we see as some of the major issues. A particular concern is the amount of capital that is required to upgrade of replace existing nursing homes, some of those which are in the Uniting Church facilities. It's felt that the money derived from the accommodation charge, concessional resident supplement and the transitional supplement should not be part of operating income. Whilst it should be the prerogative of the provider how to treat these items, maintaining any cost analysis, operating income and expenditure for these items should be excluded and certainly the capital required is certainly a major problem for the industry as a whole.

I'd just like to raise an issue really of a general nature when there has been comparisons made between the hostel sector and the nursing home sector and to how much better the hostel sector is. Historically there's some reasons for that. With the hostel sector, they have had available significant capital funding which has by and large been withdrawn, variable fees, which have been withdrawn except for existing residents, an entry contribution or bonds as they are now called. So there have been marked differences and I think they should be seen in the context when making comparisons between hostel and nursing home beds.

Brian has mentioned the difficulty of the resident nurse ration in Victoria and I think there is another issue that the Commonwealth really needs to qualify in Victoria is where they refer to registered nursing staff. They should be quite specific in my view, because what is a registered nurse division 2 in Victoria may be an enrolled nurse in another state. It is quite confusing and difficult for service providers to follow. There has been talk of benchmarking studies or benchmarking studies of the costs of facilities and we believe it's most important that any study on benchmarking must be linked to dependency of the residents.

Where rural is concerned, again in the terminology I think it should be quite specific, rather than just rural and remote it should be perhaps rural - or whatever - and rural and remote, because what is rural is not always remote and there's not many places that are regarded as remote in Victoria as the rest of Australia. So I think it's clear that in any discussions in extra money for rural facilities it should be distinct

between rural, and rural and remote. Another concept that the Uniting Church supports is that of the multipurpose service, particularly where you've got small facilities in rural areas. I see great benefit from that concept. I would point out that we've had some difficulty in getting information from the Commonwealth as to the guidelines on operational issues such as bonds and charges where multipurpose services are concerned.

Again on the issue of bed sizes, I think it's very important that in determining bed sizes in your configurations that the non-institutional home-like environment is paramount. It's not too many years ago when the Commonwealth preferred model was a 30-bed facility. As far as I was concerned, that was a great concept. I know there's costs and so on involved, but I think the idea of non-institutional home-like environment is an integral part of any planning of any facility. Again with rural areas, what is a suitable size. I think you've got to look at the need to try and keep residents in the areas that they have traditionally lived in for many years. Personally, I was disappointed with the replacement of the 24-hour top-up funding with a viability supplement. That disadvantaged a number of homes in Victoria and in the scheme of things the amount of money that it was costing under the 24-hour top-up was very minimal but that enabled those homes to remain viable and keep the people in their local communities. From my background in aid care Victoria, that is extremely important to those communities. They're really the issues that I would like to highlight at this stage and leave it at that.

MR WOODS: Are there comments from other witnesses?

MR PATERSON: No, not at this stage.

MS EDMISTON: No.

MR WOODS: Thank for those introductory comments. Turning to your submission of 13 November - and if I can turn immediately to the back page, the table that you provided, which I found very helpful, very interesting, I notice for instance that facilities of similar size - for instance, facility 4 and facility 10, are both 45-bed operations - one produces a loss of $1.43 per bed and one produces a loss of $15.45 per bed. Are you able to assist the commission in understanding why, without necessarily delving too closely into the details of either facility but to understand how such variations and outcomes could come about.

MR DONOHUE: Yes, there is one issue that is very critical. It's the level of the RCS in the higher categories. Where the losses are greater, what is happening basically is that they don't have a lot of residents at RCS levels 1 and 2 and that is having a dramatic impact on their income and certainly in analysis and future direction, it's paramount that those facilities try and increase the level of their categories in the higher area, RCS1 and 2. I would also like to point out there, where an agency in good faith takes a referral from an aged care assessment team on the basis that they're high care and they may only reach RCS category 5 and in the odd case category 6, that has a dramatic impact on their income and I would believe there

should be - that if an agency takes a high care resident as assessed by an ACAT, the minimum funding level should be RCS4.

MR WOODS: That the home doesn't wear the risk.

MR DONOHUE: Exactly.

MR MOSS: If I could just add to that point, Mr Chairman, we find that often the person comes in designated as at least a category 4 by an ACAT but before we do the RCS which is done over a period of weeks after admission, the person responds to the regular medication, the regular care that's provided in the facility sufficiently that they might only score category 5 and then there's the difficulty of where do you send that person to. If they came from the community and you send them home, inevitably they will go back down and need nursing or more care again. There may not be the opportunity to return them to a hostel or lower care setting because their bridges might be burnt behind them.

MR WOODS: Yes, I noticed you dealt with that also on page 4 of your submission. To what extent is this a common practice or an isolated practice, that when it occurs is quite disruptive but where is the balance in that?

MR MOSS: Perhaps June can reply.

MS EDMISTON: Sorry, I - - -

MR WOODS: I understand the disruptive nature and the impact on finances where an ACAT team has assessed somebody as high care and then the RCS classification picks them up as a 5. What I don't understand is how frequent is such an event. Are we talking isolated but very disruptive instances or are we talking regular instances?

MS EDMISTON: We haven't got any sort of hard data on that. I wouldn't say it happens a lot but it does happen that there are anomalies in assessment, I think mainly because residents stabilise once they're in a particular facility and I think that's why there is that variation from what the ACATs have assessed them as in their dependency level as to what they ultimately are. When we go to send in their assessment to the Commonwealth it's some time later and they have stabilised. So you do get that variation but I couldn't tell you exactly how often that happens. I would be just speaking from our own facility and that maybe happens three or four times.

MR MOSS: I think it's perhaps something worthy of study.

MR WOODS: We would certainly be interested, even if it was just some data relating to individual facilities to say out of how many admissions you had in a year, that 2 per cent, 5 per cent, whatever, of them were of this nature. Is part of the difficulty the ACAT process which identifies them in their acute phase and says what they are now as distinct from being a predictive assessment to say what would they be like if they had regular care? Or in part is it the other way around, that your 3-week

RCS procedure takes on that in fact you've restored them to a level of health and wellbeing that drops down their RCS classification?

MS EDMISTON: I think it could be a bit of both, actually. I mean, the aged care assessment teams often see residents, particularly for high care, at a crisis point and that as I said before, they do stabilise after a time in the nursing home so often, yes, the assessments will vary.

MR WOODS: What are the incentives in the subsidy system for you to rehabilitate residents to improve their overall wellbeing, and as a consequent to reduce their RCS levels from say 2 down to 3 or 4?

MS EDMISTON: Under the present instrument there are incentives to do that because opposed to the first instrument we had, there was really no incentive to rehabilitate people but under this present assessment instrument there are incentives to rehabilitate them because there's point scoring for certain therapies or rehab programs that you introduce. So there is benefits in - - -

MR MOSS: I would endorse that, commissioner. I can remember prior to the CAM-SAM funding being introduced we would regularly admit people to a nursing home and then discharge them back to lower levels of care. Once the CAM-SAM funding was introduced that just didn't happen after a time and there was no incentive at all to rehabilitate people and we lost a lot of the incentive from those earlier initiatives but hopefully the new RCS will help us redress that. We always believe that an admission to a nursing home should not be a one-way ticket.

MR WOODS: Understood. You attribute the variation in financial outcomes between facilities to the RCS profile. Are there other factors that are also relevant in those outcomes as evidenced by that table?

MR DONOHUE: There certainly is the staffing profiles as well and I think it's fair to say probably some improvement could be made as far as administrative staff goes. Those that are performing in my eyes better would be operating on perhaps a reduced administrative staff to others.

MR PATERSON: If I could say, commissioner, one of the other issues I think that impacts in this area relates to quality of life issues and to support to extended families and not simply basic core nursing services within a nursing home and the Uniting Church and some agencies have greater capacity than others; spend considerable amounts of money in providing chaplaincy services, welfare services to both residents and their extended families at a cost which comes out of funding through RCS and they're the sorts of issues - I mean, for instance, our own agency, which is quite a large agency, is based largely around four-bed wards which, within the conventional wisdom are not popular any more but we have closed our books and have had them closed for some time now and always have substantial waiting lists.

There's no doubt in our minds, even though we believe in the long term that's not sustainable - there's no doubt in our minds that one of the reasons for that is because of the reputation that the agency has in terms of providing those really terribly important quality of life issues that go beyond what you might call narrowly core services of a nursing home. They're expensive and they're the sort of things that will, you know, go, if the Commonwealth screws the industry down to a point where those services are just simply unaffordable.

MR WOODS: So quality is a manifestation of a whole series of very important factors, not just nurse hours or some other measures.

MR PATERSON: Indeed.

MS EDMISTON: Absolutely.

MR WOODS: Important though they be and fundamental.

MR MOSS: I would have to concede that workers compensation premiums would also affect the results in this table. With some homes we've had a very bad experience and are paying well above the average and some homes are doing better but you're always on a knife's edge because you only need one bad injury to occur and suddenly your premium will skyrocket.

MR WOODS: For a period of 3 years or so while there's a clawback process.

MR MOSS: Yes.

MR WOODS: To what extent do you consider there is proprietorial discretion though on the level of premium, putting aside the unexpected one-off incident? I mean, when you look at premiums generally do they reflect managerial competence in this field?

MR MOSS: Yes, or incompetence.

MR WOODS: Yes, in the reverse sense.

MR PATERSON: In the field certainly. I mean, one of the problems that we find is that particularly in nursing homes that we have nurses that work in a variety of facilities. Because of the part-time nature of the work you can have one nurse that works across five agencies and it's very hard to pinpoint in fact where an injury actually either originates or occurs and you might just be simply the end point of the injury and you only need two of those to increase your premium from 60,000 to 184,000.

MR WOODS: Yes. Is a subsidy designed to reimburse actual premiums going to provide sufficient incentive to providers to focus on occ health and safety?

MR MOSS: I would prefer to see, commissioner, a subsidy maybe based on average but an additional subsidy set aside to encourage better work practices and addressing occupational health and safety issues.

MR WOODS: Would you also pursue some sort of capped funding for one-off cases though that cause significant impact on a home's viability or is that taking it too far?

MR MOSS: I believe that would have merit, provided the facility had demonstrated that it does have appropriate occupational health and safety policies and safe work practices in place.

MR WOODS: So only in limited circumstances.

MR MOSS: So it may be conditional. I don't think we should be rewarding proprietors of nursing homes who are not addressing those issues.

MR WOODS: I quite agree. You make several references to the Nurses Victorian Health Services Award throughout your submission. Entering into the field of speculation a little, if that wasn't so prescriptive in its ratios, what changes in staff and skills mix would you see emerging over time?

MS EDMISTON: From our point of view, I wouldn't like to see any change in the ratios. I sort of endorse what the ratios are at the moment. I wouldn't see that changing at all.

MR DONOHUE: I think that is where the cost differentials come between states. Traditionally, that in our view has assisted the level of care for high dependency residents in Victoria and the funding should be geared to that content, that that level of expertise is required for quality care.

MR WOODS: Very good.

MR MOSS: In that respect, commissioner, we have some concern about the study, the Latrobe study, that your position paper has referred to because the two agencies I believe that are included in the study, two of them in Victoria, but it's a question of whether those staffing levels are because that's what the organisation wanted or whether it's because they weren't able to achieve the ratio because of the inability recruit staff. It is very difficult at the moment in Victoria to recruit trained nursing staff.

MR WOODS: Yes, I've heard that from several witnesses. Special needs funding, you've drawn attention to this as an issue and noted that we've dealt with it in our position paper. There was an earlier witness who referred to the question of rurality in Victoria and you yourself have drawn a distinction between rural, and rural and remote. Can you elaborate on that a little further, particularly having regard to a concern that the wider you make the criteria under which you get accepted in that, the

less you have a very discrete and separate category. A logical extension of that would be to emerge with sort of rural, provincial and metropolitan or something and then if you had those, plus you then divided the subcity also by jurisdiction, it strikes me that you're tending toward a level and a subsidy design based on cost reimbursement which has in itself certain characteristics in terms of incentives and the like. So how far or how broad do you draw the boundaries in what you would admit into that category?

MR DONOHUE: I think as a basis for an area to be rural or remote and so on, there is a document put out by the Department of Health and Aged Care and I think it's the Department of Primary Industry which could certainly be used as a base. Then I would like to see a loading situation rather than - if you're in a certain area that may give you a 10 per cent loading rather than a dollar figure for individual areas. In other words, a loading as a penalty for being in a certain location and perhaps a certain size.

MR WOODS: Yes, we're familiar with that database that produces factors for those. The question is whether they adequately address the specific needs that we've had evidence of and have witnessed in our various visits, or whether it is just a way of dividing the cake finer and finer into various categories. Anyway, I understand your views on that. In terms of the submission that you put before us in your opening comments, I think I've concluded the specific areas I wished to pursue but have you got any matters that you wish to raise further with us?

MR PATERSON: I'd like to just touch on the issue of accreditation and that's obviously something that you've been very interested in and the concept of continuous improvement which we're very supportive of. There is a problem with agencies that have a wider range of integrated aged care services than simply residential care. Our own agency, for example, is accredited under the Australian Council for Healthcare Standards and values that very highly. That agency accredits our day care centres, our day therapy centres, both of which have substantial Commonwealth input, and also our residential care program. We're being placed probably in a position where we will either have to have some of our services unaccredited, simply because of the costs of being a member of two accreditation agencies, one of which is compulsory.

It is an issue that I would really encourage you, if it's within your brief, to take up with the Commonwealth because we end up then having a total commitment to - and we're not on our own because there are a number of state funded aged care agencies that also have multi-programs. We end up then in the dilemma of whether we drop accreditation for part of our agency because of the double jeopardy.

MR WOODS: Thank you. Other matters?

MR MOSS: I've got some more comments, commissioner.

MR WOODS: Yes, please.

MR MOSS: One is a comment on admissions. I heard an earlier witness talking about where admissions come from and I'd like to express my view, for the benefit of

the commission, that a lot will depend on the nature of the nursing home. For example, the 100-bed facility I now administer is a stand-alone facility within the Uniting Church. We don't have other forms of residential care. Most of our admissions come from the community, although many of the residents would be admitted via an acute hospital. So there would be a very substantial number that come from acute care but have only been there for a short time and have come from the community.

MR WOODS: Their origins are fundamentally still their own original homes.

MR MOSS: That may differ markedly from the organisation that I previously worked with where we had hostels and independent living units and the majority of our admissions to a nursing home would come from those units. So a lot will depend on the nature of the organisation and its commitment to provide ongoing care to people. Ageing in place may change that and it would be good if it did and ensuring access to people in the community who have chosen to stay in their own homes because I repeatedly get people approaching me and saying, "What should I do? You worked in aged care. Should I put my name down on a waiting list?" My advice always is, "You're best off in your own home. Stay there as long as you can." But sometimes that may prejudice getting into a nursing home because they haven't gone through the whole process of independent living, hostels and the like.

MR WOODS: I agree. We have received considerable evidence about the acute care nursing home interface and it is important but it is also important to look behind the acute care episode to find out what that longer term transition is.

MR MOSS: I think you correctly made the observation previously with the other witness that, where did those people come from when they came out of acute care into a nursing home and indeed, in many instances they do come from other forms of residential care. The other point I want to comment about is size. This is becoming a vexed issue. My contention is "small is beautiful" and indeed, when we established a dementia specific program we deliberately tried to make it small. There are suggestions, when you're dealing with people with severe cognitive impairment who need nursing home care, they will not cope in a unit larger than 10 beds. However, it is possible perhaps to build multiples of 10 within the one facility and Moorefields Community did proceed to plan a new facility to replace an older dementia facility and then made a compromise and opted for 15 as a size but overall the unit is 120 beds but they're all in modules of 15 within one building of 30 alongside another building of 30 and then separately there are two more buildings of 30 to make a total of 120. So a lot of care has to go into the design of the facility.

MR WOODS: Is the multiples of 15 any coincidence with RN ratios?

MR MOSS: It had something to do with RN ratios, I'd have to concede, but bearing in mind that our optimum ideal size was 10 but we compromised and went to 15. We also have the dilemma when dealing with size, of how do we locate facilities around the community that are going to be accessible to people who need them and their

families without them having to travel inordinate distances even in the metropolitan area. In my experience over 30 years or more, it's not unusual to find people travelling from one side of Melbourne to the other simply to get access to appropriate nursing care and I don't think that that's a fair thing on some older people, especially for an old person who has a spouse in a nursing home with quite a long distance to travel. So the larger we build them to achieve economic viability, the more difficult it could become to maintain accessibility.

MR WOODS: Is some of that though also related to the restrictive nature of issuing bed licences, that if you relax that somewhat that you would have some level of vacancy but you would also have a greater number of sites.

MR MOSS: Again, I think we're forced into compromises and I support the ratios that currently exist, that is, the one, I think it's 40 beds or 38 beds now per 1000 head of aged persons 70 years and over. I don't have a problem with those. I think our problem, in Melbourne and probably in other parts of Australia, exists because in the early years there was no regional basis for the allocation of beds. It was more or less who was squealing the loudest got the approval and therefore we've got places like Kew with a huge number of beds and other places where there's a shortage. I think we've been able to address those issues in more recent years since the McLay report back in the early eighties.

Another comment I wanted to make was that of depreciation charges and the accommodation charge or accommodation bonds and in nursing homes of course it's accommodation charge. There's a lot of debate and lack of common approach and agreement within the industry of how depreciation should be treated and how accommodation charges should be treated. I believe the Commonwealth's view is that the accommodation charge should be treated as operating income. I think the accounting profession itself is having great debate about how these charges should be treated. I have an accounting background myself and my view is that we should be including depreciation as a charge which is showing the cost of the use of the facility over a period of time and even if we are - - -

MR WOODS: For consuming the facility over its economic life?

MR MOSS: Yes, and even if we are including accommodation charges as income, I believe they have to be preserved for capital use and I liken it to us making a reserve of our depreciation provision, and some discussions and debates I've had in the accounting profession over the years has been should we fund our depreciation provisions? It hasn't been necessary in most commercial enterprises because they use that as working capital. We are now in a position that if we do not preserve the accommodation charges to provide a means of redevelopment, rebuilding our facilities, we'll be lost in a few years' time. We don't have an entitlement any longer for capital funding from the Commonwealth and we are finding it extremely difficult to raise funds for capital works from our own fundraising capital appeals. There are so many appeals going on in the community it is becoming quite challenging to raise those funds. I think that the accommodation charge that we receive, even though it's

open to what we utilise it for, I think it would be most imprudent for any organisation not to preserve it in a separate fund.

MR WOODS: I can't pick up the reference immediately in your submission but I remember when I read it that I gained the impression that some of your facilities have until fairly recent times lived on their cash flow and that depreciation hasn't really been - - -

MR MOSS: Yes, I think we have shown it as an exclusion in our table.

MR WOODS: You have in the table but I think I recall also some reference that implied that - - -

MR MOSS: But I think it's something that we do need to address.

MR WOODS: - - - a number of facilities hadn't until recently been assessing their depreciation.

MR MOSS: Commissioner, in summary, I would just like to say - as we have tried to outline our thoughts, we are not opposed to considering ways to become more efficient and productive. We do, however, have a major problem identifying areas involving direct resident care when it comes to looking at how we improve that productivity or efficiency. We believe a nursing home should be a place to live, not a place to die. There was a time when we would get nearly every resident up and take them to the dining room for breakfast. Residents would be dressed and have their going out shoes on. Today, with cuts to funding that is not possible. Any further cuts to funding will impact on quality resident care.

On a number of occasions I've had the opportunity to visit nursing homes in other countries, particularly the United States. I think I've visited more nursing homes in other countries than anyone else in Australia. On one occasion I was taken to a Lutheran Church nursing home in St Louis, Missouri. They proudly showed me the dining room which had a row of long narrow tables. They were all placed down the dining room one behind the other. Six residents were seated at each table on one side only. On the other side a member of nursing staff sat on a chair with castors and moved quickly up and down the line of residents - a spoonful here, a spoonful there and then back to the beginning whilst hopefully the person had chewed up the first spoonful of food.

Similarly, on a visit to New York one year I visited the Hebrew home at Riverside, a very large complex, and they proudly showed me their dining room. Residents were seated at a doughnut shaped table and in the centre was a nurse who moved around the circle of residents on the outside of the table, feeding them a spoonful at a time. I just ask the question: is this the way we want to go? I believe that we have to provide dignity for people and that's not how to provide dignity. Feeding residents right now is a major problem. Two weeks ago I visited an old

friend of mine in a private hospital. He's now 90 years of age and becoming just a little frail but he's still able to talk and he doesn't have any sign of dementia.

I arrived just after 5 pm and shortly thereafter his tea was brought in. The young chap, the domestic, left the tray on the over-bed table which was beside the bed - and I emphasise beside the bed - and he left. My friend was in a reclining position and couldn't reach the tray. I helped him into a sitting position, with great difficulty, because he's fairly large, and then I raised the over-bed table. I had to undo the knob and raise it and position it so that it was across the bed and he could reach it. If I hadn't been there he would still be trying to remove the cover from the soup bowl. This is just an example of the sort of problem we have, even in nursing homes. Such instances are unfortunately not isolated. Often the domestic staff will return to remove the tray and they will do so whether or not the meal has been eaten.

We do not want to see this happening but we fear the worst with a possible further reduction in funding. The absence of any in-depth study, how do we determine what is efficient or inefficient in nursing and personal care in nursing homes? Commissioner, thank you for the opportunity of coming this afternoon. We were a little concerned at being last cab off the rank. It might be the end of a weary day but we have to say that obviously with the questions you've asked us, you've kept right on the ball, so we compliment you for that and again, thank you for the opportunity.

MR WOODS: I have been quite interested in the matters you raise and I had read your submissions with some interest beforehand so thank you for the evidence that you've given this afternoon. I'll adjourn the hearings until 9 o'clock tomorrow morning. Thank you.

AT 4.45 PM THE INQUIRY WAS ADJOURNED
UNTIL THURSDAY, 19 NOVEMBER 1998

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