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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 THURSDAY, 19 NOVEMBER 1998, AT 9.04 AM

Continued from 18/11/98

MR WOODS: I would like to commence day two of our hearings in Melbourne and welcome as witnesses Dr John Leaper, Mr John Brooks, Mr Bob McIntyre and Mr Brian Fitzpatrick. Would you please state your name and the position that you hold for the record please.

MR BROOKS: Yes, thank you. John Brooks, chief executive officer, ANHECA (Victoria).

MR FITZPATRICK: Brian Fitzpatrick, president, of ANHECA (Victoria).

DR LEAPER: John Leaper, deputy vice-president, of ANHECA (Victoria), and I should say federal vice-president, which would mean that in this particular session I will be addressing the Victorian submission.

MR WOODS: Yes.

MR McINTYRE: Robert McIntyre, manager, aged care and disability services, Victorian Employers Chamber of Commerce and Industry, and an adviser to ANHECA (Victoria).

MR WOODS: Thank you, gentlemen, and welcome. Can I say thank you for the submission that you made to our inquiry earlier and to the time that you gave to us on our earlier visit; that we appreciated the courtesy and the time that you gave and the assemblage of people that you brought round the table so that we could explore a whole range of issues. That was very helpful. Do you have an opening statement?

MR BROOKS: Yes, thank you very much. Thank you for the opportunity to contribute to the review of the nursing home subsidies. I will be speaking specifically in relation to the matter of the preliminary proposal 7 workers compensation and the issue of recognition along with other inputs in the subsidy arrangements. Other colleagues here will address the remainder of the proposals put by the commission. ANHECA (Victoria) has contributed to the development of the response put to the commission by our federal ANHECA body, and intends this presentation as one of informing the commission to matters relating to Victorian aspects of the ANHECA submission.

The commission has proposed Commonwealth contributions towards workers compensation should continue to be provided through the basic subsidy regime. ANHECA (Victoria)'s view on this matter differs from that of the commission. As support for this view, we would draw to the commission's attention the evidence cited in your own documentation which notes that base rates for premiums vary significantly between the states and range from between 4 to 7 per cent of remuneration. Workers compensation premiums being a percentage of remuneration represent a significant cost factor for nursing homes in all states. We would draw to the commission's attention that the remuneration base in Victoria on which the percentage premium is applied, had a significant adjustment as of January 98, that is, January this year, with the full inclusion of all superannuation contributions.

This had the impact alone in a full year of a 7 per cent increase. Such adjustments of costs at a state level is sufficient to maintain reimbursement of workers compensation costs separate from the basic subsidy regime we believe. Increased costs such as are attributed to adjustments for solvency purposes are not reflected in these indexation adjustments and therefore should be treated as reimbursible inputs as with other state taxation issues. The Victorian WorkCover Authority, VWA, figures indicate a significant improvement in claims for frequency rates for the industry over the years 93 to 98 yet increased claims costs are continuing to be experienced. There are some 504 nursing home establishments approximately recorded in their statistical works and these facilities have recorded a 43.9 per cent reduction in the claims rate per million of remuneration paid yet the average cost of claims for the same period has doubled on average to $26,500.

Premiums for the same period have risen from 17.8 million to 21.5 million. We believe these are a significant cost input in their own right. This increase when coupled with a 13 per cent increase in the liability for medical out-of-pocket costs and the increased costs of the first 10 days' wages for any one claim again indicates that the hidden cost creep associated with workers compensation premiums is significant. Again it is suggested as good and sufficient reason to have a costs constrained reimbursement formula separate from the basic subsidy. According to VWA statistics some 35 per cent of establishments have premium rates of between 6.5 per cent and 48.6 per cent higher than the industry rate of 3.95 per cent. Again, this indicates our view that a system of recognition of state-based variations must be maintained.

In conclusion ANHECA (Vic) supports the view that adequate arrangements must be put in place on a state by state basis for workers compensation and other cost inputs to be reimbursed on a cost constrained reimbursement basis. In closing, I would also like to point out to the commission that contrary to the comments attributed to the Department of Health and Family Services at page 53 of the position paper, this was regarding the previous arrangements providing no control over discretionary expenditure subsidies of workers compensation, that such was not the case for the entire period of the previous funding regime.

In fact, in the latter part of that funding regime a very successful accountability system with cost constrained reimbursement was in place which afforded both a safety net and a penalty for poor performance. We're of the view that a system, cost constrained system, of that basis would again be the adequate way to proceed. Again, thank you to the commission for the opportunity and I just seek leave to absent myself for another commitment after your - - -

MR WOODS: Are there any other opening comments that you wish to be party to or present for, and are you happy for me to pursue questions on workers comp with your colleagues in your absence?

MR BROOKS: I can wait a few moments if you have some you would wish - - -

MR FITZPATRICK: If you want to deal with those issues now, and then perhaps if we could just have a couple of moments with some other openings, and allow - - -

MR WOODS: I am just conscious of your time-frames, but would you like to be briefly party to a discussion on workers comp first with the department?

MR BROOKS: I would, yes, certainly.

MR WOODS: I thought you might, okay. The issues facing the commission in coming to a position on workers compensation is to recognise that there are several areas, workers comp, payroll tax, superannuation, where a judgment must be made as to whether they get incorporated into a subsidy, whether that is a national subsidy or a jurisdictional subsidy, and that's more an empirical issue than one of underlying philosophy. When you look through each of those for example, superannuation which is nationally based doesn't have a jurisdictional element and doesn't have a discretionary element, and therefore in terms of our position paper didn't warrant attention in that respect because it can be built into a national basket of input costs.

When you then next look at payroll tax, the characteristics of that are again that it is non-discretionary, but that it is jurisdictional based and it is also sector based that it impacts differentially on particular proprietors depending on their characteristics. Therefore that's at the other end of the spectrum and does warrant attention and we, in the preliminary paper, proposed a reimbursement proposal. The question of workers comp fits a little differently from those in that it is non-discretionary in the requirement to pay the premium. It is jurisdictionally based and each state and territory government has a different approach as to the structure of their workers compensation scheme but there is an element of discretion in that it's necessary to look to incentives for providers to put in their best occ health and safety regimes which can lead to reductions in premiums. So unlike some evidence of other witnesses that it is totally non-discretionary, I don't find that to be true.

The question therefore is how do you ensure that in the subsidy arrangements you build in appropriate incentives for workers compensation, while recognising as the commission well does, that despite one's best procedures, accidents can happen, and whether their journey to work or just purely a mishap of circumstance can significantly affect the viability of a home. So there is a need to recognise that particular component. Weighed up against that is, to what extent do we try and achieve all things through the subsidy arrangements and the more you disaggregate the subsidy and break it down to its individual elements to try and achieve lots of outcomes through what ultimately is a fairly blunt instrument, ie, a payment for care, there are some dangers in pursuing that to any great detail, but nonetheless the idea of some form of capping to assist homes where they can demonstrate that they have sound occ health and safety procedures but are met by a claim that threatens their viability, has some attraction to the commission, but that being so, I would still wish to devise a system that places the right incentives at the right points to encourage proprietors to pursue good occ health and safety practice, and to therefore benefit not

only themselves financially but their workforce and the patients and all stake-holders in reducing their premiums as a reflection of their good practice.

So they're the competing interests that we're trying to bring to bear on this question of workers comp, but I would appreciate any then further reaction that you might have to that.

MR BROOKS: We certainly support any initiative that you might indicate as regards a capping and as regards incentive. I guess deregulation is the ultimate objective of trying to fund an industry that can satisfy all demands and provide quality outcomes. The process that was previously in place whilst being far from perfect, this is the end process they talk about in the previous regime - - -

MR WOODS: The state averaging methods for capping?

MR BROOKS: The state averaging with capping, I believe, did provide incentive for those organisations that were prepared to bite the bullet, and likewise did apply that sting in the tail for those organisations that didn't. There was significant work done between the WorkCover Authority in this state, the insurers involved, and I think the majority of employees to try and reduce their risk, the situation being that unfortunately the claims rates are amortised over a period of 3 years.

MR WOODS: We understand that.

MR BROOKS: 2 years previous plus an estimate for the current plus the actual on completion, and it is a retrospective process which can lead to various difficulties in terms of an organisation being to budget in a cost constrained and a regulated fee environment. So that said, at this point in time we would certainly support the position that was in place previously of that cost constrained capping. I am not in a position to indicate to the commission what other formulas may or may not be better. I believe there would be other people more qualified to work that out than me, but I think as a general principle it indicated those aspects of deregulation. It indicated those aspects of fairness that were appropriate, but it also had that aspect of penalty where people refused or didn't indicate a willingness to participate in minimising what is a legal responsibility.

MR WOODS: Could it be iterated one further step to allow access to the cap only where the occ health and safety policies and procedures in the facility could be demonstrated to be of sound practice rather than everyone have access to the cap irrespective which doesn't seem to me to have quite sufficient incentive structure. Or is that - - -

MR BROOKS: If I may, the industry is on a path towards accreditation which is quality driven and I guess there are lots of scenarios you could explore, but certainly one can't access additional funding at this point in time without building certification being in place, so again I suppose it is a scenario that might be feasible in the sense

that once there is accreditation in place one might access the cap. However, again, I wouldn't wish to advocate that position at the moment, but it's highly feasible.

MR WOODS: But you give some further thought to that. I mean, I understand the need for access to relief when a major claim occurs and threatens viability, but I would still wish to identify some means by which the record of the proprietor had to be demonstrated before that access to the cap came about. Whether the accreditation process is the way to go, and that has potential, but if you could give that some further thought and come back to us on that point that would be very helpful.

MR BROOKS: Certainly.

DR LEAPER: Mr Chairman, while this subject is under discussion, you did mention in your comments which I found very, very helpful in terms of putting it all in perspective, the cap being perhaps in place in instances not only where occupational health and safety requirements had been met, but also where the actual viability of the operation was being threatened. I query whether the cap has to be set at such a high level and whether it might be said a little bit before the viability of the operation that was being threatened. The reason for saying that is the cap itself I don't believe will make life comfortable.

Even if the cap is in place, an operation which is bumping up against the ceiling for 2 or 3 years in a row, my feeling would be depending on where it's said that that operation would then certainly be in jeopardy because one could not expect to continue operating at the level of the cap indefinitely.

MR WOODS: 3 years is a long time to be sitting on the edge.

DR LEAPER: Yes.

MR WOODS: I understand that point.

DR LEAPER: Thank you.

MR WOODS: If you could also incorporate that in any subsequent response. If you wish to attend worthy matters of accreditation training - - -

MR BROOKS: Thank you very much.

MR WOODS: - - - I give you leave.

MR FITZPATRICK: Commissioner, Graham Croft is with us.

MR WOODS: If you'd like to come forward, and if you would like to give your name and the position you hold for the record, please.

MR CROFT: Graeme Croft, executive director, Croft Health Care Pty Ltd. Our organisation is a privately funded organisation which has developed, owned and operated five aged care facilities totalling 265 beds. Our organisation was the first to take on the privatisation of the state government nursing homes in the state. We currently won the tender to develop a hundred aged care beds out of the Bairnsdale Regional Health Service.

We won that tender in 1995. The date of effect of the transfer of the residents from the old geriatric centre to two privately built facilities - one of 60 beds in Bairnsdale and one of 40 beds in Paynesville - actually occurred in late November, early December 1996. So we've had almost 2 years of experience in that operation, and in November last year we took over the operations of the Latrobe Valley Nursing Home, a 50-bed nursing home at that point operated by state government and which subsequently transferred to us with a view that we would build a new 60-bed aged care facility in the city of Moe.

That new building is completed and operational with effect of 7 July this year. I think the issue and the reason I've been called to give evidence is really the issue of parity of funding across facilities, and the difficultly that actually represents in the nature of operating those facilities.

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

MR FITZPATRICK: Yes, I do, commissioner. Essentially the response to the proposals that we have put and issues that we would like to explore again this morning are particularly the issues of the basic subsidies in coalescence, the cost of accreditation and certification. The difficulty that the industry faces with the attraction and retention of registered staff in division 1 and division 2 areas and the wage parity that I'm sure you're aware of in Victoria that is particularly of an issue.

The issue of registered staff being required within nursing homes or high level facilities, we'd like to just draw the attention of the commission to what is an international definition of "nursing", and the International Council of Nursing defines labour force planning as a process which ensures the presence of the right nurse with the right qualifications in the right role at the right time in the right place with the proper authority and most importantly the appropriate recognition, and recognition would account for wage parity.

You have mentioned the payroll tax issues and certainly the superannuation issues, and we would have some more to say about those as well. The regulation of the extra service provision and the matter of regulating places could be dealt with in the same manner as the concessional resident places and administered with similar guidelines.

DR LEAPER: I'd like to add to that, chairman, a couple of comments in relation to the cost structure of the provision of services, and some comments in relation to the

role that wages play which has already been addressed by the commission, so it's in relation to what the paper says on that subject.

MR McINTYRE: Commissioner, just on that point too, we'd like to also put some evidence before the commission about our experience vis-a-vis the evidence given by Dr Segal yesterday where our experience is 180 degrees different from the experience of Dr Segal.

MR WOODS: That's useful to have different perspectives brought before the commission. How would you wish to proceed? Do you want to sort of take each of those issues one by one?

MR FITZPATRICK: Yes, please.

MR WOODS: I have also got some questions in relation to your first submission, some of which will be addressed in the course of dealing with those and then we can come back to it if there are any matters that we haven't covered.

MR McINTYRE: Certainly. Perhaps if I can begin with the evidence of Dr Segal and the evidence of the ANF yesterday while it's still fresh in my mind. The experience in Victoria at the moment is that there are difficulties arising in attracting and retaining appropriate staff. Some of the reasons for that are historical, and others are probably procedural because of things that have happened over the last 5 years, but perhaps if I could just bring back to the commission's attention the reason why we are starting to experience attraction and the retention problems in Victoria.

We shared a common award base with the acute sector - public and private - until 1992, and I'm talking specifically about nursing staff. After 1992 the parties diverged, the acute sector - public and private - went off one way; the nursing homes stayed in the award, but the public and private acute hospitals moved into an enterprise agreement situation whereby they were able to achieve outcomes of in the first round of bargaining 10 per cent, and more recently 11 per cent on top of that, whereas because of our funding arrangements and the inability of proprietors to negotiate, we've been restricted to safety net adjustments.

So the difference at the charge nurse level at the moment between what's happening in the acute care sector and what's happening in the nursing home sector for profits and church and charitables is a difference at the charge nurse rate of some 80 to $90 per week, and as a consequence of that it's quite obvious that we are going to have difficulties attracting and retaining the appropriate staff. Also we've had difficulty for a number of years in attracting and retaining appropriate numbers of division 2 nurses because of the inability of the state training system to provide adequate numbers of training positions.

Whilst the government does provide a large number of training hours for division 2 nurses, they are not adequate to meet demand, and as a consequence we find that we do not have the ability to recruit division 2 nurses, and as a consequence

we have had to employ personal care workers and assistants in nursing which by definition under our award structure in Victoria are the creatures of the former hostels and supported accommodation services. They have never been the creatures of the nursing home environment.

But the standards monitoring teams up until now have allowed nursing home proprietors to utilise personal care attendants and assistants in nursing where they can show that they have not been able to recruit and retain division 2 nurses, and that problem has been going on for at least 10 years in my experience; the inability to recruit that form of nurse. However, the problem about wages and the parity in wages has only emerged since 92-93, but the gap is worse. There is another 3 per cent pay increase due in the public sector early next year which will make us about 21 per cent behind the market. We can't attract and retain staff at that level.

MR WOODS: Can I just ask in terms of wages paid, we had evidence that the personal carers or attendants in nursing were in fact on similar if not in some cases slightly higher wages than the division 2 nurses. Is that your experience in terms of a practical sense?

MR McINTYRE: A personal care worker level 2 is roughly equivalent to or slightly more than an enrolled nurse, but generally assistants in nursing are entry level positions which are the base career scale if you could call it a career scale, and just on that point about the classification level of people and the possibility of over-award payments, where Dr Segal said in his evidence that in his experience there was a proliferation of over-award payments in the nursing home industry, our experience is different, and it's not anecdotal like Dr Segal's is.

Recently for a matter currently before the Australian Industrial Relations Commission, I conducted a survey of our members to find out what was the incidence of over-award payments in the nursing home and hostel sector, and of the 3000-odd nurses surveyed in over 160 nursing homes, 24 nurses received over-award payments.

MR WOODS: Is that in the private for-profit sector only?

MR McINTYRE: Private for-profit, yes, mainly. There may have been a few - - -

MR WOODS: Is it likely to have been different in the church and charitable sector?

MR McINTYRE: I doubt that it would be. Some church and charitables are members of ours and replied within that survey and indicated that they weren't making over-award payments. The difficulty is that under the old CAM and SAM-type regime, they were only funded to award levels. So if you wanted to pay over-award payments, they came out of your pocket, and the profit margins are small so therefore there was very little ability to do that.

However, where there are incidences of over-award payments being paid, they are at the DON and deputy DON where we do on some occasions use deputy DON

levels, but very, very rarely anywhere else. In fact I can only recall one occasion where a particular nursing home in the western suburbs where there are not that many nursing homes needed to attract and retain an appropriate charge nurse and saw fit to make an over-award payment. So the incidence in our experience is less than 1 per cent.

MR WOODS: If that information is in a form that could be readily transmitted to us, that would be helpful.

MR McINTYRE: I'm quite happy to provide the file to the commission so that the commission can analyse it, and provide the transcript of the proceedings where we put that information to the commission. That can be done.

MR WOODS: Thank you.

MR McINTYRE: So the ability of our people to enter into appropriate enterprise bargaining arrangements has been restricted because of the funding arrangements, and one would then ask, "How was the public sector and the private hospitals able to that?" The answer quite clearly there is that they shed massive amounts of labour to pay for it, thousands of jobs, and received a float of $60,000,000 from the Commonwealth to fund it. We haven't received anything of that nature. So our inability to bargain has been restricted.

MR WOODS: Thank you. On that question of parity, I remind you that in our position paper amongst the preliminary proposals, we say 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. What that leaves neutral is the question of whether those two are the same or different. We don't have a view on that, and for the purpose of the subsidy it's not essential to have a view of that. What we're saying is that the subsidy payable to the aged care sector should reflect the rates of pay and the wage outcomes for that sector.

If through process of indexation would reflect any prior period wage outcomes that are negotiated - and clearly there would be a lag of some period, and that no doubt is of considerable concern to proprietors, but the way indexation would work is that if a pay claim is successful in the industry, then from the commission's point of view, the next indexation process would reflect that outcome. The question then is as to how precisely it would reflect it in the sense of if it is a national uniform basic subsidy, then any one state that makes a pay claim or agrees to a pay claim that is significantly above the national average of wage rates, will have that significantly watered down which would strike me as a powerful incentive to ensure that there was some broad national set of wage outcomes in the industry. If it was jurisdictional based then clearly the impact would be more immediate and more direct and that's a factor that we'll take into account in coming to an ultimate view on - - -

DR LEAPER: Can I comment on that?

MR WOODS: Please do.

DR LEAPER: That has theoretical merit but in the practical environment the pacesetter has been the body providing the subsidy, as you call it, the government. In fact in terms of agreeing to increases there's been little or no laxity on the part of the aged care sector which has caused the differential to exist. So it might protect against a problem but the problem is not the one that we're dealing with. The problem is that in the acute sector, largely government-funded, the pay rates that have been approved - and who knows what the likely pay rates are going to be - are making the differential between aged care and that - in danger of aged care being relegated to second-rate nursing.

MR WOODS: I understand your point, although you fail in your comments to differentiate between governments - I mean, to use government in a generic sense is unhelpful in this field in that we're talking state governments negotiating with - - -

DR LEAPER: Point taken.

MR WOODS: - - - those in the acute sector. I'm charged with inquiring into a federal subsidy and we need to understand those dynamics. It doesn't help the proprietor - I totally understand your point but nonetheless I think in terms of the evidence before the commission that we need to keep those distinctions clearly in place.

MR CROFT: I wonder if I could make a comment. You made the differential between the acute and which is largely public funded and the aged care sector. In fact, in the state, Victoria has the highest percentage of state government operated nursing home beds which ostensibly are co-located alongside their aged care facilities with are Commonwealth funded, located alongside their acute facilities. So in fact state government is obviously a player in the aged care field and that is a distinction I think that needs to be made and that those rates obviously affect us.

MR WOODS: Yes, we do understand the greater role in Victoria of the state sector in aged care.

DR LEAPER: There is one further element that probably needs to be recognised in relation to the point Graeme just made, the fact that the state government is an operator in Victoria and state governments throughout Australia and that is that in the main, the vast majority of their nursing employees are not only higher paid, they're full-time; and in the main, the vast majority, as the commission recognises in its paper, of the nursing employees in the private enterprise sector, in the charitable sector, are part-time and that has a significant influence on a whole lot of factors, including one which was mentioned in Dr Segal's evidence yesterday, the use of agency staff and the mix of part-time and other staff when it's not possible to in fact employ nursing staff. It also has some significant implications for cost in terms of training which I will get on to later on. But I think there is a dramatic difference in cost structures and

particularly in the wage sector and the employment conditions that exist in what amounts to the pacesetter in wages and that is the states throughout Australia.

MR WOODS: You refer to part-time. Of course there's an important differentiation in part-time between permanent part-time and casual and I think we need to understand the dynamics of each of those subsets because they also bring an important perspective to bear. The extent to which you have permanent part-time is not necessarily significantly different from permanent full-time, but where you have casuals then that does bring a different dynamic into your sector of the industry. Again in looking at the subsidy arrangements and trends occurring in the industry, if there was some greater certainty of funding on the four proprietors on a day-by-day, let alone month-by-month basis, from your perspective would that lead to an increase in the number of permanents - whether they be part-time or full-time - and a reduction in the number of casuals employed? I mean, is that something that we need to take into account?

DR LEAPER: I think it is but I think it's in a different context in that it's more related to the quantity of qualified nursing staff coming out of the various training institutions and that quantity is far less than the demand. As a result, the current supply has to come from the other sector, the personal carers and the agency of course.

MR FITZPATRICK: I think, commissioner, the other thing that needs to be taken into consideration is the coalface issues of what's happening in nursing homes currently. Essentially, they - as Dr Segal pointed out yesterday - can be compared to medical wards in hospitals these days. I mean, residents have many multiple and often chronic and acute complex medical conditions and they can be easily equated across to things that are occurring in public hospitals today. Essentially what you've got is, you've got a situation where you have a registered division 1 nurse who might be in a charge nurse position and the buck stops with her in many instances on a day-to-day basis about whether or not she would call in a medical practitioner - a very expensive process - or indeed calling on the resources of the local hospital through the casualty wards or the ambulance.

Indeed, in many medical wards in public hospitals you will - you'll have a doctor walking around the place that you can actually tap into. To, in essence, suggest that a nurse in the aged care sector should be paid any less than somebody - and currently are paid less - than someone in the acute, is quite absurd when you actually look at the situations as they occur. Essentially what happens with a public hospital is that you've got many, many resources to call upon and essentially a charge nurse has to be all those resources to a whole lot of people within the facility - overseeing care planning, dietetics, physiotherapy, the whole works, with the particular residents in the facilities. The PCA - or the personal care worker - certainly helps with the activities of daily living but certainly not the medical management of residents within aged care facilities. So the suggestion would be that the registered nurse, division 1 and division 2, there's an upward pressure upon them because of the fact that we have a

larger base of personal care workers who are not trained in the observation of residents and their particular conditions.

MR WOODS: Thank you for that comment. But can I just reinforce my earlier statement that the commission doesn't hold the view that there should be a wage differential between the public and aged care sectors - the acute aged care sectors. What I'm charged with is recommending a form of subsidy which, as expressed in this position paper, would reflect the costs incurred by the industry. If those costs are such that there is parity between the two sectors, then the subsidy and the indexation process will accommodate that. There is no perspective in my thinking or the paper that proposes nor supports anything other than parity. What we're saying is that whatever the wage that the market forces bring to bear then the indexation system should be neutral to that process, with the one caveat of there being a lag in the process but not beyond that.

MR CROFT: I'm wondering if I could also just make a comment on the role of wages and parity. Of course it's not just the wage rate that is different between the private and public sector. There are issues such as preferential superannuation schemes which operate between the two which also make it difficult for the industry to attract appropriately trained staff and certainly when they're competing with not only a wage rate but a beneficial superannuation scheme that we can't match by any stretch of the imagination that makes our job worse. The other issue - - -

MR WOODS: Can I just stop at the superannuation. I would appreciate some information to the contrary but my understanding was that although prior employed nurses still had access to their previous scheme that newly employed nurses in the public sector were on a superannuation scheme very similar to that which you offer, ie, that they have basically the national minimum superannuation. Is that not the case?

MR CROFT: In the case of three facilities that now operate, I have approximately 50 per cent of them that are earning greater than 7 per cent.

MR WOODS: But is that because of their access to the previous scheme?

MR CROFT: Correct.

MR WOODS: So you are agreeing with me that for new employees into those facilities, they have been having access to a scheme that is not unlike yours.

MR CROFT: That's correct.

MR WOODS: That's not the impression I got from your first response.

MR CROFT: Sorry, my apologies. The other, of course, is that if you're talking about a flat superannuation rate, it's 7 per cent, which is the CGT at the moment. On an hourly rate, for instance, at the moment of Queensland at $92; 7 per cent on $92,

their average funding rate is very different, from 7 per cent on 110. So that is also impacting on the Victorian situation as that on-cost.

MR WOODS: Thank you. Dr Leaper, did you want to make a comment as well on that? You seemed interested in launching in and I'd appreciate your comments.

DR LEAPER: I took heed of your comments and I would expect they will be reflected in the report and what it suggests to us that we should campaign more vigorously outside the commission for an appropriate parity between acute and aged care, given that the commission recognises that whatever rates are being set are the appropriate rates to be used for subsidy purposes. I take your comment that it's not something which we should argue particularly in this meeting.

MR WOODS: Thank you. I appreciate that. The next issue.

MR FITZPATRICK: Certainly. The next issue is the cost of accreditation and I think it was dealt with in some of the submissions yesterday where it's an unknown quantity.

MR WOODS: I notice we don't have - and he apologises - the departmental representative in the audience today but I noticed him scribbling furiously on those matters yesterday.

MR FITZPATRICK: The fact that it's not a recognised cost within the subsidy.

MR WOODS: It isn't as the subsidy is currently constructed. In terms of the position paper that we put forward where we talk about a standardised bundle of inputs, then that would embrace all relevant inputs and if one of those costs is the cost of accreditation, that's not different from, say, the costs of training and education or other costs which are a natural part of operating a facility. So from my perspective I don't see it as necessary to put an item by item listing of all of those costs. It would be up to the consultations that would follow in determining what constitutes the standardised input mix and the costs you incur in accreditation would be a component of those, so I understand your point.

DR LEAPER: It probably is worth saying though, chairman, that all other things being equal, if the previous system was one in which a reimbursement of expenses took place and the standards monitoring process was paid for separately by the government, then an equal process now, with the government not paying for that, would see it reimbursing somebody else or some other reimbursement for the same cost structure to exist. So there has been a net addition to the costs in the non-Commonwealth provision of the service.

MR WOODS: That's because you have a current subsidy arrangement that is not transparently based on a standardised set of inputs. The proposal that we have wouldn't lead to that outcome and we are referring to then regular reviews for that standardised bundle because if there is some fundamental change to the nature of

inputs, that should be again transparently recognised. You raised the phrase "reimbursement" which, if you don't mind, we could explore for a moment. There are two ways broadly to go. One is to identify the standardised set of inputs, either at a national average or a state average, and have a direct one-for-one reimbursement proposal which could lead progressively to the imposition of that standardised set of inputs to each facility so that they must comply. We have had evidence before us from various bodies which want to isolate this bit or that bit to ensure that it gets spent only for that particular purpose, the ultimate end being a very constrained form of production process that must comply with each component and I suspect some inefficiencies arising because of it, let alone some - I use the word generically - game playing, in the sense of ensuring that each component is fully spent.

The alternative is to recognise a standardised input bundle and for the average cost to be applied to that - again either at national or jurisdictional level - and for government to set an output price which is transparently related to but not prescribing of proprietors actually performing their operations in accordance with the details of that bundle. From my perspective and as reflected in this position paper, that allows proprietors then to deal with the situation confronting them on a daily basis to apply their resources to the best care possible for their residents, which is the outcome we're all aiming to achieve. So I'm cautious of the word "reimbursement", except in particular cases where we have referred to payroll tax and maybe, in some form, relating to workers comp. In other respects, my thinking at this stage, as expressed in this paper, is to prefer to avoid reimbursement and to set an output cost, but that it has some transparency to a standardised input bundle. Do you have a comment you want to make?

DR LEAPER: I am delighted you picked me up on it. It was actually used deliberately - - -

MR WOODS: They usually are.

DR LEAPER: - - - because I have a real problem with the word "subsidy". The concept of a subsidy is foreign to my way of doing business. I would have thought pricing is really an issue and something along the lines of accreditation. Whether it be an additional cost or not is something that needs to be faced and if it's part of the input bundle to provide the service, then the pricing gets changed accordingly and if your pricing is too high compared to another operator, obviously you won't do well. That's why I was deliberately using terminology like "reimbursement", to avoid "subsidy".

But your point I think is an excellent one in relation to regular reviews and I can see the logic behind what you're saying if regular reviews do take place, and I would also argue strongly that they shouldn't be jurisdictional. The problem is we see in the indexation process, as it's been working, in the allowance for changes to superannuation requirements as they have been working, but then real dislocations in the reviews, and some of the problems we're facing in coalescence have built up as a result of non-regular review. So I just have to argue really strongly that if the model

you're putting forward is to be acceptable, it's got to go very much hand in glove with those regular reviews.

MR WOODS: Do you also agree with the proposition though of government setting an output price that is transparently related to but doesn't dictate behaviour of the input?

DR LEAPER: Very much so.

MR WOODS: Thank you. Please proceed.

MR FITZGERALD: Certainly. I think if we go to coalescence and the actual part of that discussion there and I would invite Graeme to have a word on the effect in Victoria.

MR WOODS: Yes.

MR CROFT: The difficulty in Victoria obviously, with one of the highest hourly rates on the current schedule and the fact that we did achieve a coalescence on 1 July, that obviously has an effect on our operations. The coalescence itself, obviously it needs a significant amount of time if there was to be a national rate, and we say that there ought not to be a national rate. We say that it ought to be funded on a state-by-state basis. It seems illogical to give the benefits to one state that doesn't have a cost and penalise another state that does have a cost when, in effect, the operators have little opportunity to adjust those rates. Coalescence, whilst it's a gentle way of throwing in the person in the river with a brick - and it depends on the size of the brick you're going to put on their foot - I think the issue here is that if coalescence continues, you will see a decline in the state.

We also have the highest acuity of residents in the state and that is one of the most damning things that occurs. Effectively we are going to be the most significantly penalised state, where we have the most acuity, and yet arguably there is more funding out of this going to go to Queensland that doesn't have the acuity, that doesn't have the pressure on pay rates, and I ask the question, "Why?" It seems ludicrous. I think the other issue that is going to come out of - - -

MR WOODS: Can I just intervene at that point. Is the corollary of that that the current differentials in subsidies reflects the current differentials in costs incurred by the various states?

MR CROFT: Largely because with the abandonment of CAM-SAM and CAM indexation, CAM indexation I think was 1 March 96, so there's not been significant changes. I mean, up until 96 obviously, the CAM funding was based on costs experienced across states and so it's only the difference between 1996 and now, and I think there are certainly cost pressures in states like Queensland, but no greater than the ongoing pressures that we experience in this state. So in fact if the pay rates that

are in place, as I understand it, across states continued, it wouldn't matter, there would still be that differential across states.

MR WOODS: Yes, evidence runs contrary to that of very many other witnesses, that the current differentials in subsidies are greater than the current differentials in underlying cost structures in the various states. I will take that on board.

MR FITZGERALD: There was invited comment as well, chairman. We believe the commission review is time constrained at best and should not be proposing structural change which is best handled through the 2-year review process and to do so in the short term would seem to ignore the concept of cost data related to diagnosis or complexity etcetera and is unable to be supported.

We have discussed the input taxes. They should be fully reimbursed to providers where directly related to a contract of service and the method of payment should not be included in the form of the basic subsidy increase. Cost reimbursement of payroll tax should be treated in the same manner as other cost inputs.

In conclusion, income and asset testing we believe should be carried out by the Commonwealth, with applicants advised of any tested contributions. The current system of providers testing for assets is becoming very unworkable and unjustified and is contrary to consumer wishes. I thank the commission. Do you have any questions of a general nature for - - -

MR WOODS: Yes, let's just go back through my issues and see where we have already knocked them off. You raise in your submission various questions relating to quantum, but no doubt you have read my term of reference and understand that quantum is not part of that. I think we have dealt with the parity issue in some detail and clarified views there. You refer to, "There is validity in allowing the retention of additional fees by providers without extra service status, but where single rooms with en suite and additional amenities are provided" - what is your view in terms of the opportunities for extra services, and in answering that, can you respond also to the observation I make that a number of providers who don't wish to pursue offering extra services are in fact building single rooms, either with shared or dedicated en suites which strikes me as potentially reducing the market for extra service. Could you go through some of those dynamics?

MR FITZGERALD: I would invite comment from all of the participants here.

MR CROFT: Actually I think that John Leaper actually would have that experience of - you know how you were mentioning the comments, John, about your foundation members and the difficulty you had at the time?

MR WOODS: Dr Leaper.

DR LEAPER: The first thing I should say is I commend the commission for its comments on extra services. I think a lot of them are very helpful and would

significantly improve the provision of those services. But the current situation is one where extra services really have not found and settled into the structure. The most recent dislocation is the $12 a day accommodation charge which is now leviable by what I might describe as standard nursing homes. That in many ways has lifted standard nursing homes into the category of the lower level of extra services. As you rightly point out, it is enabling many of them - and it appropriately is enabling many of them - to rebuild, construct with certification through to the year 2020 in mind and hence, private rooms, even en suite facilities are becoming a part of the new standard nursing home.

That puts a real challenge to the extra service sector which previously had a private room as its linchpin, not unlike years ago when one was thinking of private health insurance and going into a hospital and having a private room. So there's a question mark over what extra services are actually going to be in the next 10 years or more and they are likely to be significantly affected by location, for example, inner-city developments and the expense of doing those for a room size which one might describe as large, relatively speaking.

MR WOODS: Particularly if you are looking at ground-level accommodation.

DR LEAPER: Correct. Then separate from that, services, and where in the past extra service facilities have been dealing with a la carte meals and perhaps the provision of happy hours and other events in buses and so forth, again that's going to become more, I believe, the standard nursing home, and the extra service home is likely to have to provide warm spas that will take wheelchairs that will be able to roll into the spa or a dramatically different occupational health and safety facility in terms of the electronic lifting machinery and other things that are built in. So we're really in a transition phase. Extra services hasn't really found its niche yet. Our latest market research suggests that there is not a lot of enthusiasm for it in the current market whilst people are re-establishing their position in relation to the $12 a day accommodation charge. So whilst the commission's comments there are helpful, I think there's probably a worthy case for a further analysis of what it is that the policy-makers want to achieve in relation to extra services and how best to achieve it in the current market. My final comment being that although accommodation bonds are allowable for extra service facilities, it is interesting to note that in Victoria, the vast majority of extra services facilities do not charge bonds at all. So whilst it seems to be an advantage, in practice it's not turning out to be that.

MR WOODS: Are these extra service facilities who are charging the extra service fee but not the underlying bond?

DR LEAPER: Correct.

MR WOODS: Any further information you have on that again that you can bring to us, I would appreciate.

MR CROFT: I think the issue of extra service - just if I could add there - for facilities that are attempting to redevelop in the inner-city areas of Melbourne, the $12 a day of course is not significant to go and build something when you might have a land cost acquisition of, say, $2,000,000, and then need to build a two-storey building that is maybe another $5,000,000. So for those instances it's actually almost imperative that the facility becomes an extra service or it won't get off the ground. So there are those issues. The other differences of course are where a client may have means, and the only facility available for them may be a four-bed ward. In fact they may be paying the $12 a day and only receiving a four-bed ward. The fact that they're paying the $12 a day instead of the government does not guarantee them that they're actually going to get any better accommodation. So that's an issue that seems to be somewhat at odds with society's expectations that if you pay more you get more.

MR WOODS: Thank you. Could you advise the commission on what you understand is happening by way of rationalisation in the industry over the last 4 to 5 years.

MR FITZPATRICK: In respect of buildings or - - -

MR WOODS: No, size of homes - - -

MR FITZPATRICK: - - - amalgamations?

MR WOODS: - - - amalgamations.

MR FITZPATRICK: I think that it has become increasingly obvious in - well, if we start with the size of facilities in Victoria, predominantly 30-bed facility, if you go back into the 1980s, there was a reasonable number of 20-bed facilities which were considered viable at that particular stage. 30 beds was considered to be more viable. Speaking with the Commonwealth Department of Health, they're talking as a minimum 45 and being more like a viable number of beds, but to - and to age in place, you're going to be looking at something in the order of 90 beds as a viable operation because you'll have entry at a lower level of subsidy going right through to the higher levels of subsidy as they age in place.

What rationalisation of the industry - predominantly we're still 30-bed homes. There's discussion with the governments over amalgamation of two and three facilities, but certainly they would be examples only and certainly not something which is occurring at a phenomenal rate at the moment, and I think that with the introduction of the accreditation, the certification issues, that is certainly going to put pressure on people to actually make decisions, and those decisions that they will make will be do they amalgamate and become a larger facility with another provider, do they exit the industry and sell off to other providers that can afford to purchase and build those, taking into consideration what Graham had said about inner city issues. So I guess that's a reflection of what could occur and what has occurred rather than necessarily giving evidence of actual occurrences of those things in a rationalisation sense.

MR WOODS: Although the data that we have before us suggest that there have been quite a number of smaller homes that have been taken up and incorporated into larger homes - the underlying bed licences of them.

MR FITZPATRICK: The issue there is what is a smaller home. If you're taking about the 20-bed facility over the last 12 or 15 years, then certainly there's very, very few of those left, and their top-up funding which they have traditionally had is under threat as well. So, yes, if you say that there's that rationalisation of those smaller beds into, say, two 20-beds becoming a 40-bed anew. There is that rationalisation which has occurred. I would still default to the argument that there's still a lot of 340-bed nursing homes in Victoria which are yet to see a rationalisation.

MR WOODS: Yes. I understand the process. If you could excuse me for a minute.

DR LEAPER: I can comment quickly on some information in regard to that, commissioner. In the late eighties, it was quite clear that encouragement by the Commonwealth government was strongly for homes to move to 30 beds in size. Approvals in principle were being granted to a 22-bed home, eight being given for a 28-bed home, two being given, and it didn't take Einstein to work out 30 was what seemed to be a minimum critical mass or encouraged size.

In the most recent round for approvals in principle, the top of the advertisement that the Commonwealth had in various states, certainly in Victoria, stated that preference would be given for applications to move a facility to 60 places. We're only talking 8 or 9 years from a facility which could cost 2 and a half, $3 million, or even significant figures around that to build to 30 beds that now appears to be an uneconomic size or less than critical mass, and the 60-bed facility in the advertisement appears to be the one that is being encouraged.

As our president has just mentioned, our view on ageing in place is that the staff flexibility required to handle low-care residents moving to high care needs will require a facility significantly larger than 60 beds in order for that policy to work; to be able to mix and match the staff numbers according to those needs. Hence 90 beds or even 120 beds are not beyond the likelihood of the critical mass required, particularly when you add to that all the documentation and training required for things like accreditation, because there are clear economies of scale where one facility can implement that for let's say 120 beds as opposed to four facilities of 30 beds trying to do the same thing.

MR WOODS: Yes.

DR LEAPER: So for a variety of reasons we see the numbers substantially increasing in terms of critical mass, but the actual market has moved along quite slowly behind that.

MR WOODS: And in fact you would be talking about a hostel-cum-nursing home with your ageing in place, not just a 90 or 120-bed nursing home.

MR FITZPATRICK: Correct.

MR WOODS: And it wasn't many years before the 8 to 10 you were just referring that four-bed wards were seen as the state of the art and all the problems of how to retrofit those into something like two-bed wards.

MR FITZPATRICK: True. I think it probably relates to the comments you made earlier about the single and twin room and the en suites. I think that anybody building now is building for the future, and certainly those are the issues they're looking at. It's the future viability rather than just today's viability.

MR WOODS: I appreciate we're bumping on time-frames, but there are just a couple of other matters I would like to pursue. One is from your experience of homes in the private for-profit sector in Victoria of similar size and profile, do you find that they have at times different financial outcomes; that there are some that are more financially successful than others?

MR FITZPATRICK: Of a similar size?

MR WOODS: Yes.

MR FITZPATRICK: You would have to say that it would depend on the business acumen and the quality of care that was balanced and delivered to the residents within the facility. Essentially issues of the funding being very similar to the same size facilities - I guess the differential would be issues where there were - where a home may be freehold outright owned, where there may be a rent component, the leasehold issues, the varying cost of the lease, the imposition of certain clauses within leases. So it's a difficult thing to nail down in that you may have a lease which is a very generous lease to the operator in terms of the landlord doing things that in another lease that may not occur.

Essentially you would have to say for similar funding that you would have to have a reasonably similar outcome where the quality was maintained within the particular facility. I guess the other thing is that under the previous funding arrangement, if there was a purpose-built 30-bed nursing home with single and twin rooms, the staffing costs for cleaning, etcetera, may be extremely high, or on the other hand you may have an older building which was not purpose built, but it was a converted building which has very high maintenance costs because the floors are falling apart or whatever. So it's a difficult one to say that you would see similar outcomes in similar-sized facilities.

MR WOODS: So there are a range of factors that affect viability including leasehold, maintenance requirements, quality of care, business acumen. So I think we

need to keep that before us in coming to views about the degree of the relationship only between funding and viability.

DR LEAPER: That's quite correct, but there is one element which is an overriding element of significance in the recent 18 months, and that is vacancies. Occupancy rates traditionally were effectively full, and hence the differentiation between the performance of the facilities you were referring to was measured on other things that Brian has been talking about.

The current environment and, the way we see it, the likely future environment is that for one reason or another, vacancies are going to play a very significant role in the viability of an operation. One would hope that vacancies would reflect poor performance, but it is possible that those vacancies reflect some inefficiencies in the market such as the referral of respite candidates or the actual referral of residents for placement. I think it's just worth bearing in mind that this is a new ingredient for this vacancy rate, but potentially a very, very significant one.

MR CROFT: The only other closing comment perhaps I could make is that of an aged care facility's potential for viability, 75 per cent or around about those percentages are in wage and wage-related costs.

MR WOODS: Yes.

MR CROFT: Clearly if you cannot manage and you have got cost pressures on those areas, then it significantly affects the viability of an organisation, and as Mr Leaper pointed out, the occupancy rates are one thing, but certainly what we're finding in suburban areas, if we cannot attract staff, then we have to provide agency staff or whatever, and that has the significant capacity to blow out the wages budget and instead of, say, 75 per cent, you might be looking at a 80 per cent, and that is a very real opportunity of creating viability problems within nursing homes.

So I think the issue in itself of relative wage rates are one thing, and in a business where perhaps your component of wages to sales are only maybe 30 per cent it's not significant, but when they are in our business at 75 and sometimes heading towards 80 per cent plus the attendant on-costs, and the capacity also for injury in an industry, then that's a very, very significant point that is quite different to any other industry that the commission may be looking at.

MR WOODS: But a home that offers a relatively more enlightened approach to occ health and safety, that has lower staff turnover, that has a good training regime, that has good morale, that offers quality care, that is efficient in its rostering is going to draw less on agency staff and have less of those cost imposts that you're referring to. So there is scope for management to affect the financial outcomes through those proceedings.

MR CROFT: If all things were equal that would be the case, particularly if you are paying identical wages to your competitors down the road, but it's very difficult to

attract the high quality employees who can demonstrate all of those and put all of those procedures in place.

MR WOODS: Actually I was referring more to management than the employees in the list that I gave.

MR CROFT: Certainly I think most employers would acknowledge that you can have all the right procedures and processes in place, but if you can only afford to attract second-rate employees that can't get a job elsewhere in higher quality facilities, then the capacity for the organisation to implement those policies and procedures may be somewhat limited.

MR WOODS: I'm not sure all employees in your sector are second rate, but - - -

MR FITZPATRICK: I think the comment was made yesterday, commissioner, where somebody could be working for Telstra or in a ditch one day, and perhaps working in a nursing home was the comment that was drawn. I think to draw out from what Graeme was saying, sometimes when you ring an agency - you know, this is at the coalface. You ring an agency and ask for someone to fill the shoes of someone that you need to actually have on the floor, you sometimes have no choice about who arrives at the doorstep.

MR WOODS: I was just a little concerned at the broader generalisation that was made in the comment. One final issue, and that's in relation to government homes and those then on-sold. From the perspective of this position paper, we don't see that government homes should be treated any differently. There is the issue of transition however, and I was wondering, Mr Croft, if you could outline for us the procedures involved in your cases of picking up homes that were previously state run in terms of any ongoing subsidies that the state may give or any adjustments to premiums to reflect lower subsidy rates and the like. That would be helpful.

MR CROFT: I'm not at liberty to discuss confidential aspects of the agreement. What I will state is comments that have been made publicly by many parties. State government's intention when they transferred the facilities from public to private ownership was that they were not in fact transferring existing facilities per se, but more looking at a better outcome in terms of building. So that was their first concern; that they could not afford the building costs, not necessarily that it was a major move to abandon aged care. But that being so, one of the most significant issues was the industrial relations issues that would come out of any transfer process and clearly from a political perspective they wanted to minimise the political fallout. One of the things that we negotiated in our pilot was that there ought to be no difference between the revenue received from a private facility and a public facility and on that basis they sought over I think it was a 10-year period to equalise the funding and then to further review it after that period of 10 years, with a view that they would make whatever differences necessary to ensure that the funding was on parity.

But funding is only one side of the ledger. The cost side of the ledger is obviously something different. As part of our transfer process, we were given a schedule of employees which were designed to reflect the average category of the care in the home and it was based on the old care model where about category 3 was the average of the resident that were in the facilities which, say, on a 30-bed model or 30-bed wing, would have provided somewhere around just short of 600 hours of care per week. They would then allocate 600 hours of employees' time relatively split on a schedule and we were given no ability to be able to interview those employees or consider their past occupational health and safety records, whether in fact they had long-standing WorkCover claims.

In fact, the experience that we found, bearing in mind our transfers have all occurred in rural areas, has been that a public sector or acute facility would generally retain its very best recruits in its acute sector and off-load those employees that may not be the best performers into its aged care sector. Now, that has serious consequences and as a result we found ourselves in the commission this year because we sought a review of all staff's performance and capacity to perform their work and it resulted in us supplying significant redundancies across our organisation to achieve desired results. Also, the work practices and feather bedding of rosters was something that we couldn't continue to work with and we couldn't make our budgets work, so we set about creating redundancies and in fact restructured both of those businesses to the point that we could operate.

Now, that required a significant capital injection from our organisation which we were happy to do, because it meant that over the longer period of time we could actually manage the process. But as I say, there was an injection of capital required. The Commonwealth didn't provide it and obviously we did from a private enterprise viewpoint, because that was a business decision we took. But there are significant problems in that transition process as the Moran Organisation is finding out along the way. I notice that one of their chief operators was on the 3LO program last week in the afternoon Terry Laidlaw show, it was one afternoon last week, stating that they were opening new facilities and couldn't attract staff, had advertised but could not recruit staff for their new facilities that were opening. That is just one of the difficulties.

In that was mentioned the parity issue. We have problems obviously in an aged care facility at the moment where we have some people who have maintained their public sector rates of pay, some that have private sector rates of pay. You have one nurse working getting one thing; one nurse working getting another. That is extremely difficult.

MR WOODS: Thank you very much. Any concluding comments from your side.

MR FITZPATRICK: I think that is it. Thank you very much.

MR WOODS: You have put forward the issues in some detail, for which I am very grateful. Thank you very much.

MR FITZPATRICK: Thank you very much for your time.

MR WOODS: I would propose a very brief adjournment and then we will resume hearing.

MR WOODS: I'd like to resume the hearings and call to give evidence Mr Bourne and Dr Leaper from ANHECA's federal office. Could you please state your names and the positions that you hold for the record.

MR BOURNE: Bill Bourne, and I'm the chief executive officer of the Australian Nursing Homes and Extended Care Association.

DR LEAPER: John Leaper, and I'm vice-president of ANHECA federally - acting president at the moment.

MR WOODS: Thank you very much. Have you an opening statement you wish to make?

MR BOURNE: Yes. In opening, ANHECA would like to congratulate the commission on the efforts of putting together the position paper on the nursing home subsidies. We'd also like to thank you on behalf of ourselves and possibly the wider industry for the opportunity to provide input in the many meetings which you attended to gather the data. We support the majority of the proposals that have been suggested by the commission and in fact the inquiry was called on the areas such as coalescence and indexation and we support the commission's statement that coalescence should not proceed in its current form and we also support the fact that it recommends a different indexation proposal for the COPOs arrangements.

Further, we consider that the underlying or integral proposals in the position paper were the ones that look at the need to provide funding to meet accreditation certification requirements and also that there should not be a simple rebalancing in relation to the coalescence arrangements. In relation to the indexation we are unsure of what the productivity discount means and we would request that in the final paper the commission gives a wider definition of what it considers to be the definition of the discount or as we call it "the levy".

MR WOODS: I noticed your phrasing.

MR BOURNE: We do have concerns over some of the proposals. One of those which I was going to speak on at length was the policy of parity. But in relation to the discussions of the previous evidence, I now understand the commission's stance on this that they are not simply overlooking the idea of parity. They're saying that if parity comes up through the state commissions etcetera, that the awards equal each other, then that is what would happen. ANHECA would therefore request that possibly in the final paper that the commission would recommend to the government that they would have to make a guarantee to look at meeting any increases within jurisdictions which were to the aged care wages that were going towards meeting of the parity, because under the current arrangements there is a difference between the aged care wages and those wages that are paid in the acute sector.

If the indexation arrangements keep going there would still be that lag. If the indexation picks those up there would still be the timing lag, and the timing lag is

what we would be looking at the government picking up with a guarantee of that nature. The other area we were concerned about is the workers compensation premiums that by including those in a general subsidy arrangement there is a vast difference between jurisdictions in the level of workers compensation that's paid. Those levels are dictated by sources mainly outside the control of the provider and ANHECA proposes that we revert back to the constrained costs reimbursement system of upper and lower caps that was provided in the latter stages of the previous funding regime.

This would provide an incentive to providers to introduce and maintain good occupational health and safety arrangements. It would provide a cap to ensure that providers do not get put into a situation of unviability through higher workers compensation premiums given the 3-year window effect of that and would put into place an arrangement which is totally transparent. The current arrangements under the subsidy system with the initial system of the coalescence meant that not only was the subsidy being coalesced but irrespective of what the state was charging as an industry tariff rate, it would go to a national average rather than the tariff rate within that state. We look at states like New South Wales where the tariff rate has been set at a level to recompense problems within that state in the running of the WorkCover Authority. That has happened in other states as well and that is totally outside the control of the provider.

The other areas we would like to consider, the areas outside of workers compensation, are superannuation. Again that is controlled by the act. The act requires currently that a 7 per cent payment be paid. By including it under the subsidy arrangements and especially with the indexation system that was put in last time, there are increases that go through up until it gets to 9 per cent. We consider that those increases weren't introduced in an across-the-board manner that would reimburse providers for what they were spending. For example, it was a straight, flat amount that was introduced - 52 cents across the board - whether the resident was category 1 or category 7. Obviously there's going to be more spent on staffing for a category 1 resident than a category 7 resident.

So again we would suggest in that stage that superannuation become a cost-reimbursed system. We would suggest that, as I said before, workers comp become a constrained cost reimbursed system. We agree that payroll tax should be cost reimbursed. We also consider that there should be a component in there for training with the onset of the accreditation arrangements and the maintenance of those accreditation arrangements. We're going to see an increase in the requirement for training. We have had a guesstimate in our original paper of 1.5 per cent that agrees with the old training guarantee arrangements and also with the upper tolerance level under the previous funding system.

We consider that the training will be greater than 1.5 per cent in the initial stages but that is a bubble in the system. What we'll be looking for or what we would be suggesting is a maintenance-type level of training. We would also suggest that the subsidy arrangements be on a mathematical formula so that it gives it a transparency

and it makes it a little easier to - it would allow more transparent funding arrangements for funding, also for indexation and also for funding small rural home supplements which require a top-up or supplementation arrangement. Outside of those statements we tend to agree with the majority of the proposals that were put forward by the commission.

MR WOODS: Thank you. Dr Leaper, do you want to say anything following?

DR LEAPER: No. I'm happy to respond to specific issues.

MR WOODS: I've had the benefit of perusing a draft response to the position paper. You will be no doubt submitting a final of that. Should I take it that in the final that we'll be addressing the substance of the issues and therefore I shouldn't read too closely some of the particular descriptions?

MR BOURNE: Definitely. It is a draft paper. A lot of it was written at about 10 o'clock at night in a hotel room, so there are certain issues that will be addressed.

MR WOODS: Addressed in substance. I appreciate that undertaking and therefore will address my questions accordingly. The first one you raised was the productivity discount. In designing a subsidy, it's important to look at what effect that has on the various stakeholders. In the issue of who benefits from an increase in productivity, there are three broad groups who could perhaps reasonably expect to receive some of the benefit, they being the management or proprietors who support and devise some of the productivity initiatives, the staff who also contribute to both intellectually in their devising but also in practice in bringing them to account in the workplace. In the instance of aged care the taxpayer who supports through government purchasing of residential aged care, their costs related to running it other than the contributions of the residents, what view do you have on how those productivity dividends should then be distributed amongst the parties who could be expected to have an interest?

MR BOURNE: The view I would have is that firstly there is loss productivity within the system, especially if we're looking towards accreditation which will require an input from staff. We have heard there have been productivity gains in certain other areas but when you look into that, the majority of that has been from a depletion of staffing arrangements. We consider that that is not possible within aged care in order to continue with the quality of care that residents deserve and get, and to continue that quality of care to meet the accreditation requirements. Whatever productivity discount there would be, obviously would be a discount discounted from the indexation arrangement, but again it gets down to how that's measured.

MR WOODS: You used the phrase "productivity" not being available, yet from my observations of various homes and from a reading of the financial statements that I have had made available to me from various homes, I notice there is a divergence in both the running of homes and their financial outcomes, some of which is attributed to managerial and other practices put in place. All that evidence points to that some homes are operating more productively than others. Is that also your experience?

MR BOURNE: It depends on the definition one would say because the input to achieve certain outcomes, it depends on what their required outcome is of that manager, so some would have a higher expectation than others, and the higher the expectation, usually turns around into a higher cost. Some facilities have the added advantage of being able to access contractual arrangements in relation to costs other than wages and in some cases that is cheaper than having labour, but then again - - -

MR WOODS: You're talking about outsourcing of food, linen and those sorts of things?

MR BOURNE: Yes.

MR WOODS: But that's an individual discretionary choice of the proprietors as to what configuration they choose.

MR BOURNE: Yes. Again, that's the managerial expertise. Some facilities don't have the ability to access that contractual labour. Also on the corollary of that, sometimes in-house is cheaper. I have seen over the years that facilities have gone from in-house to contract, back to in-house labour, so it's a trend arrangement.

MR WOODS: But that's the proprietors making a judgment at the time on what is the best arrangement and in relation to a discussion in previous evidence by not prescribing the inputs too closely, then proprietors can make choice as to what delivers the most efficient while maintaining quality of care. Dr Leaper?

DR LEAPER: Just in relation to this, I'm interested in your concept of performing better and what that means. I presume it's relating to cost management given that - - -

MR WOODS: Well, cost management within a level of care that would reach an accreditation as an example of a benchmark.

DR LEAPER: Given that, in all other than extra service facilities, the revenue side is pretty well constrained, whether one facility does better than another would depend on how, given its care requirements being met, it manages its costs. And then one would ask, "Well, let's look at the cost structure and see what the big issues are," and clearly there will be a difference in things like rent if it's a facility or implied rent for inner city versus country locations and some other aspects. But the vast majority will be in wages, and hence the vast majority of any savings would be in rostering and an ability to deliver the care with fewer hours, might be more efficient use of time, but that concept of better, given the market which we face which is one where the revenue is severely controlled, it does focus attention very much on the labour component and how you can utilise that better.

MR WOODS: Indeed, including staff turnover and injury practice and areas of use of administrative staff. I mean, there is great variation in the level of non-nursing staff between homes, and that again to some extent has been customer practice in certain

sectors have tended to have higher levels of staff there than others. But again there's an element of managerial discretion in that, so the point I'm trying to ascertain is whether there is any reflection in the industry of variation in productivity while meeting a benchmark level of care, and I take it from your evidence that you're saying that the answer is, "Yes, there is, but not much." Is that a fair summary?

DR LEAPER: Yes, I think so.

MR WOODS: But you're not denying its existence?

DR LEAPER: No.

MR WOODS: Thank you. In which case then we do need to look at how, if there is to be productivity discount, it is distributed amongst the interested parties to that. On the question of indexation then, the design principles that we put forward in the position paper are to reflect more closely the actual cost pressures that are being experienced by the industry, albeit any indexation will demonstrate some lag, and again depending on whether the final outcome is a national uniform subsidy which then puts pressure on individual jurisdictions not to move too far out of that national stream versus a state-based jurisdiction which would see some greater flexibility, but do you see any fundamental flaws in the proposal that we identify in the position paper?

MR BOURNE: Not at all. Firstly, we consider it should be a state-based regime.

MR WOODS: Yes, I understand.

MR BOURNE: And that the indexation should reflect the movement in the cost of wages within that jurisdiction.

DR LEAPER: I would hasten to add though that where you say the current subsidies should be redirected to increasing basic rates for the currently low subsidy states, we don't see that as being a sensible approach. The indexation is required for all states. How you deal with any determination of low subsidies and their rectification should not be at the expense of other states.

MR WOODS: Yes, I'm sure you appreciate that this is dealing with two different issues, although I recognise that it ultimately comes to the one financial impact. The design principles for the indexation generally that we promote would recognise the cost pressures in jurisdictions. The question of how you adjust for the difference in subsidies that all other evidence has suggested shows Queensland in particular to be disadvantaged subsidy-wise relative to cost, although I notice that the Victorian branch's evidence didn't concede that point. It is a separate issue of transition, although I would fully appreciate that it has a daily impact on the proprietors and the question then is before government and possibly for the 2-year review as to how it deals with it, although I notice that other witnesses are placing very great reliance on

a potential $128,000,000 bundle of money which could be spent in many directions to alleviate those various issues, but I'm sure we will pursue that later.

DR LEAPER: If I could just support very strongly that comment about the 2-year review. I believe the commission has been put under very severe constraints in terms of the 6 months or so involved, and clearly an analysis of the coalescence issue as its main focal point to attempt to come up with a major review of the whole funding process and perhaps proposal for a new funding process, the commission ought reasonably to have been given much greater time or another alternative approach taken to finding it.

MR WOODS: I note your views. The commission will deliver a report to the treasurer which deals with the particular terms of reference, but as I have stated before we need to understand the context in which those issues are embedded into the broader industry and into the dynamics of the industry, ie, what is facing the industry over the next 5 to 10 years, so that they have longevity.

DR LEAPER: I put those forward out of guilt. We have barely done justice to a review of coalescence in our attempts to put evidence before the commission. For us to be able to comment on some of those broader issues in any depth would have taken us a lot longer than we have been able to put into this.

MR WOODS: Your organisation has dealt with many issues and the commission finds that very helpful. The question of workers compensation, in debate with previous witnesses the commission at this stage is open to suggestions that recognise the impact on particular homes of large claims and the fact that that impact can have a 3-year duration, and that that warrants addressing in some form, but there still remains the question of the discretionary element in relation to premiums for workers compensation. I think it's important to carefully pick through phrases such as, you know, "having no discretion" or "totally out of the control of" that undeniably there are within premium structures incentives to improve performance and in the industry there are proprietors who perform better in this field. No doubt your final report will reflect some of that. The question is to what degree does that activity on behalf of - or by proprietors and in association with their workforce have a significant bearing on premiums or not, and I would welcome any further comment you may have.

MR BOURNE: It does have a significant bearing on premiums. We have a number of areas that do that. Obviously the one I explained before is the state government's role in that. Secondly, it's the staff. A provider could put in the best occupational health and safety practices, and put in policies to ensure that those practices get carried out. However, if the staff don't carry them out at certain times, and in caring for the aged that can happen. I mean, we could have an old resident ,if you like, falling as he or she walks with a frame. The normal procedure would be to actually try and support the resident or - - -

MR WOODS: Soften it.

MR BOURNE: - - - soften the fall and that could lead to accidents. Another added component is the resident. With a high level of dementia residents we could have those that are physically abusing staff. Again, that would lead to further accidents. All of that leads to the fact that a provider can put in what he or she would consider the best occupational health and safety practices, yet still incur penalties because of the number of claims. So it comes down to a system where the majority of the aspects that affect the premium are outside the control of providers. I've seen providers that have got the best systems, even the staff look after those systems, yet their premiums increase because of one claim which was unavoidable. So the number of outside factors outside the provider's control that affect the premiums of workers compensation vastly outweigh any control that the provider has.

MR WOODS: So it's a matter of devising a subsidy arrangement that reflects those competing pressures. One matter that needs to be addressed is some concern over what constitutes a significant deviation around a national average of cost pressures facing the industry, and there has been material presented in writing to the commission which I will pursue also with other witnesses, but in some cases it has been interpreted by organisations as suggesting the figure of a 6 per cent variation as not being significant.

In the conclusions put forward in the position paper, that if you propose a national uniform basic subsidy, then the deviations either side of that would be based on those figures, no more than 2 to 3 per cent, not 6 per cent. Also that at any one point in time the jurisdictions who may be above or below the average will change. There is the dynamic in the industry that is largely driven by the date and quantum of wage claim outcomes, that they do lead to changes in the ranking of states on that measure; also the skills mix which is the other important ingredient that leads to the total wages bill experienced by providers that although that seems to change slower, if you take a longer perspective - and we've had the opportunity of going back through that over some time - that also does change jurisdiction by jurisdiction. I do recognise that's much slower movement.

Then when you look at the non-wage areas, there is greater stability because some of those are influenced by structural issues such as distance and transport costs and other factors, so there is less movement, but nonetheless the conclusion reached is that there is some level of volatility and fluidity in terms of total rankings of states according to cost pressures over time. So that needs also to be taken into account in devising and ultimately forming a judgment on whether a national rate is important.

There are also design principles in terms of if you have a national rate, that can cause the behaviour of individual jurisdictions to have regard to their own decisions that they make as it will be translated then in the indexation process and what compensation they will get for it, and to put it slightly more bluntly it will prevent any one state from jumping significantly out of the national bound. It would also potentially encourage the development of a national pool of labour at various levels, and I recognise that that is more likely to occur for the RNs for instance than for your personal carers who are more likely to be recruited, and that their wages and

condition relate to what is happening in the local regional economies; not even jurisdictional, but sub-jurisdictional economies.

So they're a range of the issues facing the commission as I ponder this issue for the final report, but I would appreciate your reaction particularly taking into account that the national average would cause the deviation either side of that to be something of only half the difference between the two, and that already between homes we find differences in financial outcomes at least of that magnitude.

MR BOURNE: Firstly it depends on whether you accept the 6 per cent. The variance of 2 to 3, if you accepted the 6 per cent, would be correct, but that's based on raw data - very much raw data. It doesn't exclude the added on cost of the award. If it included the award conditions which again vary between the states and then looked at some of the other costs if you like which should be included in the subsidy such as - which we consider should be included in the subsidy such as long service leave, the return on investment parity, etcetera - we have come up with a variation around about 25 per cent which then makes the variation if you have an average between 10 and 12 per cent which seems to be something more of a nature that should be really looked at.

MR WOODS: We have gone through in detail the previous material you put before us.

MR BOURNE: If we consider that 6 per cent was the variance and if states were adjusted by only 2 per cent to meet that variance and others up by say 4 per cent, then there wouldn't be an argument, provided that the level was set at a level which met the costs to provide the care to meet accreditation and certification outcomes.

MR WOODS: In the design proposals that we put forward in the position paper, we're proposing such a transparency of relationship because we talk about a standardised bundle of inputs, we talk about that being drawn from and we don't have to choose a particular facility size; it can be based on a range of facilities, but through then some averaging process provided that that achieves the approved level of care. That raises the question of what is an appropriate benchmark, but if we for the purposes of this discussion use accreditation, then if that were to be the underpinning of the subsidy that would then be translated into an output price paid by government for the purchase of care at various levels, do I take it from your evidence that you're saying that that in itself goes much further to addressing the concerns that you have on that issue?

MR BOURNE: Yes. It's an output price by jurisdiction. If it changes by jurisdiction, then it should be a jurisdictional subsidy regime. That needs to be done basically by jurisdiction to see what the differences are.

MR WOODS: I will need to finally conclude whether the advantages in design and subsequent behaviour of having a national rate outweigh the cost disadvantages that might be experienced by states who at this point in time are a higher cost recognising

that over time there have in fact been changes in the relative ranking of states and territories in that regard, but thank you for that; that's helpful.

DR LEAPER: Just before you leave that, there was one comment - I was pondering your last comment. The thing I should have said is that in relation to whether it be 6 per cent or 25 per cent and whether the adjustment be 2 or 3 or 10 or 12, even as low as 2 or 3 per cent can be a dramatic share of the surplus at the end of the day for the facility concerned. There hasn't been a whole lot of specification of just what a rate of return or return on investment should be in these facilities, and I quite understand that; it's a very complicated matter.

But whereas the wages bill is in the order of perhaps $2,000,000 for a 50-odd bed facility as in our submission, the actual surplus after having dealt with 2,000,000, in wages and perhaps 1,000,000 in other costs or significant figures like that can be in the less than $100,000 figure for a facility; so a variation of 20 or 30 thousand dollars is a very significant variation to the actual surpluses left at the end of the day.

MR WOODS: Mind you it's a very powerful incentive for proprietors to be on the other side of the average and to be in the better performing category, and to the extent that they are and keep performing, they will receive the benefit and distribute that either back into the facility or to investors as they wish.

DR LEAPER: Well, you're quite right. There are a variety of motivations and end results as we heard yesterday. Some facilities that the Catholic homes were referring to have larger rooms and spacious grounds. Although they were seeking for your endorsement that taxpayers fund those facilities, I think an alternative view would be that it's quite a legitimate choice that if one chooses to run a facility that way, then a surplus can be reduced as a result. I'm arguing that the surplus available, even for a sufficient provider, is going to be very small.

MR WOODS: Yes. I just need to take into account in my final deliberations not only the plight of the extreme at one end, but the effect across all providers, and understandably you would bring to my attention those who may suffer most. There are also others who could do reasonably well out of this and who have the motivation to so do.

DR LEAPER: Well, since we represent both charitable and private enterprise facilities, I felt it was important to put them both in context.

MR WOODS: Thank you very much. On the question of superannuation and training, the proposal put forward in the position paper for a standardised bundle of inputs would pick those up as costs, same with accreditation costs. I don't see there's any point to debate those any further, other than to make an observation - and here I'm happy to add to the anecdotal evidence that we have had - that I have been impressed by some homes at the level of training that proprietors organise for staff and more particularly with staff so that it reflects their needs and involves them in the design and delivery of that training. I have noticed the very good relations between

staff and proprietors in those facilities and the broader impact that has on the operation of those facilities.

MR BOURNE: We would have to concur with that and just add further that it will increase because of the impact of the accreditation arrangements and the maintenance of those arrangements.

MR WOODS: Thank you. I don't think we need to address the parity issue having clarified it with the previous witnesses. Do you have a national view - and again it was explored in some detail previously, but at the national perspective on extra services and the likely market for it? To what degree does your membership encompass for instance Queensland? Do you have - - -

MR BOURNE: We have a membership base of about 1500 beds in Queensland.

MR WOODS: Because I notice that in some parts of Queensland, extra services seem to be - the uptake is higher than some other areas, but nonetheless it has differential impacts across Australia, but at the national perspective, your views on extra service and where it might fit.

DR LEAPER: For my sins I'm chairman of the extra services committee nationally.

MR WOODS: The perfect person.

DR LEAPER: Whilst my comments previously were on behalf of ANHECA (Vic) and I described the rarity of accommodation bonds being charged in Victoria, it actually is not the case in most other states where bonds in extra service facilities are at least being quoted and most commonly translated into accommodation charges at the option of the client, the resident or the relatives. That seems to be working reasonably well. But across the board, one thing that is hampering extra services is - and it has relevance to other areas as well - it's unfortunate because I see the moral obligation, but the albatross of carrying current residents into a facility and maintaining service for them for life.

There is a difficulty in some cases in providing extra services in a facility in one sector and providing standard services in another. Often the decision is taken to provide the same services throughout the whole of the facility regardless of whether the extra service fees are being paid or not. The foundation residents, as they're sometimes called, can enjoy a wonderful time of travelling first-class and paying economy for what was at first envisaged to be approximately a 2-year period but in fact is turning out to be considerably longer. It can make the economics of extra services severely constrained. That same principle is being addressed currently in relation to standard facilities and relocations and the ability to charge an accommodation charge or, if they're going to be into a low-care facility, the ability to charge an accommodation bond. Low care usually would have had one.

So that's just an issue that I think does need to be addressed in the structure of transition to extra services. I have already mentioned in the Victorian submission, and I think that can be reiterated here, that the differential between a standard home and an extra service home has been severely reduced by that $12 charge, so I won't go into that again.

MR WOODS: And also by the design standards and building practices of those offering the standard service.

DR LEAPER: Correct - and the fact that certification is requiring so much rebuilding of the capital stock.

MR WOODS: Yes.

DR LEAPER: I would have to say that nationally ANHECA strongly supports the concept of extra services and the freedom which it creates to actually do a lot of the things that you've been talking about this morning, such as improve the occupational health and safety technology, improve the training of the staff, for the residents provide a variety of facilities and services. It was mentioned again yesterday that perhaps suites might be the next thing that the consumer requires, rather than larger rooms. There are already in fact facilities being built with suites rather than a single room. If the costs of that can be translated into a pricing structure which the user is prepared to pay for, it seems to us that's perfectly reasonable. At this stage there doesn't seem to be any problem with access that's being generated by the extra service facilities that have been approved so far or the likely target.

MR WOODS: When you're preparing your final rejoinder you might like to reflect on this question of extra service in a draft which has no status before the commission at this point. Your comments about restricting access to the extra service fees and becoming a very workable niche, you might like to reflect further on that in your final - - -

DR LEAPER: Certainly, yes.

MR WOODS: Others might interpret that as "those who have it, keeping it, so that the many don't spoil it for the few". You also raised the question of ACAT assessments of high care which then translate into RCS5s. Again, is there any empirical evidence on the magnitude of this issue? I mean, it has been raised by many witnesses. What I'm grappling for is some demonstration of the quantum of the issue. I understand the significance of the issue when it occurs. What I don't have a very good feel for at this point is just how often that is - you know, what proportion of resident intakes - - -

MR BOURNE: At this point I couldn't give you anything but the same information that you've got. I've no idea at this stage of the magnitude. Perhaps others would.

MR WOODS: All right. I will continue to pursue it with the industry, but it's important again - the severity, yes, warrants consideration but we need to understand the number of times. I think that concludes the particular questions I wanted to raise in relation to your submissions and I thank you for your substantive submission and the considerable material you have presented with it and I look forward to a final of your rejoinder submission. Thank you very much.

DR LEAPER: Thank you.

MR WOODS: I would like to now call representatives from Aged Care Australia, Mr John Ireland, Mrs Maureen Lyster and Mrs Odette Waanders to the witness stand. Thank you. Could you please give your names and the positions you hold, for the record.

MR IRELAND: John Ireland. I'm the president of Aged Care Australia.

MRS LYSTER: Maureen Lyster, chief executive officer, Aged Care Australia.

MRS WAANDERS: Odette Waanders, policy officer, Aged Care Australia.

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

MR IRELAND: Yes, very briefly, commissioner. Firstly, we too would like to thank you for the opportunity of making this presentation today. We have sought to work constructively with the commission in addressing this important issue of equity in nursing home funding. We were of course very pleased that the government took the initiative, as we had had serious concern for a number of years about the gross inequities which had developed within the funding system especially as it affects our people in Queensland and Western Australia. The government's initial proposal for coalescence was of course unacceptable to us - it was inappropriate - and therefore we strongly support the commission's review.

We would want to place on record, on the public record, our positive reaction to the commission's initiatives in endeavouring to understand in detail our particular industry, or sector, as we call it. Your visits to facilities, your meetings with providers, your preparedness to listen and to seek to understand that detail has sent very positive signals to us, particularly in respect of your independence of government. So that balance of the government taking an initiative and your arm's length approach to the whole process is very positive as far as we're concerned because it does herald the prospect of having an outcome which will bring significant benefit to older Australians, and that's what we're on about.

In our initial submission we sought to clearly and concisely identify issues which were near and dear to our heart, and in the response paper we have sought to in a very professional way with as much objectivity as we could bring to the process, respond to the various proposals that you had made. We felt that we have addressed those in a comprehensive way and we didn't want to go through each of those in detail because you've had the benefit of reviewing them already. There were in fact three issues that I wanted to emphasise again for the public record but there is a fourth one that has developed from listening to previous evidence. The first issue that we would want to emphasise is our support, our strong support, for the proposal that the primary design principle is that there should be sufficient funding to provide a benchmark level of care for all residents and that quality of care should not be, as it is now, the residual balancing item. So we would want to state that very much up-front.

The second comment that we would like to make is to emphasise that we do see merit in moving towards a nationally uniform basic or standard subsidy, as we call it, to provide a standard level of quality care to all residents. But this support is conditional upon the outcome of an objective and transparent study of the costs of providing the same level of quality care to all residents in all jurisdictions. The extent of the movement towards that uniform basic or standard subsidy is, as the commission notes, an empirical issue which should be determined having regard to the average costs of providing the same standard of care in each jurisdiction and the extent of the variation in those costs. As the commission itself notes, the question of uniform and regionally differentiated rates is finely balanced and even a cost disadvantage of a few percentage points may well affect viability, and you're very well aware of our three criteria for success in a whole range of issues is access, quality and viability.

The third issue of course is to again place very publicly on record the need to redress the issues, the subsidy process as they affect in particular Queensland and Western Australia and we have - sorry, Queensland and South Australia. That's the second time I've said that - in South Australia and Queensland. We have identified or sought to identify that source of funding because it is important that the pool of funds not be further compromised. The final thing which has come from the evidence previously is the fact that we have some sympathy with you in trying to understand how facilities of what apparently are similar size and circumstance have different performances and outcomes.

We have sought to very much address that in establishing our national management and strategic planning process. It involves the benchmarking, it involves the strategic planning and particularly it involves the training processes because we too wonder just how it can be - and whilst recognising that management expertise and practices, philosophy of care, the training of staff etcetera, and in fact the location and the nature of the facility itself do have bearings, sometimes even taking all those into regard we're still at a loss to understand what the differences are. We believe that the national project will go a significant way in both identify and more particularly in correcting some of those differences.

We are not naive enough to think that we can be quarantined from a process of productivity improvement. We do believe though in your earlier comments about who should gain from those outcomes, that in addition to management, staff and government that a particular beneficiary should be the residents. In that regard we would look at those productivity improvements being reflected in our capacities to respond to the accreditation processes, etcetera. We have got increasing cost imposts being placed upon us, we do have a situation where clearly 39 per cent of our nursing homes are worse off from a funding point of view in the RCS and so - - -

MR WOODS: Does that mean 61 per cent are either the same or better off?

MR IRELAND: Yes - so that 39 are not. So we do have to look at the sharing of those productivity improvements with the residents in those sorts of forms, but we don't believe that there is any hope at all of being quarantined nor is it appropriate.

We have advanced very much in our sector from the cottage industry concept to a situation where in my personal situation, and it's shared by many, that the more businesslike we are the more charitable we can be. So today we bring a reaffirmation of those important issues. Maureen Lyster is our chief executive who's in touch daily with our grassroots across the nation. Odette Waanders as our policy officer has worked diligently both with our researchers and with individual providers and she has a particular capacity, I think, to help us address the issues that you might want to further pursue and so we look forward to that interaction now.

MR WOODS: Thank you very much and can I place on record the gratitude of the commission to your organisation for the very great substance and consideration of the issues that you have put to us and the material and the objectivity with which you have also described the material that you have put, that you have not only identified its positive features, but you have also willingly conceded where it may have limitations and that is helpful to the commission. Also thanks to your staff for the many hours that have been put into that.

If I can pick up your last point first, just for a change, on the question of differential performance and I noted that on page 9 of your submission and you don't need to turn to it, I will make the reference, you talk about the care needs of residents' facilities. Size, management, philosophy and affordability of nurses appear to be important factors in determining staff mix and hence labour costs and I took it from that then also a financial outcome. I noted then at appendix 2, page 6 that you reinforced that point a little further. So I think it assists the commission in understanding a little more as to why there is this extent of deviation in performance and outcome between homes of apparently similar profile and size. That is useful that you can bring those various factors to bear to my attention. I am grateful for that.

Throughout this inquiry it has suggested that peak organisations in particular might like to explore a little further with the best performing homes just what are the ingredients of that success and to some extent, clearly they can be external factors of whether there are high R and M costs or the rental agreements agreed some time ago and the landlord may impose constraints or whatever. But nonetheless there are ingredients in the total mix of behaviour in a home which demonstrate considerable productivity and very good quality of care, but to the extent that can be distilled and understood and shared with others. I can see great potential and that has not recognised the extent to which that is already done, but I would urge that there be even further the pursuit of that issue.

MR IRELAND: That benchmarking process, the bench ranging when looking at it more particularly, is going to be very helpful, because it will identify, coupled with the planning process, opportunities for individual organisations to distil those issues and to make some further pragmatic but informed decisions about how to address those which fall outside that core issue. So for example if it is a building issue or a relationship regarding landlord or size of organisation or whatever, those sorts of things should become more apparent, but it should also in the process become more

possible to deal with it, because the training processes will empower the organisation to bite the bullet as it were.

MRS LYSTER: Could I add to that?

MR WOODS: Yes, please.

MRS LYSTER: Certainly we see as one of the important elements of that project in that it was an initiative of our peak body and that it is drawing on the experience of the care group and we believe that will have a very significant impact on the efficacy of that project, rather than it being an outcome of something imposed externally. The project had its genesis in a group of high performing organisations in New South Wales and we are ensuring that it does have the appropriate rigour that would be necessary for it to be of real value to the industry. We are hopeful that as it rolls out that this in fact will have a significant impact by and from the sector itself.

MR WOODS: I would strongly endorse that. That concept of ownership of the reforms, because it is the daily behaviour of the management and staff in the homes that will give effect to it.

MR IRELAND: Yes, and the fact that it has been strongly endorsed by government with its funding support is also significant.

MRS LYSTER: We are also keen to build on it in our workings with the private sector peak body organisations as well.

MR WOODS: In devising the design principles for the subsidy, I certainly want to retain to the extent possible incentives for people to chase that productivity and efficiency curve while delivering high quality care. So I will be keeping that in mind. On the question of productivity and I was pleased to note your reference to the fourth and of course the fundamental stakeholder in the process being the residents, perhaps I can clarify my previous comments in terms of distributing some of the financial consequences of productivity dividends, but of course do agree with you that ultimately it is the quality of care that can be improved through enhanced productivity to the residents that is fundamental in this process. I thank you for your elaboration on that point and do concur.

You have referred to the importance of addressing Queensland and South Australia and I note your view that you have identified a source of potential funding - I am not quite sure of status - being the $128 million indexation amount. That is clearly not within the capacity of my terms of reference to address, but the matter of quantum is one that will need to be addressed by government and I will look forward to the 2-year review, as no doubt you do, for addressing that particular aspect. But I do note your views quite clearly on that. The commission shares a similar view in terms of the urgency of needing to address the differentials between subsidy and costed delivery that Queensland and to a lesser extent South Australia and others are incurring at the moment.

MR IRELAND: Another important point though in that submission is that rebalancing the existing pool places at risk we believe the delivery of quality care in the other jurisdictions. So what we are trying to do is two-pronged; one is to say be very careful in seeing that as an option and equally sending a message to government in a public forum that there perhaps are other ways of dealing with that.

MR WOODS: No, I note your views as to the effect on both sides of the spectrum in that area.

MRS WAANDERS: Just in relation to your comments on the review of adequacy in the 2-year review, in our submission we do indicate that potential synergy between the task of actually costing a standard benchmark level of preparing this review of adequacy. Quite clearly it is something that will take time but it needs to be done within a reasonable time-frame and we were looking at that kind of dual exercise - in a sense, one becomes the other - being done within a 12-month period. It would be useful to get some comment from you on whether you see them being possibly done as a single exercise and therefore what kind of time-frame you think is appropriate.

MR WOODS: Certainly I've had discussions with the head of the 2-year review in terms of the direction and nature of this inquiry and he simply briefed me on undertakings of his in how to conduct his inquiry. I can't respond to your particular point at the moment because that's not something I've progressed further but I'll take it on board in that dialogue. The next point you raised was the support for the national uniform, as you put it, standard level of care and I understand the point you're making by using that particular phrasing and it's one that I concur with and am happy to reflect that in the final submission.

It remains a difficult question to be addressed being the corollary of that of how broadly do you draw the boundaries on the special needs supplementation or separate pool of funding. There are very many issues warranting consideration in the industry. The commission to this point has identified in particular the costs facing rural and remote areas, not only in terms of structural issues, of transport costs and the difficulty of drawing on the local pool of labour for relief nursing and having to provide accommodation and transport costs and fares and the like, but also in providing for very many of their residents, as distinct from a lesser number that may occur in the metropolitan area, a whole of life experience and provide that total support for those residents where they don't have the benefit of family or friends in the immediate vicinity and may be drawn from communities some 5 or 7 hundred kilometres away and they may have cultural and social experiences prior to coming into a home that don't sit easily with conforming to life in an aged care facility. They compound those other pressures to quite considerable degrees which I'm not sure are always appreciated by people who haven't been through that experience.

But recognising that as one particular area of need, there are arguments put before the commission that need also occurs where there are small ethnic groups within metropolitan areas that have special needs, that there is a degree of

homelessness and lack of fall-back to family and friends to provide the extra support for many others. Do you have a view on drawing that boundary, because it's a very difficult one to come to grips with? Short of treating every home and every resident according to their individual requirements which has certain attractions except for the enormous administrative and bureaucratic process and the inefficiencies that it would generate. Where are the boundary lines?

MRS WAANDERS: I think that the question has got a twofold aspect - the boundary in terms of how far is rural and how far is remote. I think there is objective data there that can assist in that which the viability supplement is already based on. I think we do need some objectivity in that area, really picking up on quite sophisticated methods of looking at what constitutes remoteness, size of population in terms of the cost implications of access to services and those sorts of things. So I think the boundaries there are actually less problematic. I think it's when you move to the special needs within the metropolitan areas that you will face greater difficulty in identifying equitably what kind of services actually warrant special needs versus others. There are some services that are very good at actually providing culturally appropriate services to a mix of residents and you would not really want to look at disadvantaging or creating incentives for ethno specific services which may not necessarily be needed or appropriate. But on the other hand, you also need to recognise that some such services already exist and that they may face special needs that do need to be accommodated.

So I think in the area of ethnic needs and also in the area of homelessness there are some difficulties that do need to be worked. I think in the area of homelessness you are looking at something more akin to the kind of whole of life experience that you were referring to in the remote areas and that is probably less difficult to deal with. It's in the area of ethno specific needs in a metropolitan or urban environment that we are going to face the greatest difficulty and I believe that that's something we'd need to consider more and consult further on. It is a difficult issue.

MR WOODS: Yes.

MRS LYSTER: And certainly it would require a sound understanding of the current resident profile of mainstream facilities where multiculturalism and the number of old residents, the increasing incidence of dementia, are all having a major impact on the nature of mainstream resident profiles.

MR WOODS: Yes.

MR IRELAND: And in that process I'm perhaps old fashioned enough to question whether or not that falls within the real role of the church and charitable sector and how does that fit into their total ministries as they call them.

MR WOODS: Yes. So I take on board your views and continue to see prioritisation for the rural remote as a particularly distinct group that needs to be dealt with.

MR IRELAND: I think we can get agreement on definitions fairly readily on those.

MR WOODS: Yes, and we understand the databases that relate to the current viability supplement etcetera. I thought I would explore with you whether you saw boundaries as being - - -

MR IRELAND: But governments and charities and communities have dealt with some of those other issues quite effectively in the past and whether or not we need to bring them in as attributes in the funding regime perhaps is worthy of consideration.

MR WOODS: And I've certainly visited homes that have been founded by a particular ethnic group. One I can think of, I think it was 42 beds. Currently they only have eight residents who draw from that ethnic background but in fact they have 17 different ethnic backgrounds in that one facility and it's the most lively and vibrant place to visit and fascinating communication strategies that have been adopted. The commission found very helpful the guiding principles that you put forward in your submission and your note that in the position paper we've included those as part of our thinking process.

MR IRELAND: There are a couple of new issues that we didn't deal with in our paper that have come up as a result of your hearings that we would want the opportunity of talking with you about.

MR WOODS: Please proceed.

MRS WAANDERS: I think yesterday, commissioner, you asked whether certification and accreditation provide an adequate description of the benchmark level.

MR WOODS: Yes.

MRS WAANDERS: It's a very important question and we would believe that they do but that those parameters need to be defined quite clearly. For example, in the context of accreditation, we would see the parameter as being achieving a satisfaction rating on each of the four accreditation standards. If we just look at accreditation initially, in a sense it's very important because you also asked yesterday are there ways of assessing quality of care other than through accreditation and whether or not the continuous improvement aspect of accreditation means that it's not able to be used as an indicator of having achieved a standard benchmark level of care.

Quite clearly we're not able to speak on behalf of ASCA in the way that we normally do at this point but I have undertaken some consultation yesterday on this issue and our preliminary view is that we do believe that the accreditation mechanism is an appropriate mechanism for assessing quality. It provides both a comprehensive and an objective measurement of quality based on performance outcomes and as you know, there are four main standards and 44 outcomes and they each have criteria. So it also has a very clearly demarcated rating system for each standard and for the

overall performance across the standards in order to achieve accreditation or not and if so the period of accreditation.

It also does offer the capacity to have the standards raised, which is important for a benchmarking level of care in terms of the policy design principle and we don't believe that the continuous improvement, as a feature of the accreditation system, means that there will be an uneven playing field in terms of the evaluation of outcomes. In fact, the evaluation of outcomes is based on achievements in terms of the specified standard so there is that objectivity there and it is something that is assessed by independent and appropriately trained quality assessors.

I think it's also to bear in mind that if the government is purchasing a specified standard of quality care which is consistent with accreditation and providing funding on that basis, then it's important that it has the capacity to withdraw funding if the appropriate standard that it's purchasing is not provided. That is the basis of the accreditation system. If you fail to pass accreditation, the funding is withdrawn. So we do believe that the accreditation system does provide that capacity to provide the framework for a standard benchmark level of care. Given its newness and the newness of a lot of the concepts that you're proposing to the industry, it will be important to expand on that and draw it out and indicate the connections and link it in to the accreditation system in terms of the definitions and quite clearly to get consultation and agreement about that.

With regard to certification, I think the issue is somewhat more cloudy in the sense that you talk about providing sufficient funding to enable a standard benchmark level of care which is consistent with accreditation and certification. Certification really links into the issues of how you cost within the standardised input bundle the cost components for accommodation to achieve standards to the level of certification. I think in the position paper and in the discussions to date it's not quite so clear as on the care recurrent funding side how that would be done in terms of the standardised input bundle. There is, I guess, in the position paper, not quite so much discussion about the capital funding elements as would need to occur in order to provide that framework link with certification.

You will recall that in our submission ACA strongly recommends that there be some differentiation between funding for recurrent care and capital funding and we see that it would be very difficult to actually cost the standardised input bundle without some transparency in that regard. We have also highlighted the benefits of having that transparency in terms of opening up people's views of understanding residential care as being the provision of housing and the provision of care in a linked way but with quite clearly different components. That distinction is important both in terms of the funding mechanisms that are used but also in terms of in the future being able to make choices and compare cost effectiveness, so to speak, between the different modalities of care provision, whether it's through residential care or community care.

If you were to bundle in the capital costs into the recurrent funding you actually lose the transparency there that's going to be important in making those choices and decisions both at an individual and a government level later on.

MR IRELAND: That has presented significant difficulty in the past and continues to do so regarding contributions by residents or clients, the use of concessional resident supplements etcetera. That lack of transparency and that merging of the issues at times when it suits and at times when it doesn't, excluding them, creates a real difficulty for us.

MR WOODS: I'm heartened by the confidence you place in the accreditation process, that it will have an even playing field in terms of those who are accredited; that the question of continuous improvement is over and above a common minimum base that will apply to all facilities and your confidence in that is useful input to the commission's thinking. In terms of the disaggregation of care and accommodation, it's something that has been addressed by others and I note the department in Victoria has also given some considerable thought to that. Do I take it though, from the way you expressed it at that point, that you identify accommodation only in its capital component and that care is all of service delivery, in which case that's a different perspective to that split than others in the industry might perceive or was that just a shorthand expression of issues?

MRS WAANDERS: In a sense it was a shorthand expression. I think that it's important to identify the housing or the capital component for the capital funding issues. I think if you have a transparency in terms of the standardised input bundle for care which will also include the hotel components, the food, linen etcetera - the things that people living in their own homes would not necessarily or in some cases they would expect to be provided - then you've already got through that transparency the ability to itemise out the other elements. I think the area that I was seeing the greatest cloudiness in the proposals was in relation to the housing in terms of capital component and I felt more confident in the proposals that you were outlining have the degree of transparency that is desirable in the other hotel component, so to speak, but certainly you do need the ability to have transparency in all three areas.

MR WOODS: Yes. In fact, I was going to pursue that we are talking about three divisions in the particular framework you offer, not two. You talk about the facilities which involve not only the fabric of the building but the plant and equipment and furniture and fittings in those. Then we're talking about the hotel services, the laundry and the food supply etcetera. Then we're talking about the nursing and care and we do recognise all three and will ensure that they're all properly addressed. If I can pursue that boundary between the delivery of the hotel services and the delivery of care, I can see some merits in differentiating the items so that in linking the residential aged care sector to broader aged care you could be at a stage of the resident - sorry, of an elderly person requiring care and then having some freedom of choice as to whether that's expressed through residential care or through delivery of service at home or even for carers who may be family and friends and things getting some recognition and recompense for the fact that they are delivering that care.

So those relationships are important but it relates particularly to the care end in some respects for the delivery of professional care. Is it possible or is it even necessary to then draw boundaries between nursing and personal care in that sense and the delivery of hotel services because I can see that the delivery of food, for instance, not only requires the kitchenhand to purchase and prepare but that it has to be prepared having regard to the nutritional needs of the resident. It has to have regard to their capacity to cut and consume and then it has to be delivered in a way that can be consumed - and whether that's by the resident themselves or with assistance, or with direct feeding and the like. So the boundary is very blurred but is it necessarily to pursue that boundary?

MRS WAANDERS: I think there are problems if you try and knock at too many boundaries because you do get models of care provision within the sector where you have a carer and what's like a sub-unit of five or six residents who does everything for the people: cooks, provides the care. It's like a housekeeper, so to speak, but more than that. I think there are difficulties. If you're going to try and place too many boundaries around things then you actually restrict flexibility and the opportunities to innovate, to be responsive to the needs of residents. I think it's enough really to know in a sense broadly, a bit like the CAM-SAM demarcation. I don't think you need to follow it to the ends of the earth or to the kind of detail that other people may want. It's good enough to know approximately what balance of funding is in there for the kinds of comparisons that need to be made in relation to community care.

MR WOODS: I'm heartened by that perspective because my concern with devising subsidies that try and pursue those to their end point can lead to a significant reduction in flexibility and to behaviours to ensure full expenditure etcetera that aren't necessarily in the best interests of the resident, which is our ultimate concern.

MR IRELAND: We believe if you look at that concept of the expert panel of stakeholders or making recommendations regarding that standard level of care it will pick up a lot of those issues. It's important that the care delivered by nursing staff and those supporting them is recognised and identified as are the other components.

MR WOODS: Yes.

MR IRELAND: There was that one other issue.

MRS WAANDERS: We have a couple of other issues. I'm not sure that the commission has yet received advice from the ABS regarding the productivity index for nursing homes.

MR WOODS: That has been followed up by our staff but I've also read the views that you've shown and I've been briefed on subsequent discussions that you've had on that matter.

MRS WAANDERS: So quite clearly we would be expecting not for you to say now but some revision to your recommendations in relation to indexation.

MR WOODS: Yes.

MRS WAANDERS: I think though it might be quite useful just to explore with you, you indicate an annual repricing of the standardised input bundle. I wondered what you meant by "annual repricing" and whether you see that as using specific indexation measures or actually doing a repricing exercise?

MR WOODS: I would envisage that the repricing would be more periodic - and whether it's 3 years or something of that nature and clearly would be called on earlier if there was some significant event or change that was occurring in the industry that needed to be taken into account. You know, if there were a new form of continence aid that was proven to be markedly successful and was being widely adopted but it had pricing consequences then that for instance might warrant some adjustment more early than the next review.

MR IRELAND: That would fit with us.

MR WOODS: Yes, it would have to be flexible to that extent but not a never ending and uncertain process. Again there is the balance between proprietors having some ability to predict with some certainty into the future what their income stream will be versus the capacity to cope with significant events that may occur. So if you're happy with that, that will balance.

MRS WAANDERS: Also, commissioner, since making our submission we've become aware of differing interpretations of what you meant in proposing that the regulation of extra services should be reduced. So I thought it would be helpful if you could perhaps elaborate on your intentions there.

MR WOODS: Thank you, which brings me to page 3 of your supplementary submission where you talk in part:

> In our view it is not appropriate that we should constrain opportunities for consumers to make choices provided we ensure that there is universal access to a standard benchmark level of care consistent with accreditation and certification irrespective of capacity to pay.

So I found that phraseology quite helpful and will reflect on that in preparing the final report. The thinking that has gone on to date in terms of extra services is to acknowledge that where residents are in the circumstance where they would wish, particularly in terms of the hotel services and accommodation, to have over and above that standard benchmark level of care that it seems inappropriate to constrain their choice to be able to access that. Clearly the nursing and personal care end, it is appropriate that all residents receive that level of care at the best available in the

circumstance but where they wish to have particular levels of service over and above in those two other areas I don't see that constraint of choice serves any purpose.

The question then though is that trends within industry such as the more extensive building of single wards and dedicated en suites etcetera may in fact be constraining opportunities for extra service to differentiate itself in the marketplace. I have noted evidence by some that provision of single wards should in itself constitute being able to charge extra service. My view on that is that in the marketplace if there are many providers providing that level of facility at the standard level of care then that will generate some market resistance to those who may offer that same level of care but at an extra service price. So I'm confident that the market will sort that out and don't see the need to intervene at that end.

What I do see is that there is a need to ensure that extra service is in fact being given for an extra service fee and particularly if it brings with it an accommodation bond, although I've heard previous evidence that in some jurisdictions the bond doesn't also follow necessarily with extra service. So provided there is that differentiation and it is significant then I'm open to the market adjusting as need be. Does that clarify that point?

MRS WAANDERS: Thank you, that's helpful. This is just a minor comment in relation to a comment that you made earlier this morning where you were referring to the possible development of a national pool of labour specifically at the RN level.

MR WOODS: Yes.

MRS WAANDERS: This is not researched here but I have some hesitations about the expectation there because if you look at our workforce they're predominantly women, the RNs, they tend to be in the older age group and have family responsibilities. So one would assume that there would be a fairly high degree of limited mobility. So that just needs to be kept in mind in considering the scope for addressing the problems and parity through the national pool of labour.

MR WOODS: I understand that. I understand also though to generate a national pool of labour doesn't require wholesale shifting but only shifting at a margin, that if you have an outflow of 5 per cent of nurses from one jurisdiction to another in response to differential wages and conditions then that in itself is enough to cause some readjustment in pricing between the markets, that you don't need the ability of the whole market to move from one jurisdiction to another but you do need some marginal mobility. If there is no mobility at all then clearly the markets won't be competing, which is why at this stage it would appear that the personal care end of the labour force reflects very local, sub-jurisdictional conditions more so than professional nursing, particularly at the RN level where there is some mobility which is enough to create some competitive pressure and possibly a national market. Do you have any further elaboration on that point?

MRS WAANDERS: No, that's helpful. Thank you.

MR WOODS: On a slightly different component of that same point, in your substantive submission you talk about how the price of qualified nursing staff is determined by the public health sector which employs around 85 per cent of qualified nurses. But then you immediately follow on to say, "There are very significant wage disparities between the public and non-public sectors." The two sentences seem inconsistent, particularly side by side.

MRS WAANDERS: That use of the word "determined" was not well advised. It would have been better to have said that the public sector is the price setter or the price leader. So quite clearly it sets price trends but it doesn't actually determine actual wages in our sector.

MR WOODS: So by setting the trend it also therefore sets the flow of labour from one sector to another but you can - albeit suffering the consequences of it - have different prices, different wage rates, between the two sectors.

MR IRELAND: And we do.

MR WOODS: Yes.

MR IRELAND: And there are significant consequences.

MR WOODS: Yes. It was just the juxtaposition of those two sentences I wished to clarify. Appendix 1, page 6, you discuss - and we have had evidence from other witnesses about for instance Victoria having the highest proportion of the most dependent residents. Previous witnesses have drawn on that and have based some claims for consideration of Victoria's financial circumstances as being partly related to the level of acuity. You go on, however, to say that:

> The reasons for this are not clear and that there is concern that this may be partly due to differing validation practices in relation to the classification instrument.

To the extent that may be a reasonable conclusion affects the degree of support underpinning claims that that be a relevant factor to take into account in assessing for instance the level of funding required by Victoria for the provision of aged care subsidy.

MRS WAANDERS: Yes. I mean, we were perplexed by the difference and we don't believe it's just a single-factor difference, it's due to a range of factors, and we have pointed out the range of factors in addition to the question of the validation issue that could contribute to that. We were really looking at it at a much more macro level than the one that you've just identified which is that it's very interesting that there appear to be quite significant state differences in the levels of dependency and nursing homes. What are the factors contributing to that? They really ought to be researched and better understood because they have implications for the way in which we plan

and provide care. So it was much more at that level than essentially saying there are significant question marks about the current funding levels for Victoria.

At the end of the day pursuing that issue in this context in my view is not particularly helpful given that I think we're moving to a position where we're looking at providing sufficient funding to provide the same standard benchmark level of care, and as we said, that's an empirical issue that needs to be pursued and for the costs to be done on that basis.

MR WOODS: Thank you. I understand your point, but I did want to just explore that. So it would be reasonable to say that you have identified - not identified; that has been done before, but you've acknowledged that there are differences and you have put before the commission a number of factors which may contribute to those differences.

MRS WAANDERS: Yes.

MR IRELAND: But they'll become less relevant if we take the line that the commission seems to be indicating.

MR WOODS: Thank you. I think that largely concludes the specific questions arising. Let me just check. I notice you put great emphasis on the question of transparency which is something that the commission itself considers an important feature of any future subsidy. You have identified a number of steps that could be taken to developing the benchmark level of care, and that goes through a process that was quite helpful to understand, and I will reflect on in the final report.

MRS WAANDERS: Partly in outlining that was trying to check with you the degree of congruence in our understanding of that. I think that's a very preliminary view of probably what we're going to end up having to do because we're also coming to terms with the implications of the new concepts and approach that has been proposed.

MR WOODS: But it's also a useful framework to build upon.

MRS WAANDERS: Yes.

MR WOODS: You raised an important issue that it's not necessary to identify a particular facility size that has some characteristics of efficiency, but that in developing the standardised input bundle, you can have a representative sample of facilities. I think that's - - -

MRS WAANDERS: Yes, although we do also say that for the purposes of future planning and allocations, the question of efficiency size is very important, and that it's desirable that the goalpost doesn't keep moving to some extent.

MR WOODS: I agree with that, but I would also not wish the subsidy in its then subsequent translation to be in the marketplace to enforce a particular facility size. I think with the broad sweep of time we've all seen situations where the four-bed ward which was the state of the art, and we now have many facilities that are looking at very expensive adjustments, etcetera; that to be prescriptive in 1998 can lead to difficulties in 2008.

MRS WAANDERS: So you are sympathetic to the use of the average rather than - - -

MR IRELAND: Or even a range.

MR WOODS: I can see some benefits in having a representative range of facility sizes rather than picking one in particular.

MR IRELAND: We think that would bring a better outcome.

MR WOODS: So that's helpful. You take a view on workers compensation costs that you don't support the inclusion of workers comp in the basic subsidy rates. You do that on the grounds of the significant variations in costs among jurisdictions and also I take it you would also argue it on the grounds of that there can be variations for particular homes due to circumstances outside their control. I am concerned however to ensure that the subsidy design provides appropriate incentive and reward so that those who do put in good occ health and safety practice - and I don't mean in terms of what the manual in the DON's office says, but in terms of working cooperatively with staff to ensure that that's the collective view and encouragement throughout the facility. Do you not see that that is also relevant in designing the subsidy?

MRS WAANDERS: Yes, and I think you've talked often about the extent of discretion that providers have in relation to this area, and you could see it as a continuum from none to complete discretion, and of course in workers compensation issues in occupational health and safety, it's somewhere in the middle which is why we've proposed a cost reimbursement system that does balance that, and I think we also need to recognise that while it's important to promote in centres within the policy design framework, there are also other measures within the system that will also promote appropriate occupational health and safety practice and the accreditation process, and the standard specifically provides standards in relation to occupational health and safety. So it doesn't need to do the whole job if you know what I mean.

MR WOODS: Thank you, but you would still be arguing for a jurisdictionally-based subsidy.

MR IRELAND: I think the fact that we have so much difficulty with those issues outside our control as regards the state's management of its affairs present a difficulty for us. The situation will be further addressed by our New South Wales association when they talk with you next week, and hopefully we'll be able - - -

MR WOODS: In Tamworth.

MR IRELAND: Sorry?

MR WOODS: In Tamworth.

MR IRELAND: In Tamworth - we hopefully will have a much fuller presentation in that regard.

MR WOODS: That would be helpful.

MRS WAANDERS: The other thing, too, there is that we have been hampered by the lack of recent data on state average costs and workers compensation. The most recently available to us is 94-95, and I guess that does raise the issue of access to information from the department, and there is an empirical issue there. I mean, if we were to know what those rates were, we would have a better sense of how the average rates actually compare rather than just the flat rates.

So in the absence of that data of course, we're not in a position to know to what extent there is variation between the jurisdictions in relation to those averages and how strong the variation is.

MR WOODS: I will be pursuing that with the department and they'll be providing their normal speedy response to these matters.

MRS WAANDERS: I think they have some impediments to provide any information which are beyond their control.

MR IRELAND: On page 12 of our submission, we'd strongly recommend that there might be a national review of that particular industry as well.

MR WOODS: Yes, I noted that, and that you slotted the commission in for - - -

MRS LYSTER: Certain constitutional matters.

MR WOODS: In that respect, we did a 1995 report on work health and safety, and one of the particular conclusions we came to was to make occ health and safety agencies more accountable for their performance, but anyway I draw your attention to our report on that matter, but maybe there is a broader term of reference that you have in mind. Presumably on superannuation though you wouldn't extend the same view; that because it is nationally-based and - - -

MR IRELAND: It can be in the bundle.

MR WOODS: It could be in the bundle. Thank you. On the question of government homes, I note your point there, and we are pursuing the question of the

transition as it affects those homes which are now in the church and charitable or the private for-profit sector and what impact it would have on their financial circumstances, and particularly positive impacts as a consequence of that.

MR IRELAND: The concept of your proposal is fine; it's just the practice of it.

MR WOODS: Yes, the translation and the transitional arrangements. I think I have noted previously your several references to the 128,000,000 lost due to under-indexation of costs. Your phrasing of standard care rather than basic care has merit in more accurately describing the intent behind the arrangements, and that concludes the particular matters that arose, although I think we have canvassed many of those in some detail, both in the very lengthy and helpful submissions you have made, and in our whole evidence today. Any concluding comments you wish to make?

MR IRELAND: No, other than to again thank you for this opportunity and to indicate that we remain available to continue the dialogue and the various inputs that might be sought between now and when the final report is presented.

MR WOODS: Thank you very much for your evidence.

MR IRELAND: Thank you.

MR WOODS: I'd like to call witnesses for Aged Care Victoria; Mr Peter Mackinnon and Mr Michael Donohue. If you could all state your names and positions for the record, please.

MS DEWAN: Claire Dewan from service industry advisory group. I'm the industrial relations adviser for Aged Care Victoria.

MR MACKINNON: Peter Mackinnon. I'm from Wallace Mackinnon and Associates. I'm a consultant and adviser to Aged Care Victoria.

MR DONOHUE: Michael Donohue, an aged care consultant and adviser to Aged Care Victoria.

MR PAVONE: Mario Joseph Pavone, and I am the president of Aged Care Victoria, commonly known as Joe.

MR WOODS: Thank you very much. Mr Donohue, we've had the benefit of your expert witness previously in this hearing. Thank you for the submissions that you have made to us. I note in a number of respects that you have observed, contributed to and supported the submission by Aged Care Australia, and I thank you for being brief in relation to those particular matters, and that you have then drawn specific further matters that relate particularly to Victoria to our attention. Do you have an opening statement you wish to make?

MR MACKINNON: Just a very short statement, Mr Commissioner; just that we support the review that the commission is undertaking and that the coalescence has been of great concern to our industry since it was first mentioned when the new funding program was first mentioned. We'd also like to, as you have already mentioned, say that our submission is complementary to Aged Care Australia's submission and that we would only be covering state-based issues.

We also support Aged Care Australia's submission that there should be additional funding provided to Queensland and South Australia, but we would note that this additional funding, whilst we support where Aged Care Australia is suggesting where it comes from, that it is not at the expense of the other states.

MR WOODS: I understand your perspective on that matter.

MR MACKINNON: Thank you very much.

MR WOODS: Perhaps then we can do several things. One is that there are particular matters arising from your submission that I would like to discuss first up, but then if there are matters of the broader issue where you support the submission by Aged Care Australia but that you would like to debate and explore - whether they be workers comp or whether they be productivity in the industry or the like - then I would welcome you coming forward on those matters as well. So I would like to

both address Victoria specifically, but to the extent you wish to contribute to the broader national debate, I would also welcome your contribution there.

MR MACKINNON: That's fine. Thank you.

MR WOODS: There is a reference on page 3 of your supplementary submission that you say:

> Therefore it is considered that the variation in labour rates could be significantly different at different times following the negotiation of award variations.

That's a point that I not only acknowledge, but need to take into account in coming to a view on national versus jurisdictionally-based subsidy arrangements, that if there are variations between jurisdictions, as you also agree here, that can lead to a dynamic in the industry, such that the hierarchy of states and territories, according to wage outcomes at any one point in time, won't necessarily reflect what happens 2 or 3 years hence. From your point of view does that reinforce the argument for a jurisdictionally-based subsidy or can it be seen as a factor that lends some support to the idea of a national subsidy, not only to understand those dynamics but also to act as a constraining influence to outcomes in any one jurisdiction over and above others within the national context?

MR MACKINNON: As it has probably been pointed out to you on a number of occasions, there's a possibility of both a national component with allowances for variations and I know that previous representatives, Aged Care Australia, noted that workers compensation would be one of those factors. I think the salaries and wages is a significant factor in relation to the cost of operating a residential aged care facility or nursing home and as such at the present moment, and based on that the states have different awards and has been stated before is often driven by the wage rates paid in the acute area, that it will have a significant variation from time to time. It was noted in your report or through Aged Care Australia's submission that going back under the previous indexation methodology that there was a 22 per cent variation in the subsidy rates. This was based on - that the CAM component was actually indexed by the movement in the award rates of pay.

Subsequent, since July 96 with the introduction of the COPO indexation methodology, some states have had significant wage variations where other states haven't. At the present moment - which Clare could probably reinforce better than I could - there's a substantial claim on the table and there is a significant variation between the wage rates in the acute sector in Victoria, compared to the aged care sector. So I would believe that, yes, there would need to be a different subsidy or a component or a supplement to allow for the state differences that would vary from time to time and in my opinion are significant. The 4 to 6 per cent in this industry at the present moment is quite a significant variation between viability and not being viable.

MR WOODS: Yes, although I'm not sure you were present for previous debate on this, but if you have a national average, then the variation either side of that is 2 to 3 per cent, not the 4 to 6 per cent total variation.

MR MACKINNON: Yes, but even that can be quite significant in what you would talk about as a reasonable-sized facility, and we have in Victoria quite a number of very small facilities, and that would have an impact on their viability.

MR WOODS: Yes. I understand the particular situation for Victoria in terms of facility size. I also note that there are homes that have such variations in financial outcome anyway within the ongoing dynamics of the industry. If I can turn to you in a moment on that point, but there is also a question - I can understand isolating the payroll component of the subsidy because of the jurisdictional variations and non-discretionary nature, and certainly we have had considerable evidence about isolating also the workers comp component in some form whether it be a state average with some capping or whatever.

Once you isolate the wages, you've taken 75 per cent out of the subsidy, and there's not a lot then left to constitute the ongoings that I need to weigh up, recognising the individual differences between jurisdictions for that component, and if that was done, that would destroy any purpose behind a national rate other than to go back to say the old SAM-type elements - - -

MR MACKINNON: CAM-SAM arrangements.

MR WOODS: - - - in which case once you got SAM-CAM-OCRE, you're back to being reasonably prescriptive of inputs and behaviours in terms of spending in each bucket and not necessarily having the motivation or flexibility to achieve the best outcome for residents in any one year.

MR MACKINNON: We're not advocating a return to the CAM-SAM-OCRE component, but we would advocate that there has to be some recognition of the variations in those issues or state-based issues that are beyond our control.

MR WOODS: Thank you.

MR PAVONE: It also means that that's why we're very sensitive to any coalescence reduction because if you have got these increases in the pipeline, then you are going to significantly have extra costs which have got no revenue coverage. So the problem with the claims in the pipeline is it's always a cyclical thing that each state is going to have.

MR WOODS: Perhaps if we can explore what claims are in the pipeline at the moment then.

MS DEWAN: In Victoria, the claim in the pipeline for the nursing staff is 10 per cent, and that was the matter that Ms Ligeti touched on yesterday that's going

to be subject to the Industrial Relations Commission dealing with that claim. The history of that is that the union has tried to enter into enterprise agreements with aged care facilities - particularly nursing homes - in Victoria over the last 2 years or so, and to my knowledge there hasn't been one registered agreement at this point. What I was going to do is to just briefly clarify the situation in Victoria as I se it.

MR WOODS: Thank you. That would be helpful.

MS DEWAN: The first thing I would like to clarify is the wage rates that apply or the classification structure that applies in nursing homes in Victoria. Yesterday Ms Ligeti mentioned that personal care workers get - I think it was $14.50 or some such figure, and that in fact was higher than an SEN or division 2 nurse rate which is not - that's not accurate. In nursing homes - say 30-bed, 60-bed models generally have a director of nursing, you have a division 1 nurse grade 4, then you have grade 2 nurses, then you have division 2 nurses, the majority of which are on pay point 3. Then you have what we call nursing assistants. Personal care workers are not employed in nursing homes; they are employed in hostels and they're a different wage rate again.

The wage rate per hour for a nursing assistant is $11.43 after their third year of experience, and a pay point 3 division 2 nurse is $13.0566 per hour, and therefore there is a differential of 1.626. So they're not the same rate of pay. I just wanted to clarify that situation.

MR WOODS: Thank you.

MS DEWAN: I've been working in the aged care field in industrial relations now for over 12 years, and my perspective of the industrial relations situation from I suppose the grassroots level if you like is that since the demise of CAM-SAM, the situation has been fairly stagnant. The staff in nursing homes have only received safety net increases while their colleagues in private hospital and public sector organisations - and this includes the nurses in public sector aged care facilities - have received pay increases by enterprise bargaining to the point where there is now an approximate 15 per cent differential which the union did raise yesterday.

The increases in these rates, most of those have been funded by the state government, although not fully funded. In our view the policies of both the previous Labor government and the current government are not conducive to either the nature of aged care services or to the funded nature of these services. The thrust has been and will continue to be very strong by the government towards enterprise bargaining with the idea that pay increases will be paid for by productivity gains. These policies are particularly directed towards the manufacturing, mining, shipping-type productivity-driven industries.

Put simply, in our view the vast majority of nursing homes are unable to attract funding beyond that provided for by the federal government and are consequently unable to generate money by productivity increases if they are to continue to provide

quality care and to meet accreditation requirements. Accordingly to my knowledge to date, there has been no certified agreement registered by an aged care provider regarding wage rates in Victoria. Therefore the vast majority of staff have simply been paid the safety net available under the safety net policy.

Even if it is possible that financial performance can be improved in our homes, it appears that it will be many years before organisations will be in a position to offer an acceptable wage increase. As employees in Victoria are covered by a state-based federal award - and by that I mean our award is a federal award but it only applies to Victoria, and this is not just the Nurses Award; it's the support staff as well - their conditions are governed by industrial relations policies and legislation of the federal government. Consequently, Victoria will continue to have different conditions applying than those of other states.

MR WOODS: Sorry, can I just clarify there. You said dictated by the policies of the federal government. Isn't it the Federal Court that has the jurisdiction on the award?

MS DEWAN: The Industrial Relations Commission?

MR WOODS: Yes, but the federal award is still a matter between the employers and employees, and it's the Federal Court that has jurisdiction. I don't understand the link back to the federal government.

MS DEWAN: Well, the federal government has policies directed to industrial relations issues, and they are intending to put forward legislation to alter the role of awards. They have policies that dictate that - - -

MR WOODS: Yes, and I understand that, but I'm just trying to relate that back to your particular award which relates only to Victoria even though it is a federal award. I don't understand the link between it being a federal award and federal government policy if you can elaborate.

MS DEWAN: Because it's a federal award, it will be affected by the policies of the government when they are translated into legislation, and the Australian Industrial Relations Commission has to put into place that legislation. That involves basically reducing awards to currently 20 available matters, and perhaps even further down the track if they get their legislation through.

MR WOODS: I'm familiar with their program.

MS DEWAN: So in our view consequently Victoria will continue to have different conditions applying to those in other states. These conditions currently include a nurse to resident ratio. No other state has such a ratio, and its existence has contributed to the high number of division 1 nurses employed in nursing homes. I accept that there is a shortage of division 2 nurses in nursing homes, and I accept that many homes are therefore unable to meet the nurse to resident ratio. However I don't

accept the premise that there is a lack of division 1 nurses in numbers in nursing homes.

I believe most nursing homes or all the nursing homes that I am aware of do have sufficient division 1 nurses. They may not have sufficient division 2 nurses. The nurse to resident ratio has also contributed significantly to the high level of part-time division 1 nurses, many of whom work in two or more facilities with employers having to employ division 1 nurses in such numbers in order not to contravene the award. Without the ability to offer better wages, particularly to charge nurses, it is difficult to attract full-time staff, or to change the culture of the industry to more staff working more hours rather than less - less staff working more hours rather than the other way round. Whilst the current funding is in place the vast majority of nursing home organisations have little room to move with wages, and with the contraction of funding in what was SAM, organisations have already made as much savings as possible in non-nursing services.

Even if the staff continue to receive only the safety nets as they occur from time to time, pressure will continue on the wage budget for reasons that others could elaborate on. There is obviously a difficulty in the fact that the government's industrial relations policies are not consistent with the funding policies which apply to nursing homes. There is simply no way sufficient extra money can be found to afford staff an increase in pay by enterprise bargaining, the percentage which would have to be approximately 10 per cent of a budget if it was to be acceptable to the unions. The problem has become clear over the previous 12 months where many members of Aged Care have been involved in workshops, and if you like, brainstorming sessions in relation to attempting to identify possible areas of tradeoffs, for want of a better word, to allow for wage increases. This exercise has been unsuccessful and therefore we're left in a position where the matter will be dealt with somehow by the Industrial Relations Commission. That's all I have to say.

MR WOODS: Thank you. That's helpful. You made some fairly absolute statements in relation to scope for productivity improvement in homes and yet from my observation there are differences in productivity between homes of roughly similar size in the one jurisdiction. Isn't there some incongruity between those two positions?

MS DEWAN: It appears to me that from my experience with trying to get organisations to come to grips with the claim by the ANF for a 10 per cent wage increase, and the fact that the majority of them are extremely concerned about a traction retention of staff given the differential in wage increases, and even though we have spent a lot of time and effort on trying to identify ways and means by which sufficient moneys could be obtained to pay a relevant pay increase which we believe would be around 10 per cent, nobody has been able to come up with anything like that.

MR WOODS: I understand your evidence that you haven't been able to find the 10 per cent but it doesn't mean that you're at zero per cent either presumably.

MS DEWAN: The most that anyone was able to offer the ANF was, I think, 2 per cent. That's only by memory and that was only one facility and that was obviously not acceptable to the union. That 1 per cent was found by changing staff hours and making changes to staffing gradings, to find the money.

MR WOODS: And yet the variation in productivity and financial outcome between various homes is greater than that 1 or 2 per cent in some instances, you know, some homes achieve considerable surpluses and some homes operate in deficit, so there is across the industry variation greater than that.

MR PAVONE: We would have to prove that that related to labour costs. I mean, it could well be that there are deficiencies in other areas.

MR WOODS: Look, I fully recognise that it can relate to the leasehold agreements, that it can relate to the state or repairs of the facility; it can relate to a whole range of factors, but given that wage costs are 75 per cent to 80 per cent of running costs, they do constitute a fair - - -

MR MACKINNON: In a small size facility the staffing levels would not be a significant barrier between those that are making surpluses and those that are running at losses.

MR WOODS: Yes, your small size facilities have particular structural difficulties in that respect.

MR PAVONE: This is not a new pressure. I mean, the industry has been pressured for 10 years or more to in fact find productivity improvements and they have been doing those. So the issue is, can you continue to find them, particularly if you're going to have an industrial situation which says the current conditions are the starting point for any changes. You know, you can't go retrospectively changing some of the historical arrangements within our industry. It was unlikely to succeed.

MR WOODS: Yes.

MR MACKINNON: Over a period of time we have had to pick up various added imposts or costs re the productivity gains; that the funding basket which the current funding is based on goes back to 86, 87, and hasn't even been added to other than through indexation for additional costs that we have had, such as occupational health and safety, infection control, incontinence management, those issues, and we now have another additional cost that there has been no increase for the funding and we have to find somewhere and that refers to the accreditation and the certification process.

MR WOODS: If it's any comfort you're not the first witness - - -

MR MACKINNON: I realise that.

MR WOODS: - - - to present evidence on the impost of the accreditation process on homes.

MR MACKINNON: We wish we could find out how much it's going to cost.

MR WOODS: I'm sure there can be some discussion and some development. Can I go back to a broader question then, stepping one back from that. I notice what you say here in terms of the design principles but for the record in our current discussion do you see that the proposal to identify a standardised bundle of inputs and to index that according to the underlying movements in those costs will ameliorate some of the problems that you're currently facing?

MR MACKINNON: So long as it's done with industry input and there's concurrence across the board; that, yes, I would believe they would address that and that the indexation methodology that is adopted, that is appropriate, and that the basket that is used is considered appropriate too. I think that needs to be sort of quantified.

MR WOODS: Yes, I understand those caveats and I would fully make them myself; that it has to be an appropriate basket of goods which reflect the full range of costs experienced by the industry.

MR PAVONE: That may well pick up the future situation but Victoria's concern is this question of what's in the pipeline. If we could get a starting point that we agreed upon then that would be more acceptable.

MR WOODS: Yes. To some extent that delves into the issue of quantum and you have read the commission's views on our interpretation of our terms of reference which I think are fairly clear on that. Nonetheless you have put it on the record as to your concerns in that field. You have suggested, and I found it helpful, in a couple of areas to reword the preliminary proposals, and thank you for the thought that you have given to those. If I can look at preliminary proposal 2, you have in effect suggested an elaboration. If I can just explore those. The two elaborations include administrative support as a separate component to level of care.

There has been other evidence put to the commission that you can think of; the delivery of residential aged care in terms of nursing and personal care, hotel service-type services, and accommodation. Here you have split it a different way, differentiating between level of care and administrative support. Is there anything underlying that particular perspective?

MR MACKINNON: I think that with the requirements of accreditation and certification that there has been an added impost of administrative time and requirements that need to be reflected somewhere along the line, you know, that the requirements now are administrative requirements we have to comply with are a lot more substantive than what they have been in the past and I think that's an issue that needs to be addressed.

MR WOODS: Yes. It's a question of whether we need to elaborate all the various subsets within that overarching proposal which is more a statement of principle than of subsidy design. I will reflect on the need. I notice that you then include the specifics of the cost of accreditation audit, and whereas I note your point I really wouldn't want that principle to get lost in a very lengthy list of costs which at the principal level I would argue should all be included in there. So I would prefer not to turn that into a potentially page long list of all sorts of costs of which that is one obviously exercising your mind, but is one of a number of costs.

MR PAVONE: If I can raise the timing issue again. Sometimes between the jurisdictions you do get timing issues as to when states undertake different regulatory regimes such as the Food Act changes in Victoria, where our people are gearing up quite strongly, and it has been a big process of getting all of our proprietors, all our providers, up to date on what they have got to do under the new Food Act. Other states will perhaps follow that later on. So you do get some timing issues as well.

MR WOODS: Yes, thank you. That's helpful. We have raised this question of state impositions on the industry and understand those, whether it be Poisons Acts or Food Acts or others, Building Codes - they're a multiplicity that you're very familiar with.

MR MACKINNON: Yes.

MR WOODS: You also on several occasions, not just in this one, keep drawing in hostels as well as homes. In terms of my terms of reference which are to - we have interpreted nursing homes as meaning high care, and to that extent it brings in hostels where there is ageing in place, but it certainly hasn't been an exploration of the issues affecting the hostel sector in total. So I understand your point but I'm a bit reluctant in the face of not having investigated and fully considered the hostel sector to extend that principle.

MR MACKINNON: It could be difficult in determining, say, a basic subsidy rate which would include an additional cost for accreditation and certification which would reflect in some hostels that have high care residents, and it could also be negative in nursing homes that have some low care residents. I think we noted before - - -

MR WOODS: The ACAT is admitted for high care, yes.

MR MACKINNON: That's right, so there are probably issues there that - - -

MR WOODS: I'm happy to deal with it in the sense of it dealing with high care residents but I'm just a little concerned about making automatic assumptions on matters that I haven't investigated sufficiently thoroughly. So I think it's within the bounds of the commission to be able to encourage the government to think across the boundaries but I don't want to pretend an expertise in an area that - - -

MR MACKINNON: We would hope that you would suggest to the government to look across the boundaries.

MR WOODS: Yes, thank you. I think that picks up - for area proposal 3, particularly for the second sentence, you have suggested an amendment but it's perhaps slightly along the lines of amendments that oppositions sometimes put into parliament where they delete all words beyond, "I propose", and put in a totally different motion. I'm not suggesting you have gone quite that far but in looking at it you have restructured the perspective to go from rural and remote to go to smaller facilities. Before allowing you the opportunity to respond, if I can make a preliminary comment that we're cognisant of the particular needs facing rural and remote which are structural in nature, not only of the type in relation to distance and transport costs and limited labour pools and the like, but in terms of the nature of care that needs to be delivered in those circumstances, and there is no foreseeable future in which those requirements will change.

Now, I am separately aware of the efficiencies or lack of and constraints in terms of efficient nursing rosters and the like facing small homes but I'm also aware of the degree of rationalisation that has occurred in the industry to date, in particularly Victoria and I've seen the figures on the number of small homes that have been closed and amalgamated or the bed licences sold out to other parties and the like, so I can appreciate the issues facing them, but I can also appreciate that there is a dynamic in the industry which serves over time to address those where they occur in a larger market such as the metropolitan area. So I'm less inclined to differentiate those on a long-term basis than I am the rural and remote issues, but perhaps if you would like to respond.

MR MACKINNON: In relation to the rationalisation, I agree that there has been a degree of rationalisation within the industry especially since the introduction of a new scheme, but I do consider that it is still - whilst it is still possible that there will be further - there will be implications around the capital cost of restructuring that is a great issue that needs to be addressed, because the cost to say build in metropolitan areas counting land and building would be up to if not in excess of $100,000 per bed, and that does lead to where is the capital funding going to come from which is a separate issue again because there has been, which I'm sure you have a copy of, the Hester studies in relation to the capital needs within the industry, let alone without sort of having to rebuild.

MR WOODS: Yes.

MR MACKINNON: Whilst I think we all support alliances, whether they be merges or amalgamations, that is not always possible to actually - in metropolitan areas to rebuild two 30-bed facilities into a 60-bed facility depending on where they're located, the land available around the area, or do they have to move to an area where there is land available. So there is a degree of difficulty in a total rationalisation to the efficient-sized facilities.

MR WOODS: My concern though is if you devised a subsidy that recognised those costs but provided little incentive to have any change in the industry, in effect you would be locking in that pattern. How do you envisage a subsidy that would to some extent recognise their reduced viability, but still encourage change within the industry?

MR MACKINNON: There is the viability supplement which is based on the rural remote. There would be an additional cost impost to operate. There could be encouragement for facilities to amalgamate or merge, especially in the over-bedded areas that could be addressed to take them to under-bedded areas. So there could be incentives there in relation to assistance with capital costs of building or a possibility even of freeing up of the method of charging a bond to nursing home residents which could provide a degree of capital input that may assist in that regard.

MR WOODS: Presumably that wouldn't be able to be restricted only to small homes though?

MR MACKINNON: It could be.

MR WOODS: Would you like to elaborate on that?

MR DONOHUE: Where Aged Care Victoria has large representation in rural areas, I think it is important that bed sizes remain flexible. By allowing bonds for high care places, that may well enable those people to remain in their facility rather than have to move elsewhere.

MR WOODS: I can understand your perspective for small homes in rural, but I guess I was particularly addressing the consequences of small homes in metropolitan. Do you hold the same view there?

MR DONOHUE: Not with the same conviction I guess those as in rural areas.

MR WOODS: Exactly my dilemma also.

MR DONOHUE: If I could just add on the comment of ageing in place, I think that has already proven extremely beneficial in rural areas, and high care funding arrangements should be structured to encourage that. I think that is already proving a benefit under the restructure arrangements. The ageing in place in rural areas and high care funding arrangements should be encouraged to enable that to expand.

MR WOODS: Thank you. You have addressed the question of workers compensation and payroll tax as they relate to proposals 7 and 10. Do you wish to debate those further or has the discussion with ACA met your particular concerns?

MR MACKINNON: I think that the Aged Care Australia submission did. Though I don't think the Aged Care Australia submission covered the payroll tax. We would believe that payroll tax should be cost reimbursed especially for voluntary sector organisations. I'm sorry, it was in there. I thought you meant the evidence today.

MR WOODS: Well, it's a matter that we addressed in our submission and there seems to be general support throughout.

MR PAVONE: Could I just make a point on the ACA discussion on workers comp, and that was - I agree with you entirely that there should be an incentive component to further increase the attention of management to better practices. However, I would hope that there is say - if a cap was operating, that it wasn't too low; that in fact it still allowed for what I would call accidents that management has no real control over. A small facility can have a couple of instances during a year leading to significant penalties, and yet they are in fact good managers. I mean, you can have significant accidents that do not relate to a bad practice.

MR WOODS: What's your view on limiting access to the cap only to those who have good practice?

MR MACKINNON: The difficulty would be how to measure good practice. That would be the degree of difficulty there.

MR PAVONE: A trend or a number of years' record of a particular facility's result would be one way of saying, "Well, you have got a good track record, and this is a blip," rather than "You've got a bad record and we're going to fund it."

MR MACKINNON: We also have a degree of difficulty in the industry in that the industry or the staff within the industry are ageing probably greater than what the residents are, and the frailty of the residents is getting a lot heavier, and therefore the possibility of incidents happening whilst we provide all the correct aides and we have the correct procedures in place, at times incidents or accidents just happen which unfortunately we can't control, and that is a great issue. We would see that it should be provided for. Yes, we would possibly agree that you would have to possibly have a measure if you were continuously over a reasonable or a level that you may have some need to have a review done by an occupational health and safety specialist that may point out any areas of concern that should be addressed.

MR WOODS: Thank you. I think that concludes the specific matters, although I notice you have a view in relation to the involvement of Centrelink in the assessment and collection of the accommodation bond. There has been expressed to the commission a series of concerns by providers that they are progressively becoming agents of government in a number of functions that they perform including assessments and collections, but there are also concerns expressed where some of those functions have been retained by government and delivered by them so that I'm in a somewhat perplexing situation of not understanding whether the industry wants government to perform all the government functions or whether industry wants to perform those functions itself. Do you have a view on that?

MR MACKINNON: I believe that we are in part a collector of taxes for government in relation to the income-tested fee, and that is one area, but as far as

determining the bond or the charge to be paid, then I believe that should be left with the facility and it can be done in a number of ways. The bond or charge is set at a specific level, and it is up to the resident to then provide evidence that they can't afford to pay that as long as they're given the criteria.

MR WOODS: Are the residents in their circumstances able to put their affairs in order to be able to meet your demands for information?

MR MACKINNON: In, sorry, what way?

MR WOODS: Well, if we're dealing particularly for those who don't have family and friend back-up support; that if you set a bond level and say, "Well, prove to me that you can't meet that," as distinct from working upwards of saying, "Well, what is it that you can afford?" is that going to put undue pressure?

MR MACKINNON: There are agencies available for those residents that do not have support to be able to approach, and I don't think anyone would be willing to take undue advantage of any person that would be entering an aged care facility. Also the industry or - - -

MR PAVONE: Centrelink requires the same information anyway.

MR WOODS: It's just the approach of the dynamics of the interaction may be slightly different is the point I was trying to make.

MR PAVONE: It might be more sensitive between the resident and the proprietor.

MR MACKINNON: The industry has had for a number of years entry contributions in hostels, and that was working well. I think that with the accommodation charge coming into nursing homes, it has probably been a new factor and probably really goes back to the selling of the program initially by government, and it was probably badly sold. I hope that doesn't go on the record, but I think that the community over a period of time will accept the methods that are in place.

MR WOODS: Thank you. Are there any other matters that you wish to - - -

MR PAVONE: I think I would like to comment on the dependency level question that you raised towards the end of the ACA submission.

MR WOODS: Yes, please.

MR PAVONE: Historically Victoria has had a higher dependency than other states as measured by whatever tools were available or whatever research was done. In the setting of CAM, Victoria was granted a further hour above the national average to meet that dependency requirement. In reference to the questions put to Mrs Waanders about the factors, I think one of the factors is the interrelationships between the acute health sector and the aged care sector in each jurisdiction, and they

I think vary considerably as to the practices of early discharge or whatever from the acute sector. So for some reason - and looking at all of the classification statistics, you will find Victoria is amongst the highest each time we have undertaken these exercises.

MR WOODS: Thank you..

MR PAVONE: Things like palliative care - there are a range of issues between the rehabilitation, between the acute sector and the extended care sector, and I think they vary from state to state.

MR WOODS: Thanks very much. Are there other matters that you wish to bring before the commission?

MR MACKINNON: No, we'd just like to thank you for your time and allowing us to put our submission.

MR WOODS: I appreciate the time that you have put into the submissions and presenting evidence today. Thank you very much. I'll adjourn the hearing until our departmental witnesses are available which I understand is at 2.30.

(Luncheon adjournment)

MR WOODS: I hereby resume the Melbourne hearings and call to the witness stand Mr Alan Hall from the Victorian Department of Human Services. Can you please state your name and title for the record?

MR HALL: Name is Alan Hall. I'm the assistant director of aged care with the Victorian Department of Human Services.

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

MR HALL: Yes, I would, thank you. I would like to I guess start by congratulating the commission on producing I think quite an interesting read on the topic of the funding of nursing homes, and I think it's a more interesting and open discussion on the topic than we probably had available in this area before. I will say that you have received our initial submission into it, and I apologise for the slowness of the state bureaucracy in managing to get you a public copy, but there will be a copy coming to you shortly which will be available for public release through the formal processes.

MR WOODS: Thank you.

MR HALL: We have also a response to your discussion paper which we can table today on the same basis; the formal one will flow as it moves through the various levels of bureaucracy, but I don't believe there will be any change in the content from what that says, and it's largely to those questions that I will talk today.

MR WOODS: Thank you for that.

MR HALL: I guess in general I would say that from the state department's perspective, we are generally supportive of the proposals that have come through in your discussion paper. There are a number of proposals which we support outright in the way that they are phrased, and they are proposals in relation to funding being adequate to support the level of care required to meet the standards, not predictably; proposal 5 in relation to subsidies for oxygen and so forth; proposals 6 and 7 in relation to payroll tax and workers compensation; and proposal number 8 which was that - also predictably - government-run homes should receive the same level of subsidy as those in the private and voluntary sector.

We support all of the other proposals in a conditional sense except for proposal 13 which is the unlucky 13 which I'll talk to you about perhaps a bit further on. I guess the conditional nature of the support is in large because of the - those proposals are expressed in outline form and therefore will be in the detail I guess in the way that those come through, but we are at least I think able to say that subject to the detail being worked out in a reasonable fashion, we think that many of them advance things significantly on from where we are.

I guess the other one that I would probably mention at the outset was the proposal relating to - proposal number 11 which relates to the subsidies being paid to providers or to residents, and I guess in our response we have put a conditional support to that, but that is conditional I suppose - it's a bit of a mixed one, that one. We actually do prefer an alternative way of dealing with that, and I'll talk at some length about that now, but in the sense of streamlining payments where people are within the current nursing home sector, we're quite comfortable in those circumstances that it should flow direct through the homes. That seems to be the path that the commission has most considered in the way that you have approached that question.

MR WOODS: Will your elaboration deal with the question of identifying the care component versus the accommodation component or is that a separate debate?

MR HALL: No, I'll do some of that in a conceptual sense in how we would approach that.

MR WOODS: That would be very helpful because I found your commentary on that in your first submission very thought provoking and very helpful, and so I would like to pursue that during this hearing.

MR HALL: In relation to proposal 1 which is that coalescence should not proceed in the form originally proposed, we do support that. I guess the conditional motion of that comes down to the way in which the alternative is developed I suppose. There was the discussion in the paper relating to particularly I guess the question of wags and the relative difference in wages across sectors and jurisdictions and the degree to which wages were apportioned as part of the overall cost structure. It was interesting. I guess we would have rather - I mean, what the commission has done is obviously take a number of different studies and try and draw some conclusions out of that, and out of that I guess we were surprised that the variance as you have viewed it out of those has come out to be as narrow as it was. We would have intuitively thought that it was by far the largest component of variants.

MR WOODS: Certainly the perspective many have come from that have also noted the Latrobe study in particular and the narrowing.

MR HALL: It's also highlighted for us perhaps that in Victoria because the public sector is such a large player and has a number of constraints on it which I think probably don't apply in the other sectors which I will also elaborate on a little, that we are placed somewhat differently in that; for example when the studies go to the award levels of pay for various types of nursing, most of the wage pressures in Victoria have not come about through award changes. Those have become in a sense a bit redundant in the way the system works. It has largely come about through changes through enterprise bargaining processes.

Since the enterprise process came into being, we have had a couple of $8 a week safety net adjustments, we have had a $10 pay rise for nurses under the 95

enterprise bargaining agreement, and 11 per cent come out of the 1997 enterprise agreement. Perhaps I should say in that that while the paper also talks about the link between nursing in the acute sector and nursing in the aged care sector, in general I am not unsympathetic to the line that the commission has taken in seeing a separation between those, and I think the difficulty for us comes about with the fact that for us it's the one organisation that provides both the acute and the nursing home component and the separation is in practical terms almost impossible for us to get to.

The other thing I would comment on I suppose is that the way that the enterprise bargaining process tends to work is that agreement is almost never reached as a straight cooperative bargaining process in relation to nursing in Victoria. It always ends up moving through the stages of protracted industrial action and then to the commission, and while not a formally arbitrated solution through the commission, one that is conciliated fairly heavily through the commission processes. By and large we get to a stage where the public hospital system is generally ceasing to function in a variety of ways which then brings as you would imagine a reasonably speedy resolution but without perhaps some of the rigour that might in a theoretical sense be associated with enterprise bargaining processes.

It was interesting to read in there the example of - I think it was a Queensland group that you cite who had done an enterprise agreement with I think a 3.6 per cent rise over 2 years, and the offsets that they had achieved for that. I mean, the offsets while talked of in a productivity sense weren't productivity in the way that we would generally see it in the sense that they didn't relate to changes in work practice; they more related to a reduction in entitlements if you like. So there was a reduction in sick leave, reduction in recreation leave and things of that sort; things which would almost be - dare I say it - impossible for a state government to actually win changes of that sort across its hospital system.

Therefore some avenues for constraining the impact of costs which are probably there through smaller and more removed private sector agencies really aren't open to the state, but I'm also aware I guess that Victoria is unfortunately somewhat uniquely positioned in relation to that since we seem to be the only state with such a large public sector holding in that area.

MR WOODS: Could I, just before you proceed, pick up a point you made of us differentiating between nurse wage rates and conditions in the two sectors - the aged care sector and the acute care sector? Yes, we do identify them separately, but don't have a view on whether they should be at different rates. What we're saying is that the subsidy design should be based on cost pressures experienced in the aged care sector, but if that coincidentally happens to be the same as the acute care sector, the commission is neutral to that outcome. So whereas some previous witnesses have drawn from that comment an inference that the commission has a view as to whether there should be some differential wage outcomes, just to clarify that we don't, we're just saying that the subsidy design should be based on what is the outcome in the aged care sector. Obviously there are some caveats to ensure that those outcomes are within reasonable bounds.

MR HALL: And that's reasonable. It's obviously a case in hospitals that you can't differentiate between nurses in different parts of the organisation. In fact there's movement across those sectors anyway. That sort of takes us on to proposal 3 which was the issue of the benchmark, and I would have to say that we are much more comfortable if we do go to a uniform subsidy rate that that being based on some sort of agreed benchmark than we would be with the current system. So in broad terms we clearly support that direction.

MR WOODS: Are you happy that we sort of debate some of those points as you go through or do you want to complete your - - -

MR HALL: No, I'm happy to debate some of it.

MR WOODS: It certainly is attractive at this stage to pursue the national uniform - and perhaps it should be rephrased as a standard subsidy rather than basic subsidy, but using the old description at this stage - for a number of reasons, some of which relate to the dynamics of the industry. If you have a national subsidy that is transparently based on the costs, then you are perhaps less likely to be prescriptive in terms of the actual inputs used.

The more you differentiate the subsidy and break it down into its component parts, the greater the tendency is to then dictate that those parts have the funds spent on them that relate to those requirements, whereas if you have a national subsidy and that it be ultimately a price for outputs decided by government that transparently related to the inputs required of industry to achieve those outputs, that gives maximum flexibility to the industry, to the individual providers to meet their individual circumstances.

If you also keep it at a national level rather than a jurisdictional level, it provides some tempering of the possibility of wage outcomes in individual jurisdictions jumping by some significant amount, but if they realise that through the indexation process and the national averaging, that if one jurisdiction moves too far ahead of the national, then it's going to have to find the extra cost of that outcome from its own resources from within the sector itself rather than through the Commonwealth subsidy payment. Whereas if you divide it up into individual jurisdictions and you keep that transparent relationship, there may be a tendency for individual jurisdictions then to pursue outcomes recognising that the Commonwealth is paying through the subsidy arrangement what those outcomes are. So it ultimately still requires a judgment as to whether the differentials are so great as to require a jurisdictional based subsidy so that you're not disadvantaging the high cost areas, but given that the majority of the costs is in the wages sector, there is some element through a bargaining process of discretion in those outcomes.

MR HALL: Equally I think having a logical base and transparent base on which the Commonwealth subsidy is based helps on the other side when, from our point of view we're dealing with the Industrial Relations Commission on some of these issues, then

it is much easier to make that clear and to show the overall limits that are there, which I think is difficult for us to do at the moment because the subsidy base has no particular logic to it.

MR WOODS: Or no apparent logic, yes.

MR HALL: Quite, yes, no apparent logic - well, maybe. Yes, that's very true. I guess equally then in - I mean, I recognise that from our position it's difficult for us to argue a case based on what suits the Victorian public sector because it's quite different from probably most of the rest of the country, but it does mean then that if we need to deal with the Commonwealth in relation to the Victorian public sector we have equally a more rational basis to do that from than we have at the present time. I mean, you also make the point in your paper about the issues of subsidy level and quality and that if there is not a reasonable link between those then quality simply decreases as other costs go up.

I guess that's where the thing comes home to roost in the Victorian public sector; that if wages are moving in a way which the health industry might see as reasonable for the health sector in a broader sense, then the impact of that on nursing homes might simply be that there is some constraint on what happens. Equally, it was interesting to read in there the comment that I think presumably came from one of the ANF submissions; that the nurse-resident ratio that's unique in Victoria, that there was only about, I think, a 15 or 20 per cent compliance with it across the industry. Now, I would almost bet that the compliance occurs in the public sector, the non-compliance occurs in the private sector for obvious reasons as well, so there are some factors I suppose which, while we can understand in a broad sense why you have come down the way you have, and in a sense they disagree with that, nonetheless leave us as a sector with some particular problems.

I guess despite that, I mean, it's still much more comfortable I think working to a benchmark model than we would be, and I guess for us it comes down to then the debate around how the benchmark is struck and how the various factors and weightings are put together. I guess we would like to see - I presume that work would be post the end of the commission's work and it would be useful for the commission to, I think, recommend strong involvement from other players, including in particular us because of our public sector. We have found that the Commonwealth has consulted reasonably - well, I should rephrase that. The Commonwealth tends to consult more with the private sector and the voluntary sector but almost doesn't consult at all with the state governments on how it deals with these things, and we as such a large provider, feel significantly aggrieved by that, I would say in general.

MR WOODS: I am happy to note your concerns. Be sure that they're passed on.

MR HALL: Thank you. I guess also related to that is the issue of the special needs pool and I guess we think that that is a reasonably sensible approach as well. I mean, we have some weariness about how the Commonwealth would view words like "rural" and "remote" because I think the current definition of "rural" and "remote"

means that Victoria has neither rural nor remote components except perhaps a little bit in either extreme end which don't have any nursing homes in them as far as I can recall. So we would hope the rural sector in Victoria gets recognised in that context as well but - - -

MR WOODS: Other witnesses on behalf of Victoria have made that point as well.

MR HALL: I thought that might be the case. I guess that also brings us to the question of where that pool comes from that's agreed to which it is simply carved out from within the current funding arrangement, whether it's dealt with in addition, but I will come back to that again when I talk about indexation. Perhaps the productivity issue in proposal four is the next one that I should touch on. Logically if one goes to a benchmark arrangement then a review of that, and the elements within it as being the basis for an indexation arrangement, I think, is a sensible way to go. The issue comes up with the issue, I guess, of the notion of a productivity discount. There are two perspectives on that I think. I mean, one would be the tendency for governments to levy, in our case, a 1 and a half per cent annual productivity arrangement anyway, but also the meaning of productivity in a work practice sense within the nursing home sector.

Within the health sector as a whole there has clearly been a lot of scope for productivity changes but they have often been related to improvements in technology and improvements in pharmacology and so forth which lead to legitimate work practice changes in the way in which treatment is provided and the intensity in which people have had to stay within hospitals and so forth.

MR WOODS: Changes in day surgery and all those?

MR HALL: Exactly, those sorts of things. The difficulty with nursing homes, I think, is that there are unlikely to be - well, we can't foresee much in the way of true work practice change that's actually possible. We don't see the technology or pharmacology isn't likely to impact much on the sort of work that generally goes on within nursing homes, and so the question about to what extent productivity in the sense of changed work practice as differentiated from a reduction in conditions, is actually likely to occur in that setting. I mean, much more comfortable with the notion that there is a review of the components that make up the benchmark, and some examination of reasonable shifts in cost pressures are on those but much less comfortable with the notion that there is simply an average productivity factor driven in.

Again, I suppose I would differentiate a bit between - there are different capacities in different sectors to deliver some of those things. I mean, we know in Victoria that the industrial activity focuses strongly on the public sector; to a much lesser degree on the private sector, and probably to an even lesser degree on the voluntary sector, and that is one of the key variables that I think how both agreements and arrangements can be worked out. In Victoria the government as part of its annual

budgetary process does impose a 1 and a half per cent so-called productivity arrangement on all departments but within - - -

MR WOODS: I'm familiar with that technique.

MR HALL: Yes. It's quite a productive one for them I think. But I guess the way it's dealt with doesn't actually bear much relation to productivity any more. I mean, we no longer attempt to meet it by identifying particular work practice change initiatives which might be seen to meet that and we certainly in our history have gone through a time of trying to do those things and seeing that they really actually delivered the savings that one made, so we now view it as an internal savings requirement which we apply differentially across different sectors. So we will much more likely apply it within the inpatient component of hospitals for example than we will to the smaller community based services which have much less of a funding base and have much less scope in fact to change the way in which they work. I guess the same sort of issue crops up here; that this is such a narrow area of business, that there's not much scope to apply it in differential ways to components of the nursing home sector.

MR WOODS: I understand your view and again others have come to similar views, but I do remind them that through our own observations and evidence put to us, clearly there are markedly divergent outcomes both in quality of care and in financial performance between homes of broadly similar size and RCS profile which suggests that there is a productivity differentiation between homes that some through management practice or other means are more able to demonstrate a higher productivity than others so that there remains a degree of scope. It's not a nil figure. There is some scope for very many homes to improve their productivity, but we would also like to have a subsidy that allows those who continue to perform better than average to receive the benefit of that which is why we have moved away from the reimbursement-type proposal.

MR HALL: Yes.

MR WOODS: So that there are the incentives to keep doing better than average and reward for so doing, but to recognise that because in practice at the moment there are very different outcomes, there is scope for those who are not achieving at the more efficient levels still with appropriate quality of care to do so.

MR HALL: I mean, I would agree with that in relation to the current circumstances because I mean, what you say is perfectly true. I guess in the concept of funding, moving to a more reasoned benchmark approach, it's whether the setting of the benchmark should not be the vehicle for delivering a view on what the cost and subsidy should be rather than the setting of that and then a discounting automatically which is how I had read the proposal in the document. I suppose it was that automatic discounting of whatever the benchmark said that was of some concern.

MR WOODS: I will reflect further on your point there.

MR HALL: If we go to proposals. The next bunch of proposals - as I have said, we agree with and have no particular issue with those at all.

MR WOODS: Can I pick up number 7 which you did include in that group being workers compensation.

MR HALL: Yes.

MR WOODS: The preliminary proposal there is to include it in the basic subsidiary regime. We have received considerable evidence from some parties that there is limited scope for provided discretion in what their premiums are, and yet others, particularly at some peak body levels, strongly welcome this proposal. I am concerned to ensure that there are incentives in there for organisations to keep pursuing sound occ health and safety practices. I am therefore concerned that a direct reimbursement proposal will merely just fund whatever outcomes they achieve, so I'm not inclined to that particular view, but I also recognise that through either good or bad practice but an occasional very large claim can threaten the viability of homes, not only for 1 year but over the 3-year call back period.

MR HALL: Over a period, yes.

MR WOODS: And therefore need to give some consideration to that particular aspect. Do you have a view on that? Presumably within the state sector itself you have some internal self-funding or through a - - -

MR HALL: It is wrapped up in hospitals overall and it has not been an issue for our nursing home component of hospitals that has come out.

MR WOODS: From your broader policy perspective relating to nursing homes in the state generally, do you have a view on that?

MR HALL: I mean, I agree with your comment that there does need to be some incentive for management to generally be cognisant of the dangers in the workplace and the need to in fact work quite hard to create safe practices and so forth, and that's particularly true in the nursing home area where - I guess lifting in particular is one of the areas that's particularly prone to be a risk. I mean, I will say that in reading the document I was also cognisant of the fact that Victoria has one of the lower, I think, subsidies in that regard and since we might have argued the case in relation to our wages, that they were a bit beyond our control.

Some relief through the workers comp going in would probably in the overall sense of things balance that out a little, so I would have to say there was a degree of pragmatism in our approach there. I guess in reality the problem of a single claim in a small facility that does impose significant burden is probably one that needs to be looked at on a once-off basis through some of special needs arrangement. I mean, I don't think you can gear a subsidy level to take account of those sorts of occurrences,

but equally where a home is of such a dimension and financial standing they clearly can't deal with that. I mean, it has to be dealt with with the same logic that the special needs pool has been argued in the document, I think, and I guess there would only be concern if there were a frequency of those sorts of accidents in which case you could deal with them on an individual basis, I would think, to try and rectify that.

MR WOODS: Thank you for that.

MR HALL: I then come to proposal 10. I mean, broadly speaking we agree with the need of non-acquittal of subsidy payments. I guess it is only conditional in the sense that as long as the issues of quality remain - I mean, the one thing acquittal did do was attempt to make sure expenditure happened which I guess was a proxy for dealing with quality issues. I mean, we do have some concern that the new regime will be less sensitive to issues of quality than the previous one. We think the previous one actually did work quite well and if there was a problem with it it was the lack of diligence perhaps that the Commonwealth had in applying it as regularly perhaps as it should have been but where the Commonwealth did apply it and did impose the financial sanctions, certainly some of our state sector services took a lot more interest in dealing with the quality than they had ever done before, and I think the easing away from that I think is probably a backward move. So the comments about acquittal I guess are only as a backstop position; that provided the accreditation system does work and does deal with the quality issues, then there should be no need.

MR WOODS: I was going to then test your view on that. We've had various degrees of perspective on what acquittal - sorry, not acquittal; the benchmark process of determining care accreditation process will achieve. One witness today was very confident that that process of accreditation will ensure that homes do provide a common minimum standard that is acceptable rather than receive accreditation in anticipation of him going through some form of continuous improvement which may have suggested that the base be perhaps a little variable. Do you have a view on your understanding of the accreditation process as to whether the base for achieving a satisfactory level would be common and rigorous and form an acceptable basis for us to pursue a subsidy design?

MR HALL: Potentially it could do that I guess. My personal view on accreditation is that a period accreditation results in a lot of activity at the time that the assessment is due and does not necessarily guarantee much in between those periods no matter what sort of organisation is undertaking accreditation. I am a touch more sceptical I suppose of that. It probably will lead to a raising of the minimum base of services, and I think it will clearly in relation to buildings. The current changes are clearly forcing those pressures, and certainly on the state if nothing else.

MR WOODS: Well, the certification process is more absolute, isn't it, in terms of - - -

MR HALL: It is more absolute.

MR WOODS: - - - fire and occ health and safety and the like?

MR HALL: Maybe it comes down to experience over time as to whether it does in fact deliver. I mean, one of the pressures for it to come about as I understand it was a view that the previous I guess inspectorial type of system was not being uniformly applied, and I would have to say that from the early accreditation assessments, the same sorts of statements seem to be made in relation to that as well. So I don't know that it has actually made much difference there. I think that in large part it is now - whereas it was more likely I think that the Commonwealth would impose sanctions to improve standards under the previous arrangement, I think that now that is less likely to happen, and I suppose that's where my concern would tend to be.

Having said that, I still think that acquittal is a reasonably onerous administrative task. I don't think it actually achieves a great deal in itself since people can deal with acquittal in all sorts of ways, and it's almost impossible to check, so the issues of quality aside, I'll probably still come down on your side on that one I think. Let me pass over 11, and I'll finish on discussion about 11 if that's okay.

MR WOODS: Yes.

MR HALL: The deregulation of extra service provision - look, we've conditionally supported that as well. I guess concerns about that come from again the potential impact that it might have in smaller communities, and it's the degree to which providers - like I accept the point that you had made in the paper that it is not reasonable to try and put barriers in the road of people with means to purchase a better level of service or support on that basis. I guess the concern would come about if providers were to be somewhat differential in who they actually admitted into the service based on their ability to take out extra services, and where we might end up with monopoly providers or - yes, well, with monopoly providers I guess in certain areas. That's where that potentially could be a problem.

So in broad terms we note that the Commonwealth in their sense has increased the proportion of extra provision places from I think 6 to 12 per cent in the current time, and would have been more comfortable with seeing how that had worked in practice before we went to a - as an interim step I suppose before seeing how it went in a fully deregulated environment.

MR WOODS: 12 per cent is their current upper limit, but the national uptake is about 1 and a half per cent, so we're a long way below.

MR HALL: Well, we are a long way below.

MR WOODS: In some regions - we understand the Gold Coast is bumping up against its limit, but many other regions aren't. We also note that as the quality of facilities improves by providers who are not interested in providing extra service places - for instance moving to single-bed wards with either shed or individual

en suites - that to some extent that's undermining the scope and potential for extra service anyway.

MR HALL: Yes, that's true.

MR WOODS: But progressively as you up the base standard in those accommodation and hotel service functions, then the differentiation in the market place for extra service reduces.

MR HALL: That's true, and I mean we would have liked to have seen I guess - if it were to be deregulated, I think it would be important to see some specification of what the standard level of care is to provide as distinct from what the extra component might be, but if the take-up is low as you're suggesting, then I guess our concerns aren't perhaps going to come into reality. We would have said in any case that perhaps the 2-year review that is planned to take place might have been the time to review what had happened, and then merely have that as a staging part and a check and balance between.

Let me come to 13 which was the question of subsidies. I'm sure we perhaps won't have a unique view on this one either. I guess we don't have a difficulty with the notion that the states that are under-funded so to speak should have their funding levels brought up to whatever the national benchmark is.

MR WOODS: That seems to have common appeal.

MR HALL: Yes. The question is of course where the money comes from, and as you would imagine, we would have a strong disagreement to it coming out of any reduction in any indexation to fund that. My point would be I suppose that there is no logic as to why it has to come out of the indexation stream of money in particular. The Commonwealth increases the scope of the overall pool each year anyway, directing it into new places. They should simply redirect that into dealing with the inequities in the funding system before they then go back into increasing the numbers of places, and I don't see why they can't do that. Anyway the notion of restricting the indexation flow doesn't work with the notion of benchmarking anyway.

MR WOODS: No, the two are tackling two different issues, and 13 is not meant to be a caveat on 3.

MR HALL: No, but it does say something about 13 as a number, doesn't it? That leads me to the issue of subsidies being paid to providers rather than residents.

MR WOODS: This is going to be an area where we can explore some issues. Can I pick up a couple of specific ones before we do that?

MR HALL: Certainly.

MR WOODS: To what extent do you see state rules and regulations and whether it be the Food Act or building codes or your version of Poisons Act, administration, etcetera, imposing particular costs and operational procedures on this particular sector? Is that a significant issue that warrants close consideration?

MR HALL: There are two answers to that I think. We haven't raised that as an issue because our view is that the Victorian government doesn't impose a unique set of requirements on the nursing home sector, not since we deregulated it from a state position some years ago and therefore we didn't particularly take issue with your perspective which was that if the state did impose particular things related to quality, then it perhaps should pay for those.

MR WOODS: Yes.

MR HALL: That's probably true.

MR WOODS: We know you didn't disagree with that.

MR HALL: We view it in two ways I suppose. I mean, our issue comes down to the fact that - I mean, we do view the things that come out of the Industrial Relations Commission as somewhat different than a state-imposed set of conditions, but one that we have very little control over in real terms despite the theory behind enterprise bargaining and how the industrial model is meant to work. So we didn't include - - -

MR WOODS: Things like the Food Act and the like.

MR HALL: - - - that. I think that where those things apply across services in general, that they're just part and parcel like the building code provisions of providing a service, and I don't believe that - nursing homes are no different to anywhere else. I don't think they should be dealt with in isolation at all.

MR WOODS: Preliminary proposal 8 looking at government-run homes and those transferred to non-government sectors should receive the same basic subsidy, and that's on the assumption that return on investment should be a preoccupation of state government as well as of other sectors, but it does raise issues of implementation for those homes that have been transferred that have taken into account one way or another the reduced subsidy that's paid.

In some cases that may be by way of a state government continuing to offer a top-up subsidy payment; in other cases it may be through a reduction in the premium paid to the state for the home that amortised the effect of the reduced subsidy over a period. Could you elaborate for the commission on the practices adopted in Victoria so that we can give consideration to this transition issue?

MR HALL: In Victoria wherever we have transferred the management of the home out of the public sector into private or voluntary sector, we have continued to pay the top-up so that their net income is exactly the same as they would have had were they

funded directly by the Commonwealth as part of that. So we have recognised in part that it would be almost impossible to transfer homes under any other basis anyway, and that there is no logic why they should be, because of the historical factor, disadvantaged in that way. So we continue to pay it even where they go out into private sector operation as some of our most recent ones have done.

MR WOODS: So you've done it through that way rather than accepting some level of discounted price that has the effect of amortising - presumably in many cases you haven't actually been selling the homes anyway, but passing on the liabilities of accumulated long service leave and other - - -

MR HALL: That's true, but all of those things in a sense have an end point, can be quantified. It's more difficult to do something which might continue for as long as the home continues to operate. So our $8.81 or whatever it is a bed day, we have simply tendered a contract to continue to provide that. I guess in a balancing sense while we might be seen to gain out of proposal 8 if it came into being, let me say that the gain we might make out of that certainly doesn't offset the amount we pay as a result of the wage loading, so we didn't feel that that was an unreasonable - you know on the check and balance basis, that that worked out reasonably well.

MR WOODS: We had evidence from Aged Care Australia that they drew some views on why the RCS1 and 2 - which is the evidence they have put before us - percentage distribution show that Victoria for RCS1 has 8.4 per cent, whereas other states and territories are significantly lower and the national average is 7.1; for RCS2, 25.6 compared to the national average of 24.3. Some Victorian witnesses have used that level of acuity as support for the particular circumstances affecting Victoria. The question is to what extent might that also reflect certification practices between states and territories or is there a fundamental underlying differentiation of Victoria from other states in that question of level of acuity?

MR HALL: Our view has been that there has not been a fundamental difference between Victoria and other states. We did some detailed work on the assessment of residents which using the data from the Commonwealth across the three sectors in Victoria and over 4 or 5 years I think up to the time when the scale actually changed and the new scale came in, and on that assessment which we can provide the data if you wish - - -

MR WOODS: I would appreciate that actually.

MR HALL: On that assessment we bulked RCS1 and 2 together, and the proportion of residents in Victorian homes was in the middle of all of the other states. I think the ACT stood out highly, but Victoria and the others came into a very clear band which didn't differentiate the state. We were in the middle was my recollection of that. We also - - -

MR WOODS: Northern Territory comes up particularly high in RCS2 on this information, and the ACT - - -

MR HALL: There are some differences in the new scale that has come out, but our view on that is that it's probably too early for that to have settled down to give a reasonable measure yet. I know that that one I think in your background paper showed that Victoria had the highest rate, and I thought that was quite odd, and we have no ability to explain that except to say it's very different than what our view had been previously, and so we think it might be an early stages - - -

MR WOODS: Your information would be helpful to us to put into context the claims made by others.

MR HALL: We'd certainly put that. We also looked at the difference in the proportion of high-cost residents across the public, private and voluntary sectors, and in fact the public sector had less of the high dependency residents than the other two sectors and more of the lower dependency residents than the other two sectors which was contrary to what was oft stated as being the impact.

MR WOODS: Do you have a view on the current nurse resident ratios operating in Victoria as to the degree that the may enhance or affect productivity and quality of care?

MR HALL: Our general view would be that it's not particularly appropriate to approach quality by specifying a mechanism of that sort. We would much rather move to an outcome-type assessment of the quality of care and leave providers free to make the judgments about how they actually did that. So we don't agree with that provision in the award which is why we partly took it out of the regulations as we deregulated. We were quite dismayed to see it, despite vigorous opposition from the sector, go in in the way that the Industrial Relations Commission did it, but it's not a thing that we would support in its continuation; not at all.

MR WOODS: I note you're not supporting it on grounds of principle. In terms of practice should it not occur, what changes would you expect to see?

MR HALL: I would not particularly expect to see any changes. We equally have not looked to see whether it's being complied with or not in our sector. I don't believe that that is a key determinant in the quality of care that's provided. I think there are many other factors which far more readily will impact on care than in fact the staffing structure of that sort.

MR WOODS: I appreciate your comments on that. Do we wish to move on to proposal 11?

MR HALL: We were uncertain - when we read your very small discussion on this topic in the paper - - -

MR WOODS: It was a thoughtful discussion, albeit small.

MR HALL: Thoughtful but small, yes. Let me put our position somewhat differently. For us we were not approaching it from a simple position of one should simply put the money to consumers and then let them choose amongst the existing range of providers. For us it is a question of that the choice of where you get nursing home care is contained to a select group of providers and there is no ability to move outside of that. If you want the care, you have to get it in those settings. You don't have a choice of going elsewhere.

Our view has more been that there should be a greater choice to the consumer about where you got your nursing home care from; that you should not necessarily have to have it from a currently defined nursing home setting. Even though standards may be improving and the care might be of a perfectly good quality within that, there are choices nonetheless. There are other places in which that care could be arranged. At lesser levels of intensity, we see the arrangement of care packages through - the HACC program provides exactly that sort of alternative where a person gets an equivalent amount of money and is able to exercise the differential choice upon exactly what that is spent on and how it is actually then configured to meet their particular set of needs.

In fact the CACP arrangement within the Commonwealth's residential system does exactly the same thing, although it's geared more at the hostel end - the low-care end of the system than the high-care end. For us the logic is exactly the same. The fact that you have higher care levels doesn't alter the fact that there should be some choice. You should be still able to exercise some choice about exactly where that care is able to be provided. The system of assessment through the aged care assessment services in the end makes the determination about whether or not you have an entitlement to a certain level of support and of the sourcing that goes with that support.

So the control if you like over the amount of individuals who are able to receive support can be exercised quite comfortably at that level; it's also exercised by the approved number of beds at the moment, but nonetheless both of those mechanisms sort of - both move to achieve the same end.

MR WOODS: Two gatekeepers.

MR HALL: Two gatekeepers indeed.

MR WOODS: The question is how many you need?

MR HALL: Yes. The Commonwealth is trialing a range of - extended age care in the home packages I think they call them which are in fact a package which allows you to have the care provided in the home instead of in a nursing home, but with the same level of support able to be provided through different means. Our proposal in essence is about extending that option and making it much more freely available within the community. We see no logical reason why one should set a quota. A

certain number of people can have either a CACP or an extended nursing care in the home-type arrangement while the rest have to have it within a certain external facility.

We think that for some people the external facilities will be the place of choice, and in fact they may be for the majority, but rather than have that as a predetermined choice, we should leave it much more open to individuals to exercise those choices. We also think that the costs of providing care will change in some degree according to where it is provided; that if care is being provided in the home, then there should be a range of facilities and other costs which would not be the same as they would be within a freestanding nursing home, and therefore one should be able to in fact provide either greater levels of care or more care to more people because you are not having to deal with one level of costs which is in the current system.

We also think that people could exercise choices about other types of facilities where they might arrange for that care to be taking place, and some of that might be quite competitive with the current system. So we have a lot of up-market special residential services in Victoria which provide a high quality of residential care and could extend to provide nursing home care; not if the individual has to pay it themselves as they do now, but - - -

MR WOODS: Can you elaborate? What are these special residential facilities?

MR HALL: They're a private sector service that operates in Victoria where they are facilities that provide a degree of care and support in a residential setting, but they do so without government subsidy whatsoever, and they range from a pension-level support which is a very low level of care and often does have issues of quality, but they also range up to quite an up-market level of support which can be very high levels of support and certainly high levels of physical environment which people will basically pay their own way into, and there are no - - -

MR WOODS: Are they sort of retirement village-type concepts that you're referring to?

MR HALL: Sort of, although not necessarily geared towards an older population. I mean, they deal with many people with disabilities, many people with psychiatric conditions.

MR WOODS: So assisted living.

MR HALL: Yes, but the up-market ones are used predominantly by older people as an alternative I guess to a retirement village concept, and people simply pay their own way in there, so there's no reason why they couldn't buy the extra nursing support within those settings, but again without the facility cost having to be paid as it is in the current nursing home structure. Equally I think there are arrangements through private hospitals and other places which would offer I think some of those supports as well.

So I guess our position is more to do with the fact that there is probably an artificial restriction on the degree to which people can exercise those levels of choices. Where they choose to go into a nursing home as currently defined, then it's quite reasonable for the money to flow direct to the provider, and that's probably the most efficient way to do it. So we don't have a problem, and that's where a conditional support fits.

MR WOODS: In the sense that where they choose - choose within the options available, but where they then choose to go, the subsidy flows with them.

MR HALL: Yes.

MR WOODS: You're not subsidising the provider; you're actually subsidising them in the sense that if they choose to go there, the provider gets the subsidy.

MR HALL: Yes.

MR WOODS: And that's the view we came to.

MR HALL: Yes, and it's not a matter of putting the actual cash into the bank account of the individual, but it is about not restricting their choice. I guess the current system is in many ways a very closed system that your choices are amongst the range of approved providers, and I guess in general we see no reason why that needs to continue to the degree that it does now. We would be much more comfortable for the market to determine the degree to which that applied.

MR WOODS: Does that mean that you would almost need to divide the subsidy up three ways? There's the nursing and personal care component which under that model a person assessed as warranting that level of care can then in effect take with them to various options and decide whether it be exercised in a nursing home or in their own place but with support. Then there's a hotel services component - the home and community care equivalent, and then there's the facility component, and it's only at such stage as they are no longer able to operate from their own or related accommodation and move into a nursing home that the facilities part flows, but in the first respect and then progressively into the second respect they can take that entitlement to various forms of care.

MR HALL: I think that's right. In terms of what will always be a constrained funding pool for this type of care anyway, it's one which not only improves flexibility, but also has the potential to extend it to a larger number of individuals than is currently the case.

MR WOODS: Is this a proposal that has been pursued with interest within the industry generally? Some witnesses have suggested the embryo of thoughts along these lines, but I found yours not only very interesting, but very well developed. I also noted with interest that that didn't seem to be appearing in submissions of others. Any reason for that at this stage?

MR HALL: We have at various times and to varying degrees got into this debate with the Commonwealth, and we have seen - - -

MR WOODS: I remember the special premiers' conferences and work flowing from those, but I recall deafening silence subsequent to that.

MR HALL: In the COAG arrangements, that's true. This sort of proposal was at the heart of what was proposed there, but it became too great I think - I put that in its broadest context - although after taxation reform should that occur, who knows? Maybe that will go on the agenda because that was certainly one of the big sticking points from I think the states' perspective there.

MR WOODS: I think Meredith Edwards at the Commonwealth end was showing considerable interest in this at one stage earlier.

MR HALL: Yes. I think from the policy perspective there is a strong interest in this sort of thing. I mean, the parallel I think is with the community aged care packages which have been around. I see no reluctance by providers in all sectors to want to access those, and I think the provision is the same way. I would have to say I'm not sure from a private perspective quite how it would work in relation to the return that might otherwise be expected on the operation there, and maybe in that sense the private providers are better suited to run with the current style of service, but certainly I think from the voluntary sector there is no I think reluctance to move into packages, and from the public sector that would be a position of choice as well.

So we have debated a number of times with the Commonwealth who have been - I mean, the system is a particularly rigid one at dealing with things like the ratios and the benchmarks, and we find it very difficult to get any flexibility occurring there for reasons I guess we don't really understand. We certainly have been successful in getting some of the trials of these packages which is the limited approvals that are out at the moment occurring in Victoria, and we think that they will work well. We would much rather extend that.

Victoria has, as you would have known if you have looked at any of the outcomes of the accreditation work that was done, Victoria generally came out quite badly out of that, and the public sector - - -

MR WOODS: We had noted that.

MR HALL: - - - came out quite badly as well, and that in fact has among other things I think made us revisit the question of transfer out much more vigorously than would have otherwise been the case. Given the current costs associated with the salaries, the capital costs associated with the rebuilding, a lot of our hospitals are now actively wanting to move out of this field, and that will be okay I think from our point of view as long as there are alternative numbers of providers who will be able to provide the service. We don't want to see Victorians unable to access these types of

services, even though the public sector doesn't particularly want to be the provider in many cases.

We are mounting through the current budget negotiations for 99-2000, 2000-2001, which are the 2 years after the accreditation threshold, a strong debate through government in relation to the nursing homes that have clearly failed accreditation, and where the state believes it has no other option but to keep them operating in those locations and within the public sector, and that's mostly small rural settings, and that bill alone is somewhere around the 50,000,000 mark that we would be up for for that. So there are high cost risks associated with most of this.

Where we have other alternatives for how we might provide that care, we're strongly motivated to pursue those. I think that for many people - I mean, if I can draw a parallel in palliative care for the moment, the option of palliative care being provided as a home-based service rather than a service within a hospital is extraordinarily popular, and the growth in community-based nursing which provides that support to families in the home has been quite strong over recent years. We would probably say now that the majority of palliative care is being provided in home settings rather than hospital settings, and that's a position that consumers are very comfortable with.

But if you approached it from the view that hospices are the only way that you can provide that care and will approve a set of hospices and that's where you must go, then the mind-set is quite different. I mean, we read from parallels like that, and I guess that's where we come to in this one. I think we recognise that where we need to provide the facilities, they have got to be of a good standard, the government will, I'm pretty confident, provide a high priority to doing that over the next couple of years to at least get up to the minimum standard. We will divest wherever we reasonably can because of both the recurrent costs and the capital costs which are just difficult for the state to meet with the magnitude that we have got, but again they're peculiar to the Victorian public sector because of the magnitude of services I guess and where we find ourselves.

I don't think other governments are quite in the same predicament that we are, but not only is the transfer of services out into other providers, I mean, equally the finding of flexible ways to do that I think is much more consistent with general approaches to human service delivery these days which we would pursue.

MR WOODS: In the final report I intend to give some space to one or two matters that have come to our attention that are more of the visionary looking for options outside of the current boundaries. I'm certainly attracted to the inclusion of these thoughts into such a chapter. If you were to revisit the presentation of that as you have in this submission and wish to make any refinements to it with a view to the inclusion of some of that material in a chapter of that sort in our final report, I would welcome that.

MR HALL: We'll certainly look at that as we provide you with the other data as well.

MR WOODS: That's not what we have here at the moment, but if you do wish to read through it again and make any changes.

MR HALL: I guess where we would have hoped you might have got to on that proposal is perhaps to draw that approach, seeing it as an extension of the package arrangement rather than quite the absolute who gets the money approach perhaps to encourage a greater move to bilateral arrangements between states and territories where there was a willingness to move down this path and to explore much more actively and perhaps to move away from the rigidity of the current planning arrangements that are there.

MR WOODS: Well, you might want to - - -

MR HALL: Were there's a willingness to do that.

MR WOODS: - - - put a covering note or something to that effect on any further material that you put to us.

MR HALL: Okay.

MR WOODS: I note that I can't of course quote any of it at the moment because you have got a confidential stamp sitting on top of the submission, but I assume when it gets through the system and pops up as a final, the confidential stamp won't appear which will enable us to access - - -

MR HALL: Yes, in our system it has to come from the premier's office. Our proposal is in, and while we understand that will come to you quite soon, it's just a somewhat laborious process that we have to go through.

MR WOODS: I would encourage its speedy resolution because while ever we're constrained by confidential, there are many thoughts and ideas there that aren't able to see the light of broad day.

MR HALL: We're certainly doing our best to do that.

MR WOODS: Are there any final matters you wish to put before the commission?

MR HALL: I think we have covered it. Let me just reiterate that we took the paper very positively, and although the devil is in the detail not much of what is there, we're very supportive of many of the directions that you have outlined in this and look forward to its adoption in some form by the Commonwealth at an appropriate time.

MR WOODS: Thank you very much. I'll at this point close the Melbourne hearings and resume by way of video conference tomorrow at 12.00 with hearings for Perth.

AT 3.41 PM THE INQUIRY WAS ADJOURNED UNTIL
FRIDAY, 20 NOVEMBER 1998

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