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TRANSCRIPT
OF PROCEEDINGS

PRODUCTIVITY COMMISSION

INQUIRY INTO NURSING HOME SUBSIDIES

MR M. WOODS, Presiding Commissioner

TRANSCRIPT OF PROCEEDINGS

AT TAMWORTH ON FRIDAY, 27 NOVEMBER 1998, AT 10.20 AM

Continued from Melbourne to Perth Video Link on 20/11/98

MR WOODS: Ladies and gentlemen, welcome to the Tamworth hearings for the Productivity Commission inquiry into nursing home subsidies. My name is Mike Woods and I am the presiding commissioner for the inquiry. As most of you will be aware, the commission released an issues paper back in August where we set out the terms of reference for the inquiry and of the initial issues that we felt needed addressing. Subsequently we have received over 60 submissions, with further supplementary submissions coming in; I think I read number 98 - was the last one that came across my desk. I and my team have visited interested parties in every state and the two major territories.

I would like to express my thanks and those of the staff for the courtesy that has been extended to us in our travels and deliberations and for the thoughtful contributions that so many have made in the course of this inquiry. These hearings represent the next stage, including presentation of final submissions which are due by close of business today. Also we have circulated background material for comment and clarification. I would like to particularly thanks those in Tamworth and from the surrounding region who have come today and will contribute to the evidence, and also extend our thanks to those witnesses who have come from other parts of the state.

The commission has recognised in its position paper that rural and remote areas do have particular needs, and that has been particularly demonstrated to us in some of our site visits and it's important for the commission to gain as much information and understanding of that as it can, and by coming to Tamworth in this inquiry process is further demonstration of our interests and concerns in this area. I would like the hearings to be conducted in a reasonably informal manner but remind you that a full transcript of evidence is being taken and will be made available to all interested parties who so wish.

I would like to welcome as our first witness Ms Julienne Onley from the New South Wales College of Nursing. Welcome. Could you please state for the record your name and the position that you hold.

MS ONLEY: My name is Julienne Lesley Onley and I'm manager of professional services and policy at the New South Wales College of Nursing.

MR WOODS: Thank you very much. Would you like to make an opening statement?

MS ONLEY: Yes, thank you. On behalf of my executive director, Professor Judy Lumby, first of all I would like to thank the commission for the opportunity to respond to this position paper today. In light of the fact that wages are such a large component of costs, as you pointed out in your position paper, the college wishes to apprise the commission of the reasons for qualified nurses to be employed in aged care facilities. The commission will have already read the detailed submission made by this college in conjunction with the New South Wales Nurses Association, so I don't intend going over the details of that submission at all. But I would like to elaborate on the reasons that professional qualified nurses are vital to optimal

outcomes for older members of the Australian community, those of them who need residential care.

Before I do that, I would like to just indicate the credibility of the college and myself as commentators. The college is a national professional nursing organisation which was established in 1949. It promotes nursing and facilitates the ongoing development of the nursing profession. It is actually the largest, longest established and most innovative provider of specialty quality skill development and postgraduate nursing education in this country. It is a professional organisation and provides education and professional services nationally for around 6000 nurses a year. Its mission is to facilitate the education and professional development of nurses, influence the process of policy development and influence the health care of the community.

Through its membership the college has continuous contact with nurses working in clinical areas, management, education, research and in academic fields. It also liases strongly with other education providers, with professional organisations, industry bodies, consumer groups, public and private health care establishments and government departments at all levels, and these relationships which have been developed over a number of years ensure that the college's activities remain current, diverse, and relevant to their needs as well as to those of nurses.

The college's activities in the aged care sector are very well-recognised. Professional liaison with peak industry bodies, professional organisations, consumer groups, special interest groups and aged care facilities, active participation in conferences, seminars, representational working parties, committees at all levels of government, consultation on policy development, implementation and evaluation with government and industry as well as, as I mentioned previously, education.

The college is being represented by me today, and I think we've established the college's own credibility. I would like to indicate to you my experience in aged care and in the health sector as well. I have a strong background in education, clinical nursing, management in aged care; I have been working in the field since 1973. I've been an educator, a proprietor, a director of nursing and a clinician in aged care facilities in the private sector. I am also involved with Geriaction through my membership of the executive of the state and national bodies.

I have with the support of the college undertaken the education program necessary to become an aged care quality assessor, and have been appointed as a member of the aged care industry panel for the Quality Society of Australasia. I share, in common with the college and with Geriaction, an ongoing commitment to maintaining a professional nursing presence in aged care, and I believe that my experience and my professional involvement will, in a very practical way, contribute to your deliberations.

The issues that the college wishes to bring forth are in the main, four areas. The college's main objective is the provision of safe care for residents of aged care facilities, and the college is firmly of the view that residents, whether their needs are

deemed high level or low level, deserve and require the provision of care by suitably qualified persons. Their assessment is in partnership with the residents and significant others and it is that assessment which establishes their level of care needs and that must remain the realm of nurses. Any strategies which remove qualified - that is registered and enrolled in this state - nurses from aged care and replace them with lesser educated and lesser skilled carers will have dire outcomes for residents and will be firmly opposed by this college. The commission will have also heard supporting views from representatives of the medical profession and consumers.

The college's main objective is also commensurate with the commission's view that care services must be responsive to residents' needs. The skills mix and qualifications of formal carers cannot be determined by market forces, neither can they be determined by the accreditation process and they cannot be determined by financial constraints. There is only one criterion for determining staff experience, qualifications and skills, and that is the level of dependency of the care recipients in whatever setting they happen to be, and tailored individually to each resident.

There are four main issues, as I said a few minutes ago, which potentially adversely affect older people, and those are multisystems disorders, earlier hospital discharge, high levels of acuity and associated care needs, and responses to relocation to aged care facilities, and relocation within aged care facilities, and I'll briefly elaborate on each of those.

Firstly multisystems disorders: commensurate with our increasing population of aged people in this country and with advances in technology and the greater awareness that we have of adapting our lifestyle to enable longevity, there are now - and there will continue to be - significant numbers of older people with multisystems disorders. The nature of those disorders often leads to disabilities which in turn exacerbate frailty which is both physical and mental. As a result of that, many older persons need extensive skilled support. An additional burden, especially in those living beyond 85 years, is the onset of a dementing disorder, which is often Alzheimer's disease.

The clinical nature of that disorder's progress of its own leads to the need for specialised care and support. However, when its concomitant with multiple problems, all too common in older age - just to mention a couple, osteoarthritis, osteoporosis, cardiac disease, cancer - the single biggest determinant in whether any of us in this room will get cancer will be our increasing age - the resultant acuity requires even more skilled nursing.

The second issue of early hospital discharge is really an interesting one. A predominant fear is that in our current health care system, older people are being discharged quicker and sicker. There are many people working in the Australian health care system who are still undecided on that issue, but data does exist which indicate that some hospitals are redefining what is an appropriate functional or health status level for discharge and hence transferring responsibility for care from the hospital to other organisations. There are many things which do contribute to a

decreasing length of stay in hospitals; one of them is improved anaesthetics, another is the changes in hospital practice, like pre-admission work-ups. However it's the last one - redefining when patients are ready for discharge - which is causing great concern to people working in residential aged care facilities.

Older people with significant care needs at the time of a relatively early discharge will need those needs to be met somewhere, and a large burden is then placed on service providers; for the purposes of this submission, residential aged care facilities. There is a perception in acute hospitals that registered nurses working within those facilities are more than capable of providing care for an acutely ill person, and that's usually quite right, but only if they're there, which is often not the case in hostels. Appropriately qualified nurses are usually only present if there are sufficient resources, which means sufficient funding, to provide that high level of care required.

Discharge 1 or 2 days post-surgical hip replacement or repair of a fractured leg, a femur, is not uncommon, and that in itself demands a high level of skill and resources, but combined with the existence of all those concomitant disorders, with or without dementia, the required level of skills and resources and those of human, technological and other resources rises to a marked degree. There's another temptation in acute hospitals - to relieve them of the burden of older patients by avoiding admitting them at all. There has been some recent publicity about the rationing of surgical procedures on a chronological basis. It would be naive to assume that this practice doesn't exist, and its extension is that some older people are left with very high levels of care needs.

Cost saving strategies in health care wherever health care is being delivered, including residential aged care, do not correlate with a humane approach towards older people. I think there's no doubt at all that the health care dollar is uniformly tight across this country. There are common themes emerging from the literature about the effects of early hospital discharge. They reveal there is a greater acuity level in older patients, the need for more skilled staff hours to service greater needs, more deficits in patients' activities of daily living, more nursing time required, more rehabilitation, an increase in the number of nursing home debts, and increase in the amount of palliative care provided, and I know that the commission has been informed of that.

Basically they need care more complex than most families can provide, and it's often stated, especially by older health consumers themselves, that they do not choose to move into residential care. The necessity to move comes from that increasing frailty or illness from disability and the inability to cope with the resources that are available to them and their families at home. In short they need support; they need skilled care and a high level of resources. They need a high level of care commensurate with their acuity provided by specialty educated nurses.

The third issue is those high levels of acuity and associated care needs which bring some figures that need to be considered. There was a study reported in the literature in 1996 from a major Victorian teaching hospital. This study revealed that

30 per cent of patients who are transferred to long-term care facilities died within 4 days. Older age was reported as a significant factor in death after discharge, whether to long-term care facilities or elsewhere. Of the 60 to 69-year age group, 21.6 per cent died within 21 days of discharge; the 70 to 79-year age group the percentage was 31.3 per cent; and in the 80 plus group 29.9 per cent. Of those transferred to long-term care facilities almost 15½ per cent of deaths occurred within 2 days, 24 per cent within 3 days, and nearly 30 per cent within 4 days.

There could be a factor of the timeliness of transfer in the high rates of death within a shorter period of time for those that are transferred to long-term care as they may have been extremely ill and less salvageable than patients who were transferred to other facilities, or they may not have been expected to recover anyway. But consistently the literature indicates that a high level of nursing care is needed, including palliative care skills, in any long-term care facilities which receive patients transferred from the acute care sector.

The commission has already heard from other contributors that the average length of stay in a nursing home is approximately 8 months and reducing, and that palliative care is increasingly being delivered in those facilities. If residential aged care facilities are able to employ suitably educated, qualified, registered and enrolled nurses, and provide the equipment and other resources necessary a number of things will happen. Firstly, the transition from acute care hospitals to those facilities will be better managed. Secondly, continuity of care will be provided. Thirdly, acute illness will be better managed, and fourth, palliative care will be delivered in surroundings which are familiar to residents and more accessible to families. Re-admissions to acute hospitals will also be lessened.

The final issue is response to relocation to aged care facility, and this is a little-known and little-considered issue. Many older residents in aged care facilities are not admitted directly from or via an acute care hospital, and the effect of relocation on them is not dissimilar to the effects I've already mentioned. Although they may not have an acute illness or they may not be in the aftermath of major trauma like a stroke or a fracture, nonetheless they will be suffering from a chronic disease state or, more likely, several: physical frailty or perhaps cognitive impairment or a combination of those factors, and they will have needs which cannot be met by undertrained and undersupported staff.

The effects of relocation in older people, as with all life changes, is a transition which combines both losses and opportunities. Enhancement of the factors which promote successful adaptation and minimise personal loss is a necessary imperative in the nursing care of older people when they relocate. These residents face the losses of youth, of health, productivity and independence. Helping them to manage those losses and to cope with the physical and the symbolic transitions and provide care for their mental frailty and/or their physical frailty and for their chronic illnesses are certainly not tasks for untrained carers. On the contrary, those types of skills are embodied in specialty-prepared, gerontic nurse practitioners.

There's such a thing as a relocation stress syndrome, which is defined as physiological and/or psychological disturbances resulting from transfer from one environment to the other, and the major characteristics of that syndrome are anxiety, apprehension, increased confusion, depression and loneliness. Contributing and related factors are perceived losses of support systems and losses of familiar environment and losses of health status. Nurses are absolutely crucial to the wellbeing of older residents. Those nurses are trained and able to recognise if certain behaviours are stemming from psychological responses to moving.

Inadequately educated staff or insufficient staff will result in residents being medicated in an attempt to control behaviours, especially if they suffer from dementia. For such a syndrome to be recognised and the effects minimised with appropriate interventions, highly-skilled professional nursing staff would be required, working with a multidisciplinary team, and that would not be feasible in any under-resourced environments.

Lastly, just a few words in conclusion. Having highlighted and expanded on those issues of multisystems disorders, the effects of early hospital discharge, resultant high levels of acuity in the associated care needs and relocation, I hope that I've raised the awareness of the commission to the absolute necessity of maintaining that professional nursing presence in aged care and therefore the necessity of providing funding across and within various jurisdictions which allows and encourages nurses to be employed, therefore providing optimal levels of care. There is every evidence around that our nursing homes are actually acute medical units but are staffed at 50 per cent only of equivalent units in the acute hospital sector.

Unless registered nurses and enrolled nurses with appropriate post-registration and enrolment qualifications are employed in such facilities, those residents who are already members of a vulnerable group will be at risk. The literature shows that they will be increasingly liable to be admitted to hospitals which results in an exacerbation of illnesses resulting in higher levels of acute confusion and increasing levels of that relocation syndrome. There's every evidence from both the literature and from practice that professional nursing care is essential to ensure the provision of pain and symptom management, the administration and review and evaluation of complicated medication regimes - and I'm aware that the commission has been listening to evidence about medications - the provision of palliative care, of rehabilitation and nursing management of those highly complex multisystems disorders.

I've brought a copy of a discussion paper which was disseminated widely by the college and it's fully referenced and backs up with empirical evidence the details that I've spoken about this morning. I'm very happy to leave that with you as reference material. The only other thing that I need to say is to thank you for your time and for your attention, and that the college wishes you well with your task.

MR WOODS: Thank you very much. I appreciate not only that statement but also the paper, particularly as it then goes into some of the studies which I'm interested in pursuing in a little more detail as well. So thank you for the referencing that's in that

document. Perhaps if we can pursue some of the matters that you raised in that statement, and then if I can ask in relation to the joint submission that you made with the New South Wales Nurses Association your views on some of the broader issues facing the commission in its inquiry.

In your opening statement you talked about early discharge policies, and I wonder if you could express a view on whether the policy - which is a pragmatic policy in a sense of hospitals looking for earlier discharge and therefore the level of acuity of patients being higher when they are discharged - is unintentionally having the effect of increasing the number of elderly who go into nursing homes and of course once in a nursing home it's unlikely that they will then go through a convalescence rehabilitation process and go back to their original home - it does happen sometimes, but there's not a lot of backward flow in that sense - and if the convalescence process in the acute environment was a day or two longer whether in fact it would allow a discharge back to a supported home environment or other - whether it be retirement village or hostel, but that level of environment - and would then allow at least a longer, if not final, process of ageing in place. Do you have a view on that issue?

MS ONLEY: Yes, I do, and I'll present the college's view as well, which is commensurate with my own professional and personal view. You would actually find it extremely difficult to find a piece of paper at any acute hospital with a policy, "early discharge" written on it. It would be in the realm of discharge planning and appropriate discharge. Of course underfunded environments sometimes find it quite difficult to plan discharge effectively because it must be planned from the day of admission or from pre-admission.

There is evidence that patients are being discharged earlier than previously, for the reasons I've outlined in that particular discussion document. There are also anecdotes. Anecdotes do abound, as anecdotes tend to. In this particular state, we won't be in a position to see whether the differing methods of funding of public hospitals, acute hospitals, has actually resulted in greater numbers of older people being discharged. The point that you were talking about in terms of rehabilitation: rehabilitation can be and is provided in public hospitals, but it is provided in public hospitals that generally are designed for that specific purposes, although some major hospitals do have rehabilitation units incorporated in their set-up.

The difficulties I think arise always when people are discharged from any acute hospital facility with a differing perception from the people who are discharging them of their needs and capabilities, and a differing perception of the resources which may or may not be available to them. Now, there are many many nursing homes and hostel environments which can and do provide an excellent rehabilitative process. If funded appropriately, I am certain that we would see a change in the picture of, instead of very few people who progress from a nursing home back to their own home or to some other less supported environment. If we had more rehabilitation in those aged care facilities, I'm sure that picture would change and we would see more people actually progressing through rather than going to a nursing home and staying.

I don't know if it is within the realm of this commission to make any comment or suggestion about how funds should be allocated towards rehabilitation specifically within the nursing home industry, but rehabilitation definitely falls within the realm of specialist nurses, and there would be a flow of nursing activities into rehabilitation were funds sufficient to allow that. Rehabilitation is not cheap.

Another difficulty I think which would need to be addressed in the broader term probably of the 2-year review is that the current resident classification scale, revised version, does not seem to reward the enabling of residents as it used to. Again the figures - the data would only have been collected from 1 November, and it's hardly time to comment on that.

MR WOODS: Other than that some witnesses have brought to the commission's attention that the way the RCS scale is structured and the funds flow from it, there is not a lot of clear evidence promoting rehabilitation back down the scale.

MS ONLEY: Well, that's what I meant by the enabling process, yes.

MR WOODS: Yes, exactly. So we are conversant with that issue and witnesses have commented on it. But to just dwell on this point a little further, from your experience would you see the most appropriate and efficient - stressing that second word as well - form of care for rehabilitation being delivered by a slightly longer stay in an acute environment albeit with an associated rehab unit or however it is best delivered - - -

MS ONLEY: Yes.

MR WOODS: - - - in the hospital infrastructure rather than a potentially longer or even for remainder-of-life stay in a nursing home?

MS ONLEY: That would have to be individually determined. That's a very difficult question to answer from a clinical perspective in broad general terms. However, people who have been in an aged care facility and then, for whatever reasons, trauma, whatever, are transferred to a hospital and then can return to that aged care facility would obviously be far better off being served by the rehabilitative and enabling process back in the aged care facility. People who have been residing in the community - again it would have to be determined on an individual basis. I can see merits in directing funds both ways. However, long-term slow-stream rehabilitation - and the evidence clearly shows that the need for long-term slow-stream rehabilitation increases commensurate with rising age and the existence of those multisystems disorders - a far better and more appropriate place for the rehabilitation to be provided would be in residential aged care facilities. That is my view.

MR WOODS: Thank you for that. The relationship between the acute care environment and nursing homes in country areas - does that have a different nature of relationship than in the major metropolitan centres, and does that affect the nature of the work undertaken by nursing homes and also the strains put on the acute care

sector?

MS ONLEY: There are two parts to that question. Is there a difference in the relationship in country and/or rural areas and metropolitan areas? Yes, necessarily there must be. There seems to be from my travels around this state in rural and remote areas a greater linking or sharing of experiences and sharing of knowledge and skills in rural facilities and remote facilities. In the city, I can speak only of Sydney, but it has been my experience that there is often not a sharing of skills and knowledge. Who is at fault, I don't know.

MR WOODS: I'm not interested in the fault.

MS ONLEY: No. I think that's a huge issue all by itself. That picture is changing, I'm pleased to say, as more and more of - particularly nurses, are sharing their knowledge through their speciality groups and getting together under the auspices of major organisations such as the college and the association. The second part of your question, I think would be directed to some of my colleagues who are based in rural or remote areas. I can state quite categorically that things are different in remote than in rural areas, but that would be better directed to one of my colleagues from here.

MR WOODS: Yes. And I'll be pursuing that with other witnesses, thank you. I was particularly interested in the material that you were describing in relation to the relocation process. A couple of questions on that. One is a particular point, which is you made the comment in your opening remarks about helping people cope with the physical and symbolic transitions and providing appropriate care are not tasks for untrained carers, and I understand your point. The question remains, however, whether it is possible to provide appropriate training to the range of people employed in nursing homes to cope with this issue. I wouldn't like your phrasing there, "are not the tasks of untrained carers", to be reinterpreted as "therefore the only people who can care are those who have been through a particular professional stream".

Presumably, there are opportunities for training and, if they don't exist at the moment, courses which could be devised which would assist the range of people employed in nursing homes to at least contribute to assisting with this transition.

MS ONLEY: At a superficial level, you could say that that is possible, but that is exceptionally superficial. What I was I talking about in this responses to relocation to aged care facilities and, in particular, that relocation syndrome - are definitely not the realm of even generalist nurses, but would require the skills of somebody who has mental health training, as well as general training and those nurses are pretty well few and far between in aged care facilities, which is extraordinary - extraordinary to me personally and to me professionally. I don't think that the education which is necessary to cope - or more than cope, to recognise and manage the difficulties associated with relocation, quite apart from all the other things about which I spoke - can be provided by some superficial or even fairly well thought-out and well-developed and well-administered program, unless there is a base training to a very high degree. It requires people with skills and qualifications such as those

embodied in the training and development of specialty education registered nurses.

MR WOODS: You spoke in very absolute terms about the imperative and importance of specialist training, particularly in the field of mental health and the like. Are you drawing from that an implication that those who are currently delivering care in senior management positions, senior nursing positions, in homes who don't have that are providing inadequate care?

MS ONLEY: No, I'm sure they're not providing inadequate care to the extent of their knowledge of such matters. I'd be the last person to suggest that care delivered by the vast majority of my colleagues is inadequate. The point I'm making is the recognition of some disorders or the effects of some disorders. The recognition of, for example - let's put it into a clinical perspective - behaviours which may or may not result from a dementing disorder, they may or may not actually be resulting from other concomitant factors as well and the problem is in the recognition that there may well be a different underlying reason to the one which is superficially assumed through, for example, a diagnosis - such as we can make a diagnosis - of Alzheimer's disease. So I'm not saying that the care is not being adequately - far more than adequately, in fact - delivered by the majority of my colleagues, but that there would be even more appropriate care delivered, were there sufficient funds to provide education to both the professional nurses who are already working in the fields or throughout their training as registered and enrolled nurses.

MR WOODS: Thank you for that clarification, because it could otherwise lead to interpretations that I'm sure weren't intended. In that respect also, you speak in fairly absolute terms in terms of the level of professional nursing staff required in nursing homes, but presumably that also doesn't lead to a conclusion that they are the only level of carer that should be employed in homes and so the question is more a matter of what is the appropriate staff mix in homes and, at the moment, is it the appropriate mix? I note from our inquiry and our travels that the staff mix, say in South Australia, is very different from the staff mix, say in Victoria, just to pick two jurisdictions, but is one necessarily better than the other or are they the consequence of various factors leading to a result that in that jurisdiction is seen to be most appropriate in their range of circumstances.

MS ONLEY: I'd have to come back to my opening remarks, where I talked about the level of skills mix. It can't be determined by anything other than the needs of the residents and it is that those needs are recognised and appropriately assessed - is the crux of that issue really. I have also mentioned the need for a multidisciplinary team and included in that multidisciplinary team are the various levels of nursing carers. In this state, we have registered nurses and we have enrolled nurses and we have working throughout the industry, I'm aware, assistants in nursing. Now, all nurses, those two ranges of nurses, enrolled and assistants in nursing, must work under the director and direct supervision of a registered nurse and that is most appropriate. I can certainly see that everybody who is involved in care in a nursing home or in a hostel is part of the team, no matter where they happen to work.

I can recall one instance myself, I made the person who was in charge of the laundry a team manager of one particular resident's care, because that is where this resident spent most of her time and she was the one who noticed if her osteoarthritis was causing her difficulties, she was the one who noticed if she was having problems with her continence, so she was the most appropriate leader of the team, but within that team were registered nurses, enrolled nurses and assistants in nursing as well. There needs to be an appropriate mix, but we need that professional nursing presence at all times.

MR WOODS: Thank you for putting that particular illustration on the record, because that's quite helpful. Your point on the need for registered nursing across the board is not challenged, it's a reflection that there are different skill mixes that have evolved in different jurisdictions and you make the point that the care must reflect the needs of the individual resident, but nonetheless there are biases in mix in different circumstances, which suggests to me that it is possible to evolve a diversity of inputs which may meet broadly similar outputs and outcomes, provided there is the fundamental elements such as you talk about of the level RN involvement and ENs, etcetera. Picking up further on this response to relocation - as I say, I found it a most fascinating contribution to this inquiry - I'd appreciate further comment from you on whether this suggests and underlines the importance of the ageing-in-place process and whether if the relocation from the home environment to a more institutionally-based environment, were more often to take place in what is currently the hostel-type of situation, where their level of acuity may be less, where their mental capacities may be greater, where they have some flexibility to adjust to the transition and then through ageing-in-place there was then not that need for a subsequent relocation process, whether that would address in some part some of these issues.

Now, that's not to say you issue an edict that says everybody, when they get to a certain stage, must enter a hostel, that remains a combination of choice and circumstance, but whether a biasing of the system to that end and then through ageing-in-place, through an enmeshment, as there is happening in some places, of RCS1 to 4 care, as a progression up from 7 or 8 up to 5, would that go some way to assisting that relocation process and reducing the trauma involved?

MS ONLEY: On the surface, it may be conceived that that would, but relocation need not actually be physical relocation, it can only be psychological relocation. Another thing that can happen is that somebody can remain in the same place, but the environment around them can change, that also is relocation, so you would have to examine the peripheral issues before you could make any firm statement one way or another on the question you've raised. The concept of ageing-in-place does not necessarily mean ageing in the one room, in the one facility.

MR WOODS: I understand.

MS ONLEY: To me and to the college, it means ageing in the one community.

MR WOODS: The environment?

MS ONLEY: Yes.

MR WOODS: But by having the stability of that broader environment, at least goes some way in part to reducing the relocation stress, that if the nursing staff, even if they've not had the same level of intensity of relationship, but if the DON is somebody who has known them for a period of time, even though they may have moved from one part of the facility to another, there is still that continuity and the same other staff ranging from ENs to laundry manager to the chef who wanders around to see if they're all enjoying their food. Those small things can assist in the process.

MS ONLEY: Yes. Continuity is obviously quite desirable for everybody. Not everybody enjoys change, whether they're old or young.

MR WOODS: Absolutely.

MS ONLEY: There is something that you mentioned that I must pick up on, too, and that was about whether it isn't recognised - you talked about increasing acuity and you talked about perhaps increasing cognitive impairment. The problem with those often, when people are ageing-in-place, as it were, is that exacerbations of them or exacerbations of underlying disorders or illnesses are actually not recognised, particularly with subtle progressive fatal disorders like a dementing disorder, so the recognition of what is happening to the person who is ageing-in-place is more the issue perhaps at one level, than actually considering to have to pick them up and move them from one spot to another. It's the movement that's going on inside their heads and bodies that requires a great degree of skill to recognise before even a management plan can start.

MR WOODS: Yes. And presumably the point of drawing on that recognition issue further reinforces the position you're establishing in this evidence.

MS ONLEY: Yes.

MR WOODS: Thank you.

MS ONLEY: The role of external people, too, can't be ignored, for example, clinical nurse consultants or specialist medical practitioners as part of the team.

MR WOODS: Or even the volunteer brigade. Interestingly, the statistics we've had before us have shown some divergence between the number of volunteers who assist with care in the church and charitable sector versus the private-for-profit sector. The figures are very divergent. Presumably they can in some way also contribute to some continuity and stability and support.

MS ONLEY: Anywhere where I've had the good experience of having a volunteer team working with me, I've ensured that they also are provided with education.

MR WOODS: Absolutely, yes, so that their contributions are not only well-meaning, but positive.

MS ONLEY: I would agree.

MR WOODS: I understand that point fully. But I have focused on the statistic that you included in your opening remarks and in your paper that 30 per cent of patients transferred to long-term care facilities died within 4 days.

MS ONLEY: That was a study in a major teaching hospital in Victoria.

MR WOODS: And in 1996 it was published.

MS ONLEY: It was reported in 1996, so the study was probably done in 1995, from, memory.

MR WOODS: But I think that statistic needs to be reflected on in terms of - from the perspective of my inquiry - how the funding system may be able to contribute to the design of care that tries to do something about that particular outcome.

MS ONLEY: Yes.

MR WOODS: And any further thoughts you may have on that - and I'm not in any way suggesting people move away from the deadline of close of business tonight for submissions, but if you were to follow up with any further thought on that, I would appreciate it.

MS ONLEY: Will do.

MR WOODS: I am given my own deadlines of needing to report to the treasurer by 13 January.

MS ONLEY: I was wondering what I was going to do this weekend.

MR WOODS: I appreciate that. But it is an area that I would like to explore a little further.

MS ONLEY: Yes.

MR WOODS: Other matters have come out of your joint submission with the association, many of which I intend to pick up with the association particularly, but are there matters in either your opening comments or in the joint submission that you particularly want to draw to the attention of the commission?

MS ONLEY: No. I deliberately didn't re - not reinvent the wheel, but repeat what I had said, because I was aware that these submissions - the prior submissions,

including the one jointly by the college and our colleagues at the New South Wales Nurse Association, would have been read and taken into account in your preparation of the position paper.

MR WOODS: There are a couple of follow-up matters, but as I look through them I think I can address them, particularly with the association. Are there any concluding issues or matters that we haven't dealt with of particular concern for the college that you'd like to draw?

MS ONLEY: Not at this stage, no.

MR WOODS: In which case I would thank you particularly for not only contributing to this submission but for your opening comments and supplying this paper. Your treatment in some depth of a couple of those particular issues has been useful to the inquiry and will give us further cause for thought and reflection on how the implementation process of my recommendations can respond to some of these issues. So thank you very much.

MS ONLEY: Thank you.

MR WOODS: I'd like to call as the next witness the representative from Geriaction, Mr Greg Price. Could you please state for the record your name and the position you hold in coming before the inquiry.

MR PRICE: My name is Gregory John Price. I represent the New South Wales committee of Geriaction. I'm a committee member.

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

MR PRICE: Yes, I do. I'd first like to thank you for the opportunity to make this submission. A bit of background information: I've worked continuously in the health sector since 1977. I have 9 years' experience as a director of nursing in a 50-bed non-profit nursing home. This is co-located with a 37-bed hostel and is situated on the north coast of New South Wales. I have a bachelor in health administration, and I've recently completed - done training as an aged care quality assessor. I have co-written two chapters in separate health texts concerning requisite management systems and policy development for nursing homes.

Apart from providing details that relate to Geriaction's written submission, I would like to give some facts and insights in relation to the changing nature of workplace demands, first, the increase in resident dependency. I have personally collated data from my local region for a period of 7 years. This data indicates that in response to the increase in resident dependency, staff numbers have increased. However, it is the change in staffing ratios which is interesting. Between 1991 and 1996 the proportion of activity and therapy staff increased in relation to nursing staff. However, within the nursing domain, registered nursing staff numbers increased 3 per cent and non-registered nursing staff decreased by 3 per cent.

The reason for the increase in registered nursing staff relates to the increased complexity of resident care needs. This is also reflected in the low band level of care. For example, the co-located hostel where I work has moved from a situation of having no registered nurse involvement 5 years ago to a case where they now have four registered nurses working on a 2.5 full-time equivalent basis. To give further indication of how resident needs have increased, the nursing home where I've worked has purchased a pulse oximeter, an ECG machine, a haemoglobin photometer, an electronic syringe pump for palliative care, extra oxygen and suction equipment, and various other items. This is equipment which is normally used in the acute sector. We use it for the assessment and ongoing management of a dynamic complexity of resident needs, and for the record I'd like to point out that all of this equipment was provided by the ladies auxiliary.

Secondly, the impact of the aged care reform strategy: since the introduction of the strategy, the nursing home sector has had to deal with a new CRS and the accreditation framework. The RCS sustained an increase from 14 to 20 questions, and the accreditation framework has involved an expansion of outcomes from 21 to 44. This represents a twofold increase in non-resident-centred activity, an increase

that has been met within the existing funding arrangements. In my view this is a fine example of a productivity gain.

In the process of achieving this gain, facilities have had to make decisions on how to allocate existing funds. However, the pressure has been placed on positions such as activity and therapy staff. To be honest, the hours allocated to these roles are under threat and, again for the record, activity and therapy staff are mostly involved in providing quality of life for the residents.

In terms of direct care staff, the expertise of registered nurses is being increasingly directed towards system management issues. The pressure, because of the accreditation framework, was taking them away from direct care into terms of setting up accreditation systems and whatever. The non-acquittal of nursing and personal care expenditure may have had a role in these trends, and the commission may consider a recommendation which has non-mandatory benchmarks which can guide allocative decision-making processes. The current changes threaten the amount and quality of human resources which are available for direct resident care. The industry needs time to take stock of the changes to the RCS and the impact of the accreditation framework upon the quality of care provided.

Thirdly, the nursing home sector differs from the acute sector in the sense that many of the direct care nursing home staff are not registered nurses. This creates a hierarchy of expertise and position specialisation which is unheard of in the acute sector, and it is for this reason that the aged care sector is able to be more productive in terms of meeting the complexity of care of its residents. Furthermore, in relation to the needs of the frail elderly, the role of the registered nurse as the major care plan decision-maker does not differ between the two sectors. They are confronted with the same issues and they marshal the same resources. The commission must bear this in mind, otherwise the quality of care provided to the elderly may be jeopardised.

The commission recognises that the aged care sector nursing pay rates already lag behind their acute care counterparts. A move towards coalescence of funding which openly dismisses the need for parity between the sectors will potentiate the existing problems within the industry in relation to the recruitment and retention of staff. The commission states that it wishes to ensure a uniform quality of care across Australia, and we wish you every success in this endeavour. However, please be very mindful that the system of subsidy should be modified to achieve this goal, not undermine it.

Before concluding, I would like to particularly congratulate the commission for its recognition of the issues facing remote and rural Australia. In the event the changes do take place to the existing subsidy framework, I would urge the commission to adopt an incremental approach of implementation. The residents and staff have undergone an onslaught of changes in recent times. Their stress levels in terms of dealing with change must be taken into account.

There are some other themes which I would like to put on the agenda,

particularly in terms of the last submission. Ageing-in-place and ageing-in-community in the rural sector in terms of hospital discharge are fairly contentious issues. Quite often people who are pressured to leave the hospital sector are moved to a facility which is quite geographically remote from where they live, and the spouse quite often doesn't have access to visit. There might be distances of tens of kilometres, like 70 kilometres, and the only way they can visit is on a bus or whatever. I believe some of the issues of ageing-in-place in terms of the imagery should be dealt with in the architecture of buildings and, to my knowledge, there's only one architecture course in Australia which is aged care specific.

In terms of the convalescence I believe that in my experience system failure is so acute and of such magnitude in the acute sector that the rehabilitation in the event of residents being admitted has failed, and when it's moved to the nursing home sector the rehabilitation takes on the role of being maintenance of existing levels, and quite often it can be quite an intensive process to have someone to be able to keep walking or be able to learn to walk again, maybe never to the extent where they can go home, but for that person it's a major achievement.

I believe that case management in the nursing home sector is becoming increasingly adopted and members of the community who experience case management expect that a registered nurse will be responsible for the resident, and the case load has to be distributed to manageable proportions. I'll have my twenty cents' worth about the mix, if you don't mind. My experience in the area I work is that discounting the role of nurse managers - the mix typically is 30 per cent registered nurses, 60 per cent non-registered nurses, AINs and ENs, and 10 per cent therapy. That's a fairly average mix. I believe facilities which put more emphasis on quality of life do have more therapy hours, however, but it's not at the expense of the registered nurse level. It's at the expense of the non-registered nurse level. I'd just like to thank you for having the opportunity to have my say today.

MR WOODS: Thank you. I appreciate that and I appreciate the two submissions that the organisation has put before the commission in assisting us in this inquiry. If I can start with a couple of points you raised in your opening comments and then revert back to some matters arising from your submissions - and I need I think to respond to the comment you made about being openly dismissive of the parity issue. The position paper that I've put out makes the comment in recommendation 3 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.

I read nothing in that which puts forward an opinion or view that there should not be parity between the two. It's purely in the design of the subsidy and indexation putting forward there that the circumstances that actually exist over a period of time and, as other witnesses have reflected, there are in different jurisdictions different wage outcomes at points in time, and in fact what's the highest jurisdiction at one point in time may not be the highest subsequently, etcetera, so there is some fluidity in that process, but this is purely a statement that the indexation should reflect what is happening in that sector but doesn't reflect on whether the aged care sector or the

acute care sector should be different.

So there's no conclusion by the commission that one should be less or more than the other. We leave that question open. It can reflect the circumstances of industrial and other processes that lead to outcomes in those two sectors. From the commission's point of view, as long as the recognition of input costs is accurately reflecting what is occurring in that sector, then the design of the subsidy is properly based.

MR PRICE: I just think it's important that the final coalescent rate is something which cannot be used as a lever to further drive the wedge between the existing disparity.

MR WOODS: Yes, I understand your point on that. The second - when you were reflecting on situations in rural areas and you were talking about the distances that can occur between a spouse and their partner who is now in a nursing home, and that that can lead to a lot of dislocation and separation which adds to the trauma during that period - I note to some extent that that also can occur in metropolitan areas where there are insufficient vacancies or insufficient homes willing to take that particular profile of patient, of resident, in one area requiring relocation somewhere well out of the community and particularly out of reach of public transport in the sense that public transport isn't designed always to just go neatly between homes and nursing homes.

Quite often the journey is quite long and disrupted and making it virtually impossible to achieve. But I also note at the other end of the extreme, we have witnessed ourselves situations in some of the more rural and remote areas where residents may be based in communities that are some 5 to 700 kilometres away which causes not only physical separation, but the process of becoming a resident in a nursing home can also create a very strong cultural dislocation. I was very admiring of those nursing and personal carer staff who I talked to and met within those situations, and with residents, as to the efforts they go to ameliorate those impacts. So there are a range of dislocations in the physical sense throughout the spectrum unfortunately.

MR PRICE: I think the dislocation that I really want to make clear is the fact that the hospital discharge policy will often be the triggering factor, and that the choice is taken away from the resident and the family and if there's no bed available locally, the person is sort of slingshotted to whatever available bed there is, and the system sometimes just doesn't work because like I say, there mightn't be adequate public transport. It might be 70 kilometres away, they might only visit once or twice a week when they should be there every day if they choose to be.

MR WOODS: Is that in part in situations where the notice given to the intending resident and their family by the hospital can be on very short notice, and there's no predicability about when that occurs and very little flexibility in recognising those circumstances. I mean, is that somewhat behind what you're saying?

MR PRICE: I think there's a power imbalance that's exploited to its full degree.

MR WOODS: Are you suggesting those who can discharge have more power than those who then have to go forth and find - - -

MR PRICE: Unless someone is particularly enlightened to defend their own case that's quite often what happens and we're left to pick up the pieces.

MR WOODS: Thank you. I appreciate your evidence on that point. You made a reference that I wouldn't mind understanding a little further. In the acute care sector you talked about the system of failure. I just wasn't quite sure which bits of the system you were referring to in particular. Could you elaborate on that? This was in relation to the discharge policy and the rehabilitation policy but you used the phrase "system failure".

MR PRICE: Okay, fine. Yes.

MR WOODS: The system is a big thing and I am just wondering what are the bits of the system that you - - -

MR PRICE: Typically the rehabilitation process would refer to post-surgical or post-acute medical such as hip replacement or a stroke, and quite often they can be of such a magnitude and there can be so many other co-morbidities that the person, even in a really intensive rehabilitation environment, simply cannot be rehabilitated, and there is no hope that they can go back to their house. So there is no real opportunity for that type of person to be rehabilitated in the nursing home sector. The facility where I work have a hydrotherapy pool which the community actually use as well, so we do try to implement the requirements of seamless care so people can be discharged from hospital to their home and still participate in rehabilitation programs from the community. I think in the nursing home context, unless a facility gears itself towards a market niche that they can provide rehabilitation to fast-track people back to the community, most of the rehabilitation which occurs in the aged care sector is more of a maintenance-type rehabilitation.

MR WOODS: Stabilisation.

MR PRICE: Yes. It's more to do, in my view, with quality of life. The simple joy that someone who has lost the ability to walk for the last few months can be rehabilitated to the level where they can take a few steps, and that's a milestone achievement for that person.

MR WOODS: Is there in your view some way of addressing, however, this figure raised by the previous witness, that showed up in one particular study in Victoria, of 30 per cent of residents dying within 4 days of being located to a nursing home or long care environment?

MR PRICE: I believe it's a symptom of system malfunction that occurs. I believe

the pressure must be so enormous on the hospital beds that they've got no choice but to discharge. I think it's inappropriate that people should be discharged to an environment such as a nursing home with the prognosis that they'll die within a few days. I believe that nursing homes shouldn't exist for that function, unless again they cater for a niche part of the market and set themselves up as a sort of hospice-type environment. I can't explain that. I have seen it on a smaller scale from time to time and it's always generated by the pressure on the hospital beds, not by the facility wanting to take the residents.

MR WOODS: So admission back into a general ward is not seen as a solution in those situations, or the hospital just doesn't have the financial capacity to allow that.

MR PRICE: I think the hospital just hasn't got the beds to start with, so that's why the nursing home will take people. But the nursing home, unless like I say, it caters for a niche market to meet that particular need, it will not openly take people in order to have them expire within a few days because it's not the right thing by the other residents because it's a homelike environment, and it's not a very homelike environment if you have a major influx of people who die within a few days.

MR WOODS: It is showing up the point that has been brought to my attention on a number of occasions, of the increasing palliative care nature of nursing homes now compared to a decade or so ago.

MR PRICE: Yes. I think Julienne alluded to that point. The average length of stay may decrease but it's got to be put in context of the average age of residents coming in, and with the co-morbidity that she spoke about, the likelihood that they will be develop some sort of cancer or some sort of advanced Alzheimer's where they will require palliative care, and because they are ageing-in-place, it's not the right thing to send them to a hospital say or somewhere else. We should hold them where they are and provide that specialised care. Like I say, in our particular facility we've gone out of our way to buy a lot of equipment to facilitate that process, and it's better for the resident in the family that that person dies in an environment that they're accustomed to.

MR WOODS: You suggest in your November submission that the non-acquittal of expenditure of nursing salaries against subsidies is a possible contributing factor to some of the difficulties that have emerged in the sector. My concern with such an approach, both of identifying a component of a subsidy and then going through an acquittal process, is that that in itself can cause resources to be allocated for the purpose of being seen to be spent against that particular line item rather than resources being directed to the best interests of resident care. Can you explore that trade-off for me in your own mind between identification of a component and its acquittal, which is a two-part process creating even greater rigidity in the system, versus the DON and management coming to a collective view on what is the best interests of the patient, the resident?

MR PRICE: If I may be so brave as to say - - -

MR WOODS: As long as you remember that it's on evidence and it's being recorded, you may be brave.

MR PRICE: - - - - there is a possibility that employer groups may have different agendas, apart from resident care, and that they can be profit-taking agendas.

MR WOODS: There is a private for profit sector operating in nursing homes?

MR PRICE: Irregardless of the sector I think there is a business ethos in place in any form of management in order to drive home higher profits, and the acquittal process is a very firm safeguard for that. It may not have to go to the extent that it's a full-blown acquittal process, but I believe there should be some sort of - as I referred to - some sort of non-mandatory benchmark that gives the facility some guidance as to how they can allocate funds to - industry benchmarks which are context specific to the size of the facility and where it's located; the type of facility it is, whether it's a major church group or whether it's a small stand-alone. Rather than just rely on the accreditation process to drive that, I think there's the risk that without some sort of guiding framework, assets can be stripped away and put in the profit side of the equation and taken away from the resident care side.

MR WOODS: You pursued the question of having an indicative benchmark which I see as one step back from bounding a particular part of the bucket and then also requiring its acquittal against that allocation. Do you have in mind, or can draw upon a particular benchmark? If I can give some elaboration to the question: in going through a subsidy design process the commission sees it as important to ensure the quality of care, and equity has been identified as our primary principle over and above efficiency and others, although they also have an important part. But in so doing we want to identify a bundle of inputs, to calculate an average cost of those, but to ensure that those inputs are appropriate to causing an output that is an acceptable quality of care, and then having a process whereby the government in choosing the output price that it offers to homes is transparently related to what that process of devising an input bundle would be. But it does require and presume that there is some way of assessing whether such a calculation would produce appropriate care.

Now, we are aware of the accreditation process that is being developed. You have indicated some measure of uncertainty - that may be the right word - as to whether that is sufficiently robust or comprehensive, or even accurate perhaps, to provide that benchmark. But are there other benchmarks that you can draw upon or must we rely on the accreditation process?

MR PRICE: I think it's naive to rely on the accreditation process, particularly as there's no feedback about how effective it is. I can speak from the experience of having completed the assessor course, and my view is - I am very dubious about the fact that the two assessors can go into a facility and come out with a comprehensive analysis of how effective the quality really is. I think they can get sort of like an overview of what it's like but they can't have a nitty-gritty idea. I put the benchmark

which I speak about in context of that assessing process, that if there are perceived problems and there are benchmarks available which have not been followed at all, then there may be some relationship between the two.

At the end of the day we're after the best quality of care for the residents, and I just see that the temptation may be there to go and create this mirage effect of quality which meanwhile assets are being stripped away from the resident, and without some sort of guiding factor as to how to produce a template of what provides good quality in terms of an input benchmark, then I just think it should just be there in the background, either that or it does go to the next step of acquittal and we've been down that pathway, and I think that maybe some sort of hybrid system where it's available and where there's proven noncompliance with quality, then the benchmark can be invoked.

MR WOODS: But the noncompliance with quality would always need to be assessed at the output side of the formula not at the input side, because at the moment the system is very input-driven and I would welcome your views on whether that process has in itself led to a diversity of levels of care between homes or, in fact, has it produced a standard common sound quality of care. Are there homes that produce a greater quality of care than other homes even within the same funding levels and in similar circumstances?

MR PRICE: I believe that's probably the case. I can't cite any evidence, but I'm certain that if I was to research the matter that you would find from the previous outcome standard surveys that there was a wide variation. You've got to bear in mind that the funding levels in terms of the resident care side, haven't really changed and, like I said, that the amount of outcomes were 21 and now they're 44, so I just think that what facilities are tending to do is to reallocate their resources and they are, to some degree, reallocating them away from the resident in order to set up system frameworks which have yet to be proven in terms of what quality they produce.

MR WOODS: Yes. But if I can take two points from that. One is that despite a common level of funding, quality of care can differ between homes, which suggests there's something else in the mix that is generating that, not just dollars. The second point is more then to say if the accreditation process in your view has the potential in some circumstances to create "a mirage" - I think was your phrase - of care that may not be well-founded underneath, is that therefore a plea to change or modify the accreditation process? You ultimately have to rely on the outputs, you have to rely on fundamentally what is the quality of care being delivered as your ultimate test. How do you measure that if the accreditation process isn't going to do that fully and properly? What can we rely on?

MR PRICE: I think there would be a battery of techniques that could be used.

MR WOODS: Does that mean 424 should become a hundred or something?

MR PRICE: That tends to be the trend. Like I say, we're seeing the RCI to turn

into the expanded RCS. We've seen the outcome standards expand into the accreditation framework. At the end of the day, we can wind up with an - - -

MR WOODS: I'm just worried that your phrasing "battery of tests" may encourage along that line. But what do we rely on? How can you ultimately determine whether the quality of care being delivered in a particular nursing home is that which is most appropriate for the residents?

MR PRICE: As I say, I think there are probably a battery of techniques that could be used and I believe that some research would need to be done and I think some sampling of different-type facilities in different areas which are more in-depth rather than superficial and I believe the accreditation framework, in terms of its assessment component by the agency, will be fairly superficial, given the amount of time they spend. It's relying on the organisation to self-appraise and to put action plans in place and whatever and there aren't really any benchmarks to follow. There are guiding criteria, but there aren't any specific industry benchmarks to say, "This is the level of falls which we would accept," and so at this stage, it's hard to really give a concrete answer on that, but I think that the industry should be looking to adopt, like I say, a range of research methods which can identify specific benchmarks which can give more accurate information at the output side of things.

MR WOODS: And your views on the accreditation? If you could just remind me of your level of understanding and involvement in it to date.

MR PRICE: I've been involved in the previous system on several occasions on the receiving end.

MR WOODS: As a DON in a nursing home?

MR PRICE: Yes. I've studied at university the principles of total quality management, total quality improvement, and several years ago, I believe I was fairly vocal about the fact that we should have accreditation processes in place in the aged care sector and, as I say, I've been involved in the aged care assessor training side of things and seen how the framework was set up and I've been out amongst the workplaces and seen how people are reacting to it and they are reacting to it differently, which isn't necessarily a bad thing, but I tend to think at the moment the industry has got two extremes it's following: it's got at one end an extreme where there's nothing to worry about and everyone will breeze through and at the other extreme is that it's panic-station time and we've got to change the whole organisation, and this is where I say the threat for resident care in the interim period is, that people have taken resources away from the resident and put people in offices to sit down and develop program booklets and whatever.

MR WOODS: Thank you. Which would also pick up the comment about the process in your view generating more middle management level staff, which you made in your submission of September.

MR PRICE: Yes.

MR WOODS: I noted that comment in particular. Are there other matters? You make some matters in relation to overall quantum of funding and you will have noted that my terms of reference don't extend to that particular issue. Nonetheless, we have gained an appreciation of it, so that we understand the context in which this inquiry is being placed. You make reference in several instances in your submissions to the unique differences between states and territories and rural and remote you identified, I think we've explored sufficiently, and depressive ageing-in-place in one's own community. The unique differences between states and territories, there are unique differences in many respects. They relate to wage rates, they relate to the mix of staff employed, they relate to workers compensation premiums.

They relate to the distribution of homes throughout the state or territory and the proportion that are smaller homes or larger homes. Some of those factors cause one state to have a higher cost structure than another. Other factors cause a different state to have a higher cost structure. There is no one overall state or territory that is highest in all of that range. My concern is that when you add to that any examination of cost structures over time, that in fact even the rankings of states changes according to, for instance, who may have recently achieved a wage rate outcome through a bargaining process, so there is considerable flux and balancing that if you bring all of these issues together, which Aged Care Australia - as one witness attempted to do through a study process, you find that using those figures to illustrate the point that you would, if you had a national subsidy, that the deviation from that would be only in the order of 2 to 3 per cent either side.

Now, we note from other evidence that, in fact, if you look at the financial performance of homes who are similarly funded in similar circumstances, they can themselves produce different financial outcomes of a greater magnitude than that, so there are a number of factors that can cause such an outcome and, with accreditation or pursuing your further exploration of that, hopefully they are only homes that produce an acceptable quality of care. The issue that I'm grappling with here is do you then recognise not only the variations between states - the net variations, not for any one cost component, but netting all things together - and recognise that volatility in that some will go up and down more than others at different times - or up and up, there are not too many downs - or do you pursue a national rate, but then try and catch those who fall significantly out of it, as we have suggested here for the rural and remote sector? I'd appreciate any comments on that issue.

MR PRICE: I believe that there are disparities between the states and I just find it difficult to reconcile how they can be coalesced into a uniform rate with offset provisions, which gets back to the issue I raised earlier about a mechanism for driving a wedge between parity, because the rates set in each state are state awards and I can't - - -

MR WOODS: That's the wage rates that are set.

MR PRICE: Yes.

MR WOODS: As distinct from the subsidy rates, which produce a totally different pattern.

MR PRICE: Yes. But they feed into that process.

MR WOODS: They certainly constrain the process, yes.

MR PRICE: I'm just concerned that the end product does not disadvantage the aged care sector in terms of being able to attract good quality registered staff.

MR WOODS: I understand that. And that's a process of ensuring that there is a transparent development of an appropriate input bundle and a proper costing of that and a transparency in between that process and the price that government chooses then to pay for different RCS outputs, but it doesn't cause me to necessarily conclude that a current variation of 2 to 3 per cent, either side of a national average, is sufficient - particularly as there are then dynamics within that and changes in relativities - to create a state level subsidy rather than a national level subsidy. To ensure that the subsidy is the right amount doesn't cause me to therefore conclude that it must be state based. It's a matter of how big is the variation either side and whether that is significant in the overall process and not only significant now, but significant over time.

MR PRICE: I realise there are time constraints before the report has to wind up, but I'm just a little bit sceptical about some of the reports that have been put to the commission in terms of how were the sampling processes done in terms of what organisations were selected and did such sampling skew the results in the interests of the proprietors, who I've gone on the record as saying may have different agendas, so it is difficult for me to answer that. I just want it on the record that I have concerns that in the long run it can affect the viability of attracting good quality staff and I would just wonder if we were in a different room elsewhere and we were looking at issues of uniform subsidy rates across the nation for the provision of other health services, and how it would be perceived to influence the pay rates, say of the acute care sector nursing establishments, and how they'd react.

MR WOODS: If you do have any further reflections on that and recognising my reporting date, I would welcome a comment.

MR PRICE: Okay.

MR WOODS: Are there other matters that you wish to put before the commission while you're currently giving evidence?

MR PRICE: I just believe that we should continue to move towards a seamless care delivery and I think there are other strategies for improving productivity. I've been in another forum before and made this clear, that I think there are benchmarks in terms

of, for example, pooling together purchasing arrangements between facilities, particularly in rural areas, where they can make efficiencies in terms of bidding for the lowest supplier. They tend to go it alone at this stage. I think that there are some economies to be made there and I just believe, in summary, that the aged in society are generally marginalised by the wider society and that whatever you come up in your final analysis should make sure that aged care is not marginalised by the health society. Thank you.

MR WOODS: Thank you very much for your evidence. I propose a very brief adjournment.

MR WOODS: Thank you. I will resume the hearing and welcome as witnesses the New South Wales Nursing Association and other witnesses who are coming in under that umbrella. Could you each state, please, your name and the organisation which you represent?

MS MA: Janet Ma. I'm a professional officer of the New South Wales Nurses Association.

MS DAVIES: Kath Davies. I'm director of nursing, Anita Villa Nursing Home, Katoomba.

MS OATES: Rosemary Oates. I'm the executive director of nursing for the Columbia Quality Care Group in Sydney.

MS JENKINS: Elizabeth Jenkins. I'm the director of nursing, Hilton Nursing Home, Armidale.

MS PROWSE: Dianne Prowse. I'm the director of nursing at Nazareth House, Tamworth.

MR WOODS: Thank you and welcome. I appreciate the efforts that you've gone to to have before the commission in this inquiry a range of expertise to support your submissions. So thank you all for coming along to this particular hearing. Before I invite you to make a comment, can I just note to this hearing that in our adjournment break I was speaking to people from Quirindi and Coonabarabran and exploring some of the rural issues that they were facing and I found that not only interesting but useful for the inquiry which reinforces the benefit of coming to somewhere like Tamworth to get that experience from those operating in the region. So thanks to those as well. Would you like to make an opening statement?

MS MA: Yes. The way we wish to present our presentation is I do a brief introduction but I won't read through our whole submission because it's already in written form for the commissioner, and I will sum up the issues that we want a response, and I will highlight the issues that we are concerned, and I will hand over to my colleague that have a different perspective from different nursing home. In that way we can allow the opportunity for the commissioner to gain full insight - as he requested at the Melbourne public hearing, that he would like to gain more insight from director of nursing, and I fulfilled that by inviting four directors of nursing to come along with me today.

To start, on behalf of the Nurses Association I'd like to thank the commissioner for holding the public hearing in New South Wales, and also giving us the opportunity to respond to his position paper. The association is the professional and industrial body which represents all nurses in New South Wales. The association is also the New South Wales branch of the Australian Nursing Federation. Association membership includes director of nursing, registered nurses, enrolled nurses and assistants in nursing. The association has consulted widely within our membership in

the preparation of this response and our response is structured to address the 13 preliminary proposals outlined by the Productivity Commission in their position paper.

Our general comments: the association strongly supports the position taken by the Productivity Commission that equity of access to quality aged care must be the main criterion for assessing alternative subsidy regimes. The association also supports efficient and responsive service provision; elimination of unnecessary administrative cost and a transparent system, and then we respond to the 13 proposals one by one, which I have no intention to read it out.

MR WOODS: I note for the record that we have that material before us and I will draw on that in any questions. Thank you.

MS MA: Right, okay. In summary, the association supports the provision of a nationally consistent quality of care for residents of aged care facilities. It is our view that any funding methodology must be sufficient in quantum to allow a nationally consistent quality of care to be achieved. It must be cost-sensitive and vary to the extent that costs vary between jurisdictions and must be reviewed and adjusted regularly. Urgent adjustment must be made to those states and territories currently receiving inadequate daily subsidies. However, additional funding should be used for this purpose, not funds earmarked for indexation. Any funding methodology must take into account the additional cost burden for service providers of meeting accreditation and certification requirements, including the education and training needs of staff to meet accreditation standards. Concepts such as benchmark level of care, efficient size facility, and average input mix need careful definition and research. Following on the previous two presentations, I would like to highlight the issues of benchmark level of care and efficient size facility and also input mix.

We believe accreditation is the first step towards the right direction. However, there are many issues we need to consider seriously. We are aware accreditation should take place in 2 years' time. All facilities need to be accredited by January 2001. The actual accreditation will actually not start until early next year, so that gives us 2 years exactly to conduct a survey of aged care facilities. In New South Wales alone there are around a thousand facilities; that is nursing home and hostel. Even if the agencies working Christmas week and Easter week, they have to survey 10 facilities in each week, and each facility on average will take 2 days to survey. So to start off there are problems in the time-line to survey every facility by the year 2001. So that's the first issue we're looking at.

The second issue: in the standards of care, when I look at it, the terms used, "output" and "outcomes" seem to be use quite loosely. We are talking about an aged population, and I personally believe when we look at health and personal care, we need to differentiate the term "output" because we're not talking about a factory product here. We should use the term "health outcome". I noticed previously the commissioner asked a question, "How do we measure that outcome?"

Yes, there are ways to measure outcomes. To measure health outcomes is actually to measure the health status of an individual or a group. That is attributable to a particular intervention or a particular health service. To measure that you can use health outcome indicators; that is statistics or a unit of information that you can measure directly or indirectly: what is the effect of the care that the individual receives or the whole population receive? That is the way in acute care centres, where they're moving now in the last 5 years, where in the acute sector they have funding on performance agreements. They also have health outcome indicators to measure whether that input balances up.

What concerns us is in our position paper we talk about input mix, we talk about benchmark level of care but we actually haven't got the strategy in place to measure the quality of care, and that is our concern, despite the other initial teething problems with accreditation. When we talk about benchmark, what are we benchmarking with, if we haven't actually got indicators to look at. So initially I think there will be a fair bit of problem in acute sector. Now, they're just starting to use health outcome indicators to measure the effect of a particular health service or intervention. They had technology information in place for many years and they're still finding a lot of problems with data issues.

In aged care facilities, number 1, there is no data to measure health outcomes at this moment and technology information is not there at this stage. So all I'm trying to highlight is it won't take a long time to get to that measurement. ACHS is a facility that survey most of the acute care facilities and it has taken them 20 years to develop quality care indicators and those indicators are now being validated and look at how reliable they are? Are they actually measuring what they're supposed to measure? That links on to my next question on efficient size facility. Where does that efficiency definition come from? Are we only looking at input? and again that links back to all my previous comments. I now hand over to my colleague.

MR WOODS: Thank you very much.

MS DAVIES: Mrs Kath Davies, director of nursing, Anita Villa Nursing Home. I would like to outline, Mr Commissioner, firstly our appreciation for the opportunity to talk with you today and present some information. I've been a nurse for well in excess of 30 years now. I started out in general nursing, I also have a degree in psychiatry, I have also a degree in health sciences and through benefit of study at the College of Nursing, gerontology. So I feel I have some background to give this information.

Over a period of many years care of the older person in Australia was finally recognised as a legitimate specialty only 16 years or so ago. It was an area of health care considered to be of least importance and the efforts of those involved were largely unrecognised and unrewarded. The industry has endeavoured to overcome years of neglect and move forward. In the position paper of November 1998 on nursing home subsidies, it states that currently just over 100,000 are employed in nursing homes, mostly providing nursing and personal care for the stated

72½ thousand people accommodated.

Despite the major changes included in the aged care reform strategies, expected sustainability is not occurring. Funding remains inequitable and has remained underfunded since 1987. The problems currently experienced are widespread, largely due to the fact of compounding errors committed by the Department of Health and Family Services, consistently hampering facilities. While the range of supplements may be added to the basic care subsidies, these compounding errors have an resounding effect on sustaining and maintaining even a basic level of service.

In addition, the many changes experienced over the past 13 months have produced a unprecedented level of workplace stress. As a result ad hoc figures discussed earlier this year in the Blue Mountains area suggest a 30 per cent loss of experienced professional senior nursing staff. If those ad hoc figures are even close to accurate, then the aged care sector is indeed in a state of crisis. There are also reported attempts of suicide, some of which have been successful. No industry could sustain this exceptional loss. The stresses associated with these changes are not only suffered by nursing staff but throughout the industry at all levels, and this may be an indication of an even higher loss of experienced workers.

From a personal and professional point of view, I believe an urgent inquiry and attention is indicated in this matter. The predicted demands over the next 12 years will require a significantly larger workforce. If we are already experiencing such high loss of experienced people, how will we prepare for the future and how can quality care be achieved? The accreditation process alone will not solve or be the solution to the provision of quality equitable care. This process needs to flow along a continuum. You can't have a hump in the middle of a continuum from which accreditation springs. It must flow along that continuum.

The current rates of employment are also a factor for consideration of future care needs. Regardless of other factors there is no doubt the proportion of Australians over 70 years of age will double by 2011, and those over 80 years of age will triple. If the Australian Institute of Health and Welfare has examined the impact of these changes on future care demand and an extra 12½ thousand beds are required by 2011, how can this industry continue to operate under current conditions? The expectation that this industry can continue to do more with less, provide increased services, upgrade or build new facilities, educate and sustain high accreditation costs by 2001 is totally unrealistic. Any further changes require careful analysis and consideration with realistic performance-based time-frames. Thank you.

MR WOODS: Thank you. Are there further comments?

MS OATES: I'm Rosemary Oates. As already indicated I have the unique position of being an executive director of nursing for a private company who run five facilities across Sydney of varying sizes. So I guess we not only look at different areas but certainly different types of facility. I have actually been in aged care since 1970 and I've been a director of nursing for some 25 years now. Having been in a 40-bed

facility I then moved for 20 years into a 300-bed church run facility and 5½ years ago I made the quantum leap into the corporate world of the private sector in my current position.

There have been many changes, and I guess I've got some advantage of seeing the changes over this huge period of time. I've also had the experience of taking four aged care facilities and one private hospital through the ACHS accreditation process, the most recent being three of our own facilities who succeeded in being surveyed last year and achieved full accreditation with the ACHS, being three of six facilities in New South Wales to have achieved this goal. So I guess I can speak with some authority on the process of accreditation. Given that it's the ACHS process, which certainly is not applicable necessarily to aged care, but the concept itself can be easily applied.

On that subject, just going on from what Janet indicated, that certainly clinical indicators are terribly important in terms of providing benchmarks for care, and in the aged care sector, at this stage, we haven't come of age to have developed such indicators. The ACHS are currently working on those and we're told that it takes some 3 years to actually develop an indicator, so the amount of data required and the amount of work to be done is still ahead of us in that. We're very much in the infancy of that process. As an organisation, we have started that process and we've been looking at issues which may be utilised as appropriate performance indicators and care indicators for the purposes of our own benchmarking, particularly between our facilities.

We have the advantage of being able to network and that in itself is a great advantage. I guess the issues that I would like to just very briefly touch on is certainly to confirm the issues in relation to the general frailty of residents that we're seeing now, compared with even 5 years ago. Procedures such as dialysis, enteral feeding and intravenous therapy were procedures which we very rarely saw in the nursing home industry 5 years ago. That is now becoming fairly commonplace and that's quite apart from certainly the early discharge from hospital post-surgery, which of course adds to the pressure and the resources that we're able to offer. Staff wastage is certainly a very large issue, particularly in relation to the stresses which are occurring in this day and age and, of course, everybody talks about stress.

I would contend that there's probably no such thing, that most people need to be stressed enough to get out of bed in the morning, but what one defines as stress is certainly talked about very loosely and we certainly have a situation where it is a reasonable workers compensation claim these days for people to in fact get stressed and then plead that they have a workers compensation claim, which may or may not be accepted. Certainly, the high level of unskilled staff that we are forced to employ creates extra pressure on the registered staff that we do have and, together with that, of course, are the issues of legal liability.

The litigation process is very rife in Australia at the moment; we're becoming very Americanised in that area. The Health Care Complaints Commission would

indicate that the level of complaints has increased markedly and if one analyses those complaints, many of those come from the aged care sector, where relatives see the Health Care Complaints Commission as first port of call, rather than trying to sit down and talk about issues which are of concern, and all of these things add to the pressures that we're confronting today, compared with maybe the way it was some time ago.

There has certainly in the last 12 months been income problems in relation to nursing homes. We ourselves did a study on the actual income on the quarter July to September last year, compared with July to September this year, and on one of our facilities alone - this is in relation to the process of the RCS compared with the old RCI - there was a $140,000 difference in the actual income obtained on the new funding levels. That, together with a 1 per cent overall reduction in occupancy, because of the changes that have occurred and the confusion out there in the community and the ACAT teams and all of those issues, has in fact produced extra pressure on facilities to remain viable.

Of course, extra documentation requirements and staff trying to get their heads around those sorts of issues - and I've already talked about the legal liability, workers comp situation is becoming a huge problem - and I can't overestimate that - in that the requirement to have very formal rehabilitation programs and the support that is required for people who report injuries are all of concern and maybe I can leave it there, commissioner, and I'll be happy to answer any questions.

MR WOODS: Thank you, some could arise out of that. Thank you very much for that.

MS JENKINS: I am Elizabeth Jenkins. I am the director of nursing of the Hilton Nursing Home in Armidale. It's a 64-bed nursing home, privately owned by a single proprietor, and I've been in that position now for 5 years. Prior to that, I was actually the manager of a health centre of a very small community, about 800 residents in the town itself, but with a catchment area of several thousand. We had no resident doctor and at that time, it was probably what would now be termed a multipurpose centre, before that term was actually coined. It worked very effectively for that particular situation. However, here today, I would like to speak of some of the issues that we have for our facility in Armidale, which of course is a much bigger centre than what I was working in prior.

I believe the emphasis on the high dependence of the people who are coming to us now - I agree with Rosemary, the change that there's been just in the last 5 years has been absolutely huge in the level of dependence that we're seeing with the people coming to us now. Therefore, their length of stay has decreased drastically. I think the inherent demands that that has created on our staff, both at a physical and emotional level, cannot actually be quantified. I think also the issues that we are now addressing, quite appropriately I believe, in the aged care sector of both palliative care and rehabilitation, do not happen without an extreme cost, once again both financially and at an physical and emotional level.

I have particular concerns for something which does not seem to have appeared in the papers and that's the cost of allied health services, which I personally have accessed at our facility quite extensively in the past, and I find myself now looking at those and wondering whether I can actually justify those, because to do so would be at the cost of nursing and personal care hours. When I talk of allied health services, I refer to things like dental hygiene; dietary assessment and input; podiatry, which while recognised as being a service that we must provide, would probably in the past have been provided more extensively than I'm now able to justify.

I agree the issue of workers compensation to be a huge issue in our sector. I don't think it matters what measures we put in place - and we personally have put a lot of funds and training into the area of occupational health and safety - the one thing that we are never going to be able to overcome in aged care is that we are often dealing with a non-compliant group of people. If you're working in the acute sector, your patients basically want to help you. In aged care, often you are dealing with people with a high degree of dementia. You can have staff doing everything possible, everything correctly, and at precisely the wrong time, a resident will do the wrong thing and, no matter what things you have in place, an injury will occur, and we have experienced this at Hilton. Our costs of claims quadrupled in 12 months and the cost of that, of course, as the system goes, was carried on. I believe the measures that were put in place actually brought our premiums down, but the issue of workers compensation must be addressed and addressed appropriately, not across the board nationally but on an individual state-by-state basis.

Regarding the issue of acquittal, I have to confess as a director of nursing, I had some concerns when that side of things was taken away. I would have to say that in sitting down with our proprietor and discussing that quite openly and frankly, there has been no change to my staff ratios whatsoever with the abolition of the acquittal process. I think it has freed up funds probably quite appropriately, but I would have to say on the funding issue and relevant to the RCS, while our funding has not decreased, it has not decreased because of an enormous amount of work that my staff have put into the whole documentation process in ensuring that our categories are correct and therefore appropriately funded.

Now, I would have liked to have said that in the past, the fact that people coming at a higher level of dependence and therefore requiring higher care needs and therefore coming into higher categories, would have actually given me more money. In actual fact, we're probably just breaking even under the new process. I believe the expectations of people coming to nursing homes these days, both the residents themselves and their families, have increased and I believe that's quite appropriate, both the expectations of the care provided and in the aesthetics of the environment in which they live, but those things aren't achieved with a cost and I think that cost has to be recognised. That's all I have to say, thank you.

MR WOODS: Thank you. That was very helpful. Final contribution?

MS PROWSE: My name is Dianne Prowse. I'm the director of nursing at Nazareth House here in Tamworth. It is a 23-bed nursing home, co-located with a 97-bed hostel. I'm employed by the Poor Sisters of Nazareth. The main problems that we experience in our facility is the ability to gain and retain trained staff. One of the difficulties of living and working in a remote or rural area is that you have difficulty getting those staff because it is seen to be of lesser importance to work in an aged care facility rather than the acute care set-up. My experience as a director of nursing is something close to 14 years. For the first 11 years I worked in the acute sector in both the public and private areas and the last 17 months have been in aged care. I see aged care as being suitable end care for a human being as they get near the last days of their life.

I would not like to see that undertaken by staff who are inappropriately trained or educated in that concept of nursing. It is very important that with the increasingly aged and frail people that we are looking after - and this has been spoken about previously by my colleagues on this bench - that with the high level of frailty and the longer times they are living, it is necessary that we provide for them a high level of care. Going along with that, I agree with the concept of accreditation. I have gone through about four processes of accreditation with the ACHS program and I see that on the whole as a very good process. At the moment, one of the speakers previously said that they had a lot of high turnover in their nursing home. That is not my experience. In the last 17 months, I have about 40 per cent of residents who were there the day I came to the facility. It's just that they are being well-cared for and living longer, not necessarily in better health, although every opportunity has been given them to provide an excellence of care.

The cost of education in remote and rural areas is a big problem. If you take someone out of the facility and send them away for a day's education or 2 days' education, you are confronted with the cost of either plane travel or reimbursing for car travel, as well as replacing them at their duty place. Sometimes the areas to get to are just too far away or not conveniently located, so that they can be accessed by plane travel especially. Workers compensation, I agree with Elizabeth. There's a big problem. I was proud to say, up until yesterday actually, that I'd only had one case of workers compensation.

We spend a lot of time and money educating our staff in back care and occupational health and safety standards, but it is inevitable, as Elizabeth stated, that somewhere along the line something is going to happen and therefore a case for workers compensation will be forwarded to you. I think that's all I have to say at this stage, thank you.

MR WOODS: Thank you very much. And can I say I appreciate not only the diversity of information that has come, but that it has come from people with long experience and history in this area and that's very valuable. Can I pick up a couple of issues out of the introductory comments and then we can go back to both the submission that you've prepared jointly with the college and, as I've been able to quickly address it, your views on some of the individual proposals. There was

reference to the difficulties in rural areas of gaining and retaining staff. Is there a hierarchy of difficulty, the greatest difficulty at the RN-type level and then, if you look at the assistants in nursing, that you find you do draw more on your local pool of employment for that form of labour? If so, does the level or the nature of the staff position change in terms of difficulty of recruitment and retention?

MS PROWSE: I believe it does. I think that it is more difficult to gain enrolled nurses. It's usually relatively easy to employ a registered nurse, but she probably does not have any experience in gerontological care and she probably doesn't want to work any more than a couple of days a week, so getting someone to work a full roster or even the majority of a week is very very difficult out here. We do not have agencies to employ staff from in the rural areas. Usually when people want some employment they approach the facility where they desire to be employed on their own and make their acquaintance. Sometimes those people might be working between two or three facilities in order to gain their employment.

MR WOODS: But at the EN level you're saying is the greatest difficulty - - -

MS PROWSE: Yes.

MR WOODS: - - - and is the least difficulty at the AIN type level or at the RN level?

MS PROWSE: I think my experience is that you would have similar difficulties gaining AINs and RNs, but more difficulty gaining ENs.

MS JENKINS: Could I just make a comment there. I actually agree with Dianne. I would just like to make a comment though at AIN level. I have a couple of staff members still at Hilton who have been there for over 20 years. Now, they're brilliant nurses, but we are no longer seeing people coming into our industry who are going to be there in 20 years' time, and that is to do with the sheer physical hard work that we expect of them on a day-to-day basis. I will no longer employ any assistant in nursing in a full-time capacity because I consider the work to be too hard to be working in a full-time capacity.

MR WOODS: I've noted various statistics which show a very high part-time labour force, but I also note that up to 22 per cent of employees are employed on a casual basis. Is that the right sort of statistic in country areas or is that more a peculiarity of metropolitan areas to have such a high casual staff rate?

MS PROWSE: In my facility I am the only full-time employee and I am the only one who wants to be. The others will not work any more than 3 or 4 days because they find it - as Elizabeth has said - very demanding physically.

MR WOODS: But are the others primarily permanent part-time rather than casual?

MS PROWSE: Yes, they are.

MS DAVIES: The largest part of my workforce is certainly permanent part-time, and certainly if I have inherited full-time assistants in nursing and they depart the facility for one reason or another, I certainly do not replace that full-time position with another full-time, I split it, again for the same reason, that it is extremely difficult work, not only physically but emotionally and mentally, and if you're working with people who have extensive behavioural management problems as well as the physical stresses, then you cannot expect that a full-time worker is going to avoid major injury.

MR WOODS: Others?

MS OATES: Yes, I've had a somewhat different experience, I guess. Our facilities are very large. We've got 146, 104 and 113 beds and we've just acquired one 64-bed and one 50-bed facility. By and large our employment pattern is that the majority of our staff are full-time. However, some years ago - in excess of 5 years ago, I took the step of looking at rosters, looking at the actual workload planning, which happens to be a bit of an interest of mine, because I think we constantly have to look at how we can do things a bit smarter rather than working harder, and I know that's a bit of a worn-out cliche, but it is a fact.

Our full-time staff actually work over 4 days. They do a 9½-hour day and therefore have a clear 38-hour week. The reason for that is that I believe they then are able to have 3 days off every week. That extra day off per week is an incentive in relation to the actual reduction of fatigue levels, and it also has an effect - we've had a marked effect of reducing sick leave and absenteeism since we implemented this program. Permanent part-time staff, of which we do have some, still work an 8-hour or less shift per day and we do have some casual staff, although in the city areas once again we have an overall shortage of quality skilled staff generally, whether that's AINs - we hardly see any ENs, and that's been since the EN programs went into the TAFE colleges. We've had marked reduction in that category of staff.

RN shortage is just incredible at the moment in the city areas, and we're not seeing the new graduates coming through having a choice or having aged care as an option. So that in itself is producing serious problems in relation to our quality and skilled staff, and, as I said, we're bending over backwards in an attempt to have a look at what we're doing to in fact do all sorts of things to make life not only more interesting but rewarding and certainly reducing that incredibly fatiguing physical workload, which is quite an issue.

MS DAVIES: I believe that already information has been given to the commission regarding the 8 per cent reduction in trainees.

MR WOODS: Across what's happening in - Ms Jenkins?

MS JENKINS: Just a comment on the casual aspect of a percentage of our employees: I think our very funding structure almost insists that we keep a component of our employees casual so that we actually have the flexibility within

those numbers to actually go up and down as we need to do. Once again at a personal level in Armidale we are lucky in that we have a university and I access quite a lot of the students from the nursing faculty there on a casual basis.

MR WOODS: Yes, we're aware of the consequences of the current subsidy design feature so that if you're replacing 2 or 3, 1 or 2 category RCSs with a couple of 4s that your income has changed considerably and therefore you need some flexibility in your staffing to adjust to that. Thank you for those comments on that issue. Another one that just picks up a particular focus of rural is the question of the length of stay of residents, and a reference to some residents having been there for at least 17 or 19 months or something, as you were referring, and from personal inspections in other rural environments I've met residents who have been in nursing homes for 8 to 12 years and have been high care for that whole time, which places a different set of strains and circumstances on the staff and on running the facility.

Is that sort of bias more acute in rural and remote than in metropolitan areas? Is that a feature that where the facility is virtually the only option for residential care that you find people who are going in and upon entry are stabilising their food and care and personal care and other things and there is a greater longevity occurring in those circumstances, or does it also occur equally in metropolitan areas but it's just not as talked about?

MS DAVIES: I don't know what the statistics are in rural areas, but certainly over the last 13 months for us we've had 59 admissions during that period. 38 of those admissions were acute. Respite care numbered 16, and the number of deaths 13. It's a fairly high turnover rate in a 13-month period for a nursing home whose turnover rate prior to that was extremely low.

MR WOODS: And is that reflecting the increasing acuity of intake?

MS DAVIES: Yes, it is.

MR WOODS: Others wish to comment?

MS JENKINS: I would just have to agree there with Kath. When I first came to Hilton - and there are still a couple of those people there, residents who've been there for 7, 8 years, but probably looking back on the system that was operating then were probably very inappropriately placed in a nursing home at that time. What we're seeing now I believe is a good assessment in that we're seeing people appropriately placed in nursing homes but inherent with that is that their length of stay is much less. In the last 12 months - I actually haven't any statistics, I'm sorry, but certainly our turnover has been much much greater, and at this particular time in Armidale we have nobody on our waiting list for nursing home placement, and that's the first time, as I understand it, that has ever happened.

MR WOODS: Thank you.

MS OATES: I would agree that the resident turnover we would turn over - and I looked at these statistics just a little while ago - our turnover generally across certainly the three larger homes would be around 45 per cent in each home. Over the year there are a few who actually go home having been on respite care, but the vast majority are certainly in relation to deaths, and it certainly does reflect the general frailty of the residents by the time they get to us, because we're finding that the home care, the care packages and all the other strategies that are put in place actually maintain people for a longer period, so that they are in fact more ill when they get to us, whether it's from home or whether it's via the hospital.

MR WOODS: Ms Prowse, do you want to comment?

MS PROWSE: I can only comment for my home, because of the short time that I've been working in aged care, but I have 100 per cent occupancy all the time, I have a lengthy waiting list, mainly through the hostel, which is 97 beds. I do take from the community on occasions if the needs basis out there is greater than those waiting in the hostel. The people that I am looking after in the nursing home are extremely frail, and those who have been with the nursing home longer than 12 months are mainly bed-bound or completely demented, completely physically frail and need a full standard of nursing care. There is absolutely nothing that they can do for themselves. I only have one gentleman who can walk but a few steps on a daily basis. The rest are either bed or chair-bound.

MR WOODS: Thank you for that.

MS MA: The association conducted a first survey in all nursing homes and hostels at the end of July, and that survey looked at the staff skill mix and the acuity level of the residents, and we intend to do that for over 2 years and follow the trend, and from that survey the comments I receive from the directors of nursing is would I be able to add a question in my next survey to ask about the turnover or length of stay of residents because some of them have been in aged care for a long time. The last couple of years residents seem to die quicker - as soon as they arrive there they die within a week or a month - and they would like some statistics on that, and that was a request from them.

MR WOODS: Thank you very much. In your response to our position paper - and I notice on one of them that you strongly supported it, which was number 2. Let's turn to number 1, though, as a start. You raise concerns about a national uniform basic subsidy, and I want to bring 1 and 3 together if I can, but on that question you note that salaries vary considerably between jurisdictions and that there is no reason to assume this situation will change in the foreseeable future, but would you also acknowledge that at any one point in time there will be changes in the ranking and relativity of jurisdictions, so a jurisdiction that might at the moment have the highest labour costs doesn't necessarily always stay at the top of the pile, that there is some change in rankings between jurisdictions?

MS MA: I have to confess I'm not expert in industrial issues but looking at the

attachment 1 that we attached for the commissioner - - -

MR WOODS: Yes, thank you for that.

MS MA: - - - if you look at from 1991 to 1998, the difference seems to remain, and that is how we look at the trend. I think that trend will remain in the foreseeable future.

MR WOODS: Okay. We recognise this information relates to RNs specifically, and then there are patterns relating to ENs and personal carers or AINs, depending on the jurisdiction, and we acknowledge that wages and wage-related costs - 75, 80 plus per cent cost of total operation - the question then is, is a national labour market, particularly for RNs, emerging in Australia? We have had evidence about progressive shortages of nurses at the professional levels. Will that cause there to be at the margin some transfer between jurisdictions of nurses who go to different states and territories reflecting wage outcomes, and would the development of a national pool therefore lead to some bringing together of wage outcomes across the states? It's a complex question but I would be happy for you to wander through those issues.

MS MA: It is complex but I'm not sure what you raise that a national pool is a feasible proposition because I think it's up to individual nurses which state they want to - - -

MR WOODS: Sorry, not in a directive sense but just looking at the fact that are there nurses who choose to change the state that they live and work in, in consequence of the different levels of wages being offered by states, or do they work and live in a particular area for circumstances totally unrelated to differences between states for wage rates?

MS MA: From a nursing perspective myself, for individual nurses to choose which state they go to work, there are many factors involved. Number 1 is who is the state government in that state and what is the industrial relations like, let alone just wage differences, and what the health care system in that particular state is like; whether it's deregulated or regulated, and probably the cost of living as well. So I really cannot answer that question without taking all those situations into consideration.

MR WOODS: Thank you. Do others want to comment on that?

MS DAVIES: I think there's more movement within the system intrastate because people are moving into and out of that system intrastate all the time.

MS OATES: I wouldn't think that the wage rate has very little, if any, bearing on a nurse working between states or in a different state. I think if a decision was made to transport to another state, then it would be on the basis he or she would be accepting of whatever conditions were in the state rather than the reverse, that they would move because of the conditions which applied. It is certainly very complex because of the different state regulations, which we also have to comply with, quite apart from the

Commonwealth regulations in relation to staffing, and hence there are huge differences.

MR WOODS: (indistinct) to other things.

MS OATES: Yes. So it does become extremely complex.

MR WOODS: It's a common view for you also.

MS JENKINS: Yes. I guess I would like to think that the aged care industry was powerful enough to influence the wage awards in other states and bring them all onto a parity line but I'm not quite sure about that.

MR WOODS: There are currently discrepancies in various other jurisdictions between the acute and aged care sectors that we're very conversant with.

MS OATES: It would be nice to lead the team rather than being behind as we tend to be.

MR WOODS: The question of benchmark level of care and quality of care outcomes - you were drawing on issues of health outcome indicators, and I noticed you made a reference to somewhat "loose use of terminology" which perhaps I can address. My perspective on that is there is a clear differentiation between the inputs used to produce a care service, which are the inputs of nursing and nutrition and health care and the like - health services. There are outputs which the government purchases in terms of levels of care for residents, and then there is the quality of life which is the outcome being sought by government, and should the commission not be clear on any of those, I would appreciate you advising us so I can make the necessary amendments. But I feel that particular framework is not only useful but is one that I will continue to rely upon.

I understand your point about the quality of care and use of outcome in that phrase and as you say, care services aren't factory products but they are nonetheless a service that is purchased by government which is delivered by nursing homes, so if you will bear with me in using the output context in that framework - I find it helpful. Nonetheless, we then need to ultimately assess whether the range of inputs being marshalled produces an appropriate quality of care and we need to form a judgment on whether it is better to identify, isolate and to some extent constrain flexibility in relation to the inputs, the labour and other resources applied in providing care, or whether it is possible to assess how good the care is. What is it being purchased by government and is it being purchased at the right standard and level?

The requires there to be some form of benchmark and I'd appreciate your views on whether accreditation is going to meet that. I know you have some concerns about accreditation and in fact, as you phrase it here, "The association is seriously concerned by the reliance of the commission on the accreditation process." My question back to you is how else do you assess whether the quality of care being

delivered is an appropriate level of care?

MS MA: We like to make it clear the association supports accreditation process. My opening remark is that is the first step towards the right direction. But all I am trying to highlight is there are lots of issues to be considered, and when I look at the care standard issue from the Health and Family Services, when it comes to standard to health and personal care, most of the expected outcomes are open for interpretation. To me that sort of process is very much like a tick book - you know, you have that policy in place, dah, dah, dah, but there is no actual measurement.

MR WOODS: Can you show the manual?

MS MA: Yes.

MR WOODS: In respect of what's happening anyway.

MS MA: But it doesn't guarantee the quality of care - or my term is health outcome of the residents are actually better.

MR WOODS: I understand that but how do you then get to that next step?

MS MA: That's what I mean. That is the indicators where it comes in, and it will take a long time to develop that system in aged care facilities. I tried to highlight the issue in the acute care sector; they are using that to measure health improvement, and they are facing a fair bit of difficulty in data issue. When you look at aged care facilities we have no data and there is no information technology in place even to contemplating starting. I think it's a correct way to do things, but all I'm trying to stress is the difficulty and the time-frame to achieve that stage.

MR WOODS: Yes So it's the only option and it's a useful option but it's still not perfect.

MS MA: That's right, it's not perfect.

MS OATES: It's not the solution.

MS MA: What I am saying is if your proposed coalescence takes place within the next 7 years or 5 years or whatever, the outcome measure is not catching up with that same process; that's what I'm going to say. If the funding is not coming, there's no way we can measure what is that adverse outcome because of the lack of funding, and that is our concern.

MR WOODS: Are there other comments?

MS OATES: I think there are two issues and I think we need to be very careful about separating them. One issue is certainly accreditation, and I agree certainly with Janet - and I think we all agree - that the accreditation process as such is certainly

heading in the right direction. I term it as aged care coming of age, that we at last at the point of looking at a true accreditation process. But the other part of that is the benchmarking, and the benchmarking is a separate issue, and I think we haven't got to that point yet. One of our esteemed colleagues, who in fact used to head up the Nurses Association, used to relate to benchmarking and point out that benchmarking was in fact introduced into the manufacturing industry many, many years ago, where you could actually count the number of bolts and nuts and whatever went through.

At the moment in aged care we would have to say that we don't have any point of benchmarking but if we did have a point what do we measure? How many residents die or how many we keep alive? So there is that issue which at the moment we haven't really come to terms with but I think that will be the ongoing process which we will go through and in which accreditation will certainly assist but I think we've got to be very careful that we look at the two separate areas.

MR WOODS: Thank you, Ms Oates. Are there any others?

MS JENKINS: My only comment there is that the aged care industry has probably been, and continues to be, the most regulated industry of all. At least with the accreditation process it is aimed towards a self-regulatory. It is a positive approach whereas I believe all of the regulatory monitoring factors that have been there in the past have been very negative approaches. It will be difficult to benchmark; and I agree, I don't know whether you count the number of people who die or the number of people who stay alive. But surely the residents themselves and their families are going to have to have a lot of input into how good our quality of care is. So that in itself has to be a factor in the benchmarking of our particular industry, because it is not just about health outcomes, it is certainly about all those other issues, including quality of life outcomes.

MS DAVIES: And I think Janet's earlier comments about the time-frame.

MR WOODS: Yes. Thank you. Just to briefly touch on a couple of points: you asked the question what is meant by an efficient size facility. In designing a subsidy, at the moment there are within each jurisdiction a single payment at each RCS point which is received by homes whether they are large or small. So that is being dealt with by homes of varying size at the moment. The issue comes up because of the commission's desire to increase the transparency of the process, that when you are devising a standard input bundle, you must base it in your survey and data analysis on a particular size or sizes of facilities; that if you just try to do the average between 25 and 300-bed facilities overall you may not get useful data.

But also there is a possibility that both ends of the extreme generate inefficiencies in staffing flexibilities, in covering overheads spread across the income that you receive, particularly in relation to small facilities, or for large facilities the fact that you start to disaggregate some of the support and care so that you have to employ particular tradespeople rather than the general handyperson who fixes a whole range of issues, and some rigidities start to lock in at the very large facility size. I

notice one of our witnesses having experience in a 300-bed facility, which is quite an amazing size. The proposal that we're looking at now in the light of further evidence that's being brought before us in these hearings, is to look at a range of facility sizes as part of the procedure, but my inclination is still to look at facilities that are within the bounds of reasonable efficiency and whether that's from 45 through to 100, 120 or something, is yet to be determined. But there is rationalisation in the industry, in some jurisdictions in particular, in relation to small facilities, so there is recognition in the marketplace that a number of those cannot continue to exist.

It's recognised in the position paper that that is one of the features of rural and remote, however, and that that should be separately recognised through a special needs pool and that any subsidy that government chooses to determine based on these recommendations wouldn't, of course, prevent small homes in metropolitan and provincial centres from operating, they would just need to reflect on the subsidy they get and how best they cope with that, which is no different in fact from what happens at the moment, so that's an answer to your question. I don't know if you then want to respond further or not.

MS MA: Thanks, commissioner. I appreciate your explanation and elaboration on the efficiency size. I'm sorry, I personally still have difficulty understanding the definition of "efficiency", because in the acute care sector, when they measure efficiency, they can look at things like length of stay. For example, if a person comes in with a fracture of the femur, you compare different hospital data, then you can look at this person has the same procedure, but only stays for 4 days and the other one stays for 10 days and one hospital has more post-operative complication and the other one has less. But in the aged care sector, when you look at efficiency, how do you measure that outcome to fit in the definition of "efficiency"? And that is my personal difficulty in understanding that, because you can't use the same criteria in measuring aged care facilities, because are you going to look at length of stay? You can always look at input, how many staff to run that activity, but you also need to look at the health outcome of the residents, that is the nurses' concern.

MR WOODS: I totally understand that concern. But that gets us back to the earlier conversation, that what you are looking at is efficient use of resources within an acceptable quality of care, so that you have to ensure that the homes that you may be using to generate the data through some survey or analytic process, that those homes are delivering an acceptable quality of care and then, within that, you then look at what is the range of inputs used. But in developing that sample of homes, I'm suggesting that it would be appropriate to narrow the range of homes drawn upon to be within an area that various witnesses have given evidence on. I'm suggesting that from 45 through to over a hundred in size creates a lot of efficiencies in operation in terms of utilisation of staff, development of rosters, spreading of overheads and many other factors.

MS MA: So the importance lies in what we call acceptable quality of care and we need to define that.

MR WOODS: You need that fundamental benchmark, yes.

MS MA: We need to define that, because acceptable to one may not be acceptable to another.

MR WOODS: Yes. And that's an integral part of proposal 3 in our paper, that that has to be your starting point, but from then, you then work out how to deliver efficiency. Also, you'll note that we choose then within that boundary to look at average costs, not best practice costing. I mean, we're not trying to suggest that the industry should overnight all move to whatever constitutes best practice. Not only is that not practical, but it is extremely disruptive and would cause an awful lot of cost in transition, so we haven't proposed that. We're talking average, but in so doing, have the view that those who are performing at an acceptable quality of care, but better than average, will be generating surplus, which they can either reinvest in the home or apply however the proprietors wish.

Those who are operating at higher than average will need to reconsider their performance and hopefully move back, at least within that average bound, and I freely admit that it would be my hope over time therefore that the average moves down towards best practice, that there is a natural bias and incentive to move down that scale, because although I have identified equity as the key and foremost criterion, I don't lose sight of efficiency as being relevant for consideration as well.

MS MA: Thank you.

MR WOODS: If I can take you then to workers compensation, which is a matter that a number of you have raised. In coming to a final view on this, I need to balance several things. One is that it is recognised that different states and territories conduct their workers compensation policy by government in very different ways and that that can impose considerable changes in premium level over time, and this is proposal 7 that I'm looking at your response to - proposal 7, point 9. So there is, well outside of your control in the industry, the design of workers compensation and the running of that by the relevant governments. There is, at the other end of the scale, however, the need to ensure that proprietors and staff are fully motivated to have best practice in occ health and safety and that's one area where best practice, I would be less compromising on - that it is essential to move to that - and as a consequence of best practice, there is a bias that says premiums are less on balance for those who have better occ health and safety practice than others.

But it is also recognised that despite one's best endeavours, accidents can occur and that premiums over a claw-back period, whether it's 3 years or so, can endanger the viability of a home and it's not just a 1-year get-through-it event, it's a several-year - having to repay the effect of that through your premiums. There needs to be a balance that somehow provides the right incentive, but recognises that despite best effort, significant costs can be incurred and I look forward to your views on how to come to that balance, because I don't think just direct reimbursement of whatever the costs are is the right answer. I don't think that provides the right incentive structure

or the right recognition structure.

MS OATES: Perhaps I can just comment from fairly large experience. I think that one of the problems that we confront, and we continually do it, is the fact, I guess in essence, that it really doesn't matter how good your best practice is or how good your rehab programs are or how much education you actually give staff - and I have to say in all our facilities, we actually educate on a one-to-one basis and put people through manual-handling assessment competencies and, basically, we bend over absolutely backwards to try and reduce the actual costs. However, we have a problem inherent, which is the no-fault issue which a staff member can actually blatantly not comply with the written procedures and processes, totally ignore any education they've had and do something which is going to disadvantage, not only them - and, as I constantly say to the staff, it's ultimately they who suffer, because if they have an injury, basically, it's not very pleasant.

But we have this thing where - and particularly it can be cultural as well, but sometimes, and I have to say it, I guess, staff see it as an easy way to make some money and we have this problem constantly and it is a source of incredible frustration. It's a source of depression in many respects, because we feel as if we're beating our heads against a brick wall and getting absolutely nowhere. We have staff who blatantly go out and basically cause a problem. For our facilities alone at the moment, we are paying in excess of $700,000 per year, certainly between the three of the facilities, in workers compensation premiums, even though we would have one of the best programs available and we're extremely aware that we need to often protect staff against themselves.

We've got mechanical lifters, we have a no manual handling policy, basically, that staff must use mechanical lifters in those sorts of areas. Staff are trained, we have exercise programs and in spite of all of this, we sometimes just feel as if we're not getting to first base, so it is a source of frustration and it's certainly a source of concern, because it's an area that can actually send, particularly a smaller facility, to the wall.

MR WOODS: Thank you. Mrs Davies.

MS DAVIES: Certainly throughout the industry, there's a high incidence of injury throughout the aged care sector and I think that's a reflection in premiums across the board. Certainly in our facility, we've reduced our claims by two-thirds, yet our premiums are still high and - I was looking at some figures here earlier today, our workers compensation payments, I've got a 2-year comparison here - have increased by more than 100 per cent.

MR WOODS: Is that through the fundamental structure of the workers comp in New South Wales causing that or is it related to your industry or is it related to the experience of your homes?

MS DAVIES: I think that's yet to be seen, particularly with the advent of the new

workplace injury management programs, whether that will make a difference to the actual claim structure, and whether that in fact will have the impact desired and that is early return-to-work programs. It's too soon to say, really, seeing it's only just come into being, what impact those new programs are going to have on occupational health and safety, despite, as Rosemary was saying, the programs that you might have in place on site, as far as your staff training is concerned, so it will be interesting to see the impact of that new program.

MR WOODS: Other comments?

MS JENKINS: Could I just ask whether it's a feasible alternative to continue with the system as is, but have an additional pool of funds, whereby if a home does find itself with extraordinarily high premiums, that you actually have the opportunity to put your case forward, and if you can identify that you have actually had in place very good practices and, despite all efforts, you have still had big claims against you, that they could actually be considered on their merit.

MR WOODS: It's certainly something that I've given consideration to and in the commission we've looked at to see if there is some way of having a capping for exposure where you can demonstrate that you have sound policy in place. The only question then becomes, again at the margin, of those who argue they're inside that net, and those who argue they should be, but are outside of it. So the principle has merit. I just don't know quite how it would be put into practice in a way that still maintains some level of administrative simplicity and clarity and the like but certainly it is something in our thinking.

MS JENKINS: I suppose the other thing is that the argument seems to have been, still be, that if we are totally cost-reimbursed, then we actually won't do the right thing and we won't try to be proactive and we won't try to put best practice in place. I mean, very legislative requirement dictates that we must do those things, and I think the changes in workers comp legislation over the last 12 months actually don't really give us much choice in that.

MR WOODS: I understand that, but if I was also provided with evidence that everybody has best practice occ health and safety in their homes, then I'd be satisfied that that actually happens in practice, but so far nobody has put that evidence to me. I would welcome it but I haven't received it.

MS JENKINS: Once again, what is best practice?

MR WOODS: I do notice that with your premiums in your sector that you're aligned with poultry farming, stevedoring and fishmongering, and I thank ASA for providing that information.

MS DAVIES: That shows where our place is, doesn't it?

MR WOODS: No, it shows others who have the same premium as you. I was just

flicking through there. I thought you may wish to be aware of that.

MS OATES: Commissioner, if I could just make one comment.

MR WOODS: Yes, please.

MS OATES: I believe that somewhere along the line we have to try and encourage our staff to in fact take some responsibility for their own - and I think the legislation at this point in time doesn't do that. WorkCover in fact instruct insurance companies to pay all claims regardless and I think this is the inherent problem. I think we've got to start, rather than throwing money at the system - and I mean WorkCover themselves, certainly in New South Wales, have blown themselves out in terms of their budget, as you would know. But I believe we've really got to get to the first line and be able to say to employees that basically they must take responsibility and remove perhaps this no-fault situation.

MR WOODS: Thank you for that. Did you wish to comment?

MS PROWSE: The only comment I would like to make on that is it seems to be too easy at the moment for people to make a workers compensation claim, claiming that the injury occurred at work, when in fact it may not have done, particularly where the industry employs a high percentage of people who, dare I say, are middle-aged. Along with that, as we all know, we get a few creaks and groans. These seem to be put down as workers compensation claims and they may not necessarily be. They may be as a result of our own lifestyle or things that we do in our free time. That was the comment I would like to make there.

MR WOODS: Thank you very much. The last one I'd like to raise is you don't support the idea of not having to acquit subsidy payments, and your colleagues at other state levels have also brought that perspective, but not many other witnesses have come to the same view. I would therefore like to explore it while I have the benefit of the panel in front of me. I am concerned that acquittal does restrict flexibility and we explored a little bit of this earlier. I've noted evidence that you've provided in terms of sitting down with the proprietor and identifying appropriate care levels, but is that still a strident and non-negotiable position by the association on acquittal or are there circumstances in which you could see a subsidy designed that doesn't require acquittal but still meets your concerns?

MS MA: From the union perspective we are concerned there's no accountability and transparency in how the funding is being used, and that's why we support acquittal. We do agree it's pretty inflexible with extra administrative costs to the facility, but if there are other better alternative arrangement can reassure the director of nursing to have the authority to use the fund - for example, maybe like a joint verification between the proprietors and the director of nursing. The directors of nursing are the key personnel to make sure the facility is being run efficiently and allocate resources and employ adequate staff, but directors of nursing do not have the authority to use the funding or most of them don't even have the knowledge of how much funding the

owners are receiving. Not everyone has; the majority of directors of nursing don't have, and also based on the data we have from our survey.

We feel the consultant repeatedly informing us that there has been a 10 per cent increase in funding since RCS was introduced, but from our survey there are more than 45 per cent of directors of nursing telling us their funding, what they've been given, was actually reduced. So that tells us in the middle there the funding may have been increased but the directors of nursing have been given less funding. That's why we raise the issue of acquittal. If there is some strategy to make sure accountability and transparency are in place, we will be happy to support that.

MR WOODS: Okay. So they're your fundamental concerns.

MS MA: Yes.

MR WOODS: At the moment you see acquittal as a way of delivering that but the underlying issues are accountability and transparency.

MS MA: Yes.

MR WOODS: Thank you. That is helpful. You mentioned the RCS issue, and I noted in your submission you make the statement, "There is at present, however, no relationship between the daily subsidies and the relative cost of providing the level of service needed by clients within the various care classifications." That's a very clear statement of position. I'm somewhat surprised. I thought there would be a relationship between the two. This is on page 2 of your submission of September - 3A.

MS MA: That's based on the feedback we receive from the directors of nursing.

MR WOODS: Well, I have a panel of DONs here in front of me.

MS MA: They don't have the September submission with them - 3A.

MR WOODS: No. I'm wondering if the point is that the RCS scale as you see it at the moment doesn't accurately reflect needs, rather than it doesn't reflect needs at all.

MS OATES: I think the comment was made earlier today that in fact it's a little too early to say whether that's going to be so or not. The RCS - and I have to say from a practical point of view, and having done a study of our facilities across the board and having looked the comparison with the RCS that was in from October between the new one which started on 1 November - I believe that the new RCS as from 1 November will be a little more flexible in relation to reflecting the need, but at this stage of course that is still too early to see, but the trend certainly looked to be in the right direction.

MR WOODS: Any other comments?

MS PROWSE: The first RCS I found reflected the care needs of dementia very well, not necessarily those of others.

MS JENKINS: At the cost to the frail aged.

MS PROWSE: Yes. I would comment on that too. As I mentioned before, all my residents are extremely frail aged. I have a couple who are at best noisy, but because, as I mentioned before, they are bed-bound or chair-bound, they are certainly not wanders and absconders and interfering with others' belongings, etcetera, which is where you seem to pick up the points. They are people in their end term of life and they need a lot of care in other areas but it is because they are extremely mentally and physically frail, it is not because they are dementia patients.

MR WOODS: Thank you for that. If there final matters that you wish to raise with me here's your opportunity to put them on the transcript.

MS OATES: Can I just make one comment in relation to efficiencies and the measurement of efficiencies. Having worked in the non-profit area as well as now the private area - I'd rather call it private than for profit - the non-profit sectors certainly would seek to make surpluses but there is a slightly different agenda often, and I think we've got to look at the fact that often non-profit organisations don't see it as appropriate to make efficiencies in terms of costs because then they don't attract the donations and the actual voluntary assistance which certainly in the non-profit sector we don't have access to. So I think in terms of whether a facility is efficient or not the bottom line should not be the only benchmark of that because there are inherent differences.

MR WOODS: Thank you very much. I greatly appreciate the time you've all given to this inquiry and being able to draw on your own very relevant experiences has been helpful to me in this inquiry. So thank you for your time. I propose now a short adjournment and we're scheduled to resume at 2 o'clock.

(Luncheon adjournment)

MR WOODS: I'd like to resume this Tamworth hearing and welcome representatives from the Aged Services Association of NSW and ACT. If you could please state your names and positions for the record.

MS FREAN: Isobel Frean, executive director, Aged Services Association of NSW and ACT.

MR COWLAND: John Cowland. I'm the secretary and treasurer, Aged Services Association and CEO, Illawarra Retirement Trust.

MS CAHOUN: And Robyn Cahoun, director of Cahoun Elton Management.

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

MS FREAN: Yes, we'd like to thank the commissioner for providing the opportunity for a public hearing in New South Wales and particularly outside of the metropolitan area. We wish to make some statements in relation to benchmarking in aged care and workers compensation, elaborating on our previous written submission and the recent public hearing submissions by our peak body, Aged Care Australia. We would also, if we have the opportunity, like to briefly speak to some case studies which illustrate concerns of members regarding some of the potential impact of any reductions in subsidies and their impact on labour costs.

With your permission I would like to introduce the topic of benchmarking. We would like to iterate the comments made by Aged Care Australia in their submission and we believe the commission has made a significant and important contribution in determining that quality of care must not be a residual balancing item of the residential aged care funding system, and we also welcome your comments rejecting the coalescence proposal in its current form for this reason.

Your position paper highlights some important issues which we feel might be - you might benefit from hearing of our recent experience in managing a national project to develop a first generation, if you like, set of financial, organisational and quality benchmarks for aged care. Our peak body, Aged Care Australia, has been funded by the Commonwealth Department of Health and Aged Care, and the development of this first generation set of benchmarks has been brokered, if you will, to the Aged Services Association. We hope by the middle to the end of December to have a first generation set of a document. The working title at the moment is Benchmarking in Aged Care. This will be a resource that will provide information on the important elements to benchmarking.

We envisage the resource will list a first generation set of benchmarks with suggested definitions and we intend to pilot this resource in the early part of next year in a number of regions. An integral component to the resource is a planning kit which assists providers to apply and validate or refute accordingly the benchmarks and assess their relevance at the local level. It is hoped that the pilot will help in the

refining of both the benchmarks and the planning kit, and demonstrate the commitment needed to benchmark and their use as a model for planning.

I'd like to ask Robyn Cahoun from Cahoun Elton Management to briefly share with you some of the experiences to date that we feel would be helpful to the commission in the context of your current deliberations, so I'll hand over to Robyn Cahoun, if I may.

MR WOODS: Thank you.

MS CAHOUN: The comments that I will make will be brief but will reflect the experience we've had during the life of this project, and to some extent also the experience of the team we have put together to examine the issues of benchmarking in the industry. I'd like to start, I think, by saying that one of the key aspects that has emerged over the last months of the project has been the importance of clarifying the terminology around benchmarking, because benchmarking in fact seems to mean different things to different people.

In its purest and, I think, in its most beneficial sense to the aged care industry, it's primarily a management tool which provides a method for continuous improvement in an industry, and certainly involves some kind of ongoing systematic evaluation and incorporation of external products or services or processes. That concept of benchmarking and the word "benchmark" often in fact gets turned around a little bit to in fact more clearly define a unit cost exercise rather than a benchmarking exercise per se, and I think it's important, as we walk down the track of benchmarking, to clarify that terminology and not confuse the two.

Unit cost exercises are in fact more about allocating some kind of average cost factor to a unit of service and within that framework it is often in fact quite difficult to align quality of care or a quality level of care with a unit cost exercise. A benchmarking exercise is much more likely, in its broader definition, to be able to align those two factors of costings and quality levels of care. Certainly the benchmarking concept, I think it's fair to say, across the industry is a fairly new concept, and there would be some level of confusion around those different definitions and how they might be applied. Benchmarking, as we see it and as we have been experiencing it as we've moved through the project, is a much broader exercise around GAP performance, planning, and not just merely a unit cost exercise.

I think the other thing that's worth mentioning, just to round off those definitions, is that benchmarking in that broader sense is also a process which demands a significant change in culture in any industry in which it is introduced. I think it's a fair enough comment to say that across the board the aged care industry is probably still fairly unsophisticated in the area of benchmarking and in the aspects which underpin benchmarking, which is self-review and analysis. Accreditation is a new concept within the industry and in fact has not been developed or operationalised at this point in time. There is in fact a need for growth and development in those areas of self-review and self-analysis.

Our experience in terms of examining the database across the country in aged care has also, I think, highlighted some of the issues that need to be considered around benchmarking. The data that we have examined has in fact little consistency in terms of its organisation and structure, and definitions by and large are not common across the industry. There's a substantial lack of cohesion as to how those definitions are in fact applied and constructed, and I think a good example of that is that there seems to not be a great deal of cohesion across the industry as to what constitutes operating expenses and revenues, and I think that highlights some of the issues around definitions that we're certainly identifying in this project.

There's no doubt in our minds that the adoption of a common structure to the chartered accounts within the industry, which will allow facilities to collect data in some common format or aggregate it up to a common format, is an absolutely essential component for utilising benchmarking in the industry, but that in itself is a large task and it's not something that will happen overnight.

MR WOODS: You start getting an appreciation into everybody's set of accounts.

MS CAHOUN: Yes, it hasn't been noticed in all the accounts, on our experience, at all. The other comment that I think is important to note in relation to those quick broad comments around data is that as well as no common definitions there are also substantial variables, some of which we believe would impact on your ultimate measures; others in fact just need to be quantified and rationalised in some way. At this point in time the data and the lack of definition really do not allow you very easily to quantify and categorise those variables in any sensible format.

There's a variety of practices across the industry which support various delivery models, and within those various delivery models you find quite a range of financial and organisational practices, and in that process what you find is a variety of cost variables which at this stage, in our first generation of benchmarks, we can really only note, rather than actually quantify or peg down to any kind of common denominator. Some organisations choose to outsource laundry activities or catering activities; other facilities will do that in-house. It's very difficult to actually peg down all the cost factors that actually link into those and come up with some common concept around costings and measures; and similarly some significant issues with staffing.

There was a comment coming out of the last submission around staffing and the relationship of staffing to the RCS levels and that certainly the relationships are unclear at this stage in terms of the data and the analysis that we've been able to do. Certainly our consultations with providers have suggested that the levels of care provide some kind of linking to staffing time but there seem to be other factors in terms of the subtle differences of care needs that operate within each of those levels and the kinds of demands that they would then put on staffing numbers as a result of that. That is, I think, another area within those variables that is complex and needs a lot more work and examination done on it.

MR WOODS: Is the corollary also true, that the responsiveness of staff to (a) recognising and (b) responding to that care also varies across different - - -

MS CAHOUN: It could well be, yes. We, within our team, have also had some significant experience across some related industries that in fact have gone down the track of benchmarking or unit cost development, and specifically I'd be referring to the HACC sector and the health sector. The HACC program has been working towards a unit costing system now for some time and I think it's important to note that that has not been a simple exercise and it has not been an easy exercise in terms of developing common definitions within that sector.

With regard to the health sector, as was commented on in the previous submission, the sector has worked for many many years to try and develop some performance indicators around quality of care. Despite a long haul in that area the general consensus has been that the quality indicators that have been in the past developed have in fact not been able to adequately indicate care, and I think there are some pointers within that for some caution in terms of the aged care industry as well.

The key issue, I think, for industries where you are working in the delivery of services to people, particularly in a health environment, is that whatever methodology you adopt for benchmarking, it needs to be a methodology which is able to both identify and to quantify the common ground within the industry but also equally be able to identify and quantify the significant variables in costings as well, and most importantly, how they then link back to quality of care. Our experience to date is that the accreditation standards and achievement of those accreditation standards will in themselves not be an adequate pointer to quality of care. They will certainly be an adequate pointer to overall management processes that set up the potential for quality of care to be achieved and on that basis are a useful starting point in the industry, but the standards themselves will not, we believe, be able to adequately indicate appropriate outcomes for clients within aged care.

I think probably the last comments I just need to make in relation to our experience is, as Isobel Frean commented, the project will ultimately move into a pilot stage across a number of regions about Australia next year and the model that we have defined for the purposes of the pilot is a two-tiered model, which in fact works on a regional benchmarking process where groups form together in a region in a benchmarking cooperative, compare their data and analyse their data and identify some areas that they can target for benchmarking and ultimately move those up into a second tier, which is a state-to-national tier where in fact further analysis and cross-nation review can take place of that data and the benchmarks.

The benchmarks that are developed at that level can then in fact be referred back to regions for assessment in terms of their local issues and in fact if they can identify quantifiable issues which impact on that national benchmark, they may in fact, in that process, strike a regional benchmark in that particular category that is more applicable to their area. Within that benchmarking activity of course there would be other weightings that would be involved in some of the measures as well. So in a

broad sense, that's the kind of process that we are suggesting in the pilots and hopefully the information from that pilot will inform us better as to how a model nationally may work in benchmarking for the industry that will produce, not only some information and some guidelines around best practice in the financial and organisational areas, but most importantly in the quality of care areas as well.

We are trialling a methodology around getting some measures of quality of care. That is embryonic at this stage but has in the early phases of consultation met with a degree of approval from service users in terms of its potential applicability, so that needs to be tested out further obviously in the pilots and further developed in later generations of benchmarking as the process continues.

MR WOODS: Thank you very much. Mr Cowland, did you have any - - -

MR COWLAND: I understand we can talk on the workers comp, which I am quite happy to do.

MR WOODS: We might pick that up as we go through then, if that's all right.

MS FREAN: Perhaps the only comment I might just add in closing on the benchmarking is just to reiterate a comment that I made earlier, that we believe that there is a fairly long haul required to address the issues that Robyn's just identified. Certainly from our perspective in terms of coming out with some useful tools to assist the industry in strategic planning and business planning obviously with the ultimate aim of delivering quality and best practice care in a modest sense would take 3 to 5 years just from the work and the scale of activities that we have envisaged from what has to be seen to be modest beginnings.

MR WOODS: Thank you for that. Do you have any other - - -

MS FREAN: What I would like to do is move on to the workers compensation issue and just briefly highlight those before handing back to you. We did spend some time in our initial submission to you talking about workers compensation and the particular situation that exists in New South Wales, and included a report summarising the legislative changes or turmoil, depending on your perspective of the New South Wales workers compensation system, that was prepared with assistance from Price Waterhouse Coopers. In that submission and restating the position that Aged Care Australia has already presented to the commission, we're recommending that workers compensation needs to be funded using a transparent state averaging system. John Ireland, who's our national president, undertook at, I believe, the Melbourne hearing that we would present a bit more detailed information for you on that and so we'd like to do that now and I'll hand over to John Cowland.

MR WOODS: Fine, thank you.

MR COWLAND: Thank you, commissioner. I would like to talk about workers comp in general. There has already been some discussion with the problems with

resident staff behaviour, the fact that in people we are dealing with an unstable form rather than a stable form such as a box and the no-fault part of workers compensation premiums, and also the desire of the government and of course of nursing home operators to make sure that we don't keep people in beds or in chairs but we actually encourage them to take part in activities of daily living and it's part of our process of looking and improving quality of life to do that. That has risks associated with it if you took a true OH and S attitude that you wouldn't take.

I would like to say that workers comp is probably the most serious expenditure over New South Wales. Operator problems and claims history can result in the escalation of premiums to levels that have the potential to put them out of business. The essential problem appears to be that the $6.59 OCRE which was set at 1 October has been calculated from historical data which does not take into account the huge increase that has occurred in workers comp insurance rates from 1 July. Using 94-95 as a base year, the percentage increases in tariffs alone for New South Wales were, 95-96 41 per cent; 96-97 11.9 per cent; 97-98 13.9 per cent, and 98-99 there was no increase, thank goodness, but they did change another part of the insurance scheme, which I will look at.

Also I think a major part in the time from 30 June 95 was that the maximum claim that could be assessed in your 3-year calculation of premium, the estimate, increased from 100,000 to 150,000 per claim. That's a 50 per cent increase. Obviously there would be no account of that in the 94-95 figures but it impacts considerably on any claim after 94-95 that is any length of time. So any major claim after that time would, instead of being capped at 100,000 would be capped at 150,000.

When we looked at the OCRE numbers, the $6.59 which is apparently allowed, we took a sample of 36 nursing homes from 20 departmental assessments and the average of that sample was $9.26 a day, which is virtually 50 per cent more or 40 per cent more. In fact unofficial advice from departmental officers indicate an average of $9.39. I am sure you could confirm that later on. Also part of the calculation of the insurance is not only a base premium based on salaries but also a claims experience factor which is affected by the level of claims, the amount that they will put on a maximum claim - 100,000 to 150,000 - but also a multiplier which is the F factor.

From July 1998 these F factors increased from 3.4 to 3.9 per cent for 97-98, which is an increase of 14 per cent, and from 2.4 per cent to 2.9 per cent for claims in 96-97, which is an increase of 21 per cent. In my own organisation we asked our insurance broker to calculate our insurance rates for budget, and he did that using the old F factors and our workers comp is about 950,000 a year. The increase in the F factors - the only consideration we took into account when we looked at our actual premium that we were being expected to pay - increased by 113,000 on that 950. So the increase was about 12 per cent just because of those F factor changes in the premium.

The other part that affects larger organisations, which isn't necessarily affecting the small ones to quite the extent, is the grouping system in New South Wales which means that if you're part of a group organisation every nursing home is treated as part of the major nursing home as opposed to individually. The adjustment level that you can have for claims for a small nursing home - that is, it would be one with an insurance premium of under 100,000 - is basically limited to the amount of the premium. If you are part of a group though, it's not limited. This means that essentially you have two systems in New South Wales: one for organisations that are grouped and one for organisations that aren't. This can be if you're part of a church organisation, part of a not-for-profit organisation or whatever.

There are considerable differences and in fact one nursing home, which is part of a group, 36 bed, and is owned by a large church organisation, has an estimated 98-99 premium of 136,000, nearly 137, or 10.9 per cent of estimated salary and wages - a daily bed cost of $10.42. That premium could have been halved if they hadn't been part of a group. So it's a considerable impost for smaller nursing homes that are part of a group and it doesn't allow you the flexibility to actually adjust or react to the workers comp insurance as you would be if you were standing alone.

MS FREAN: It's probably worth just adding that the New South Wales workers comp authority is encouraging the grouping of premiums under organisations that can and, in their view, should be defined as a group. It is an issue that I'm sure the commission will want to take into account in this debate on efficient-sized facilities because the trend within the industry is certainly towards particularly the larger networks of church groups to identify economies of scale throughout their infrastructure and yet this remains a disincentive for many of them.

MR COWLAND: Commissioner, we felt that we ought to make a recommendation to you and we think that there should be an incentive to nursing homes to not just ride along on the subsidised rate of workers compensation. So we would propose that workers comp be reimbursed on a state average level to nursing homes; that there be an amount of 20 per cent, or approximately 20 per cent of the base tariff that would then be unfunded, but any amount over that would be totally funded. So if you have a catastrophic claims history in your nursing home, you would not be penalised to the extent that you could be but there's a definite incentive to get down to that state average or to get better than the state average.

The second part of the recommendation would be that the state average be calculated on two bases; the first for those facilities with a ceiling on their premiums, that is where it doesn't exceed 100,000, and the second one for those facilities that do not have a ceiling, ie that are part of a group and their group premium is more than 100,000. We appreciate that could be difficult for the department to come to grips with because each nursing home reports separately whereas they may be part of an overall group, but that shouldn't be hard to recall or track on a computer.

MS FREAN: I would also like to take the opportunity of just restating our recommendation contained in our earlier submission, and we would be grateful for

your assistance in this regard that the commission formally requests a detailed report from the New South Wales WorkCover authority because at the moment we are unable to get data despite the fact that it's collected. It's just not collated into reports on the number and type of injuries occurring by occupation, demographic and gender profiles in nursing homes, hostels or retirement villages, and the range and mien cost of claims by injury type, age, gender and workplace location is fundamental information that most other industries, certainly large manufacturing industries, have ready access to, and that is constantly denied. It's put in the too hard basket and we continue of course to repeat those requests, but any assistance by way of your recommendations that you might make to assist in accessing that sort of information would be appreciated.

The information is useful for fairly obvious reasons but not the least because the association is very conscientious about the whole issue of workers compensation on behalf of our members. We're in the third year of our own statewide occ health and safety benchmarking exercise and I would have to just make a comment in relation to your invitation that you would sorely like to receive some information of the nature of best practice in relation to workers compensation in this industry.

I would like to undertake to provide you with some detailed copies of the reports that we have that are prepared thus far from our benchmarking surveys. Of necessity participants are self-appointed, it's not a pure science, but I think we have on average about 150, 130 facilities participating now, 3 years, and that's generating some important information about exactly what it is that organisations are doing. Most of the 15 indices that we ask organisations to self-report on, and the process does have a validation component to the methodology, are relating to legislative compliance requirements, as well as defined best practice.

We have, as an association, also been running for a number of years now an occ health and safety conference annually, which is probably our most well-attended of conferences and I think the industry deserves a lot more recognition for the work that it is undertaking. The recognition of the notion of best practice is probably much more developed in this area for obvious financial and viability reasons and it's a tedious thing to have to keep hearing the hairy chestnut about, "Well, if the industry could lift its game, it could impact on things better." I hope that the information that we've presented in our previous submission, together with the information that has just been presented, highlights again that the driver in New South Wales, in our opinion and the opinion of a number of professional actuaries in New South Wales, is the need to ensure that the New South Wales workers compensation scheme doesn't go bankrupt, and has little to do with the performance of the industry.

But, if you are interested, I would be happy to provide you with some of that information on that work and I know other states are also looking at comparing the work in order to refute the perceptions that certainly a number of government departments have about this industry's apparent complacency in relation to workers compensation.

MR WOODS: Thank you very much. I appreciate and welcome those statements and also will take up your offer of further information on workers compensation. Two areas I'd like to explore just a little bit more, a couple of questions on workers compensation and then, if I can pick up a bit more on the benchmarking referred to by Ms Cahoun. Then if we can explore some of the issues in your detailed submission and subsequent correspondence of 10 November. On workers compensation - and I do thank you for the extensive material that you have already provided and will be adding to, there seem to be several elements of your concerns. One is whether the subsidy at the moment is adequate to recognise increases in the base premiums in New South Wales, and other states have raised similar concerns, and then whether practice in homes, in individual homes, or the claims experience as a consequence of that is recognised in variations to the premiums.

You also raised separately, but I don't think I need to pursue it any further - I understand your question of the difference between grouping and non-grouping, that's something we can take on board and will reflect on. But when you go through the preliminary proposals in our position paper, which is to look at the appropriate input mix, clearly workers compensation, in terms of base premiums, would be in there as an essential element and that any changes in those base premiums would be reflected in the indexation process. I would welcome your views as to whether proposal 3 in our position paper will correct what you see - and have given figures on a current level of underfunding for that item in the current subsidy, recognising of course that what that is designed to do is to produce a transparent cost base and then government will, on the basis of these recommendations, determine an output price that it's prepared to pay, but at least there is a transparent cost base that should pick up at least that level of concern, the concern about the base premium in a jurisdiction and its subsequent change for factors outside of your control through the design of the system or an actuarial assessment of underfunding or some other factor that causes a change in those premiums. Does that satisfy at least that first part of your concerns?

MR COWLAND: I think it's important from our perspective in New South Wales, in that because so many of the costs are outside of our control, if there were a base national level of care, that it be priced at the New South Wales rate.

MR WOODS: Okay. Well, there are two distinctions then. There is whether this process has the capacity to reflect the actual base premium that you're paying and then the question of whether that needs to be jurisdictionally separated and I can understand both of those concerns. The next question then is, though, to what extent does experience affect the actual premium of a home and to what extent does occ health and safety practice in that home affect claims experience, which affects actual premium paid?

MR COWLAND: Speaking for my organisation, we had a year that was particularly bad, about 3 years ago. We had one accident in each nursing home that was a major accident and it left us with a claims experience of about $600,000.

MR WOODS: That was the actual - - -

MR COWLAND: Yes.

MR WOODS: For three homes or how many homes was that?

MR COWLAND: That's five nursing homes and 11 hostels. So that's not a particularly bad record per nursing home, but when you take it as a group organisation, it was. We, over the next 2 years, reduced our claims experience to a third in the next year and to just under a quarter the year after, so that was just over a hundred thousand-odd, and yet our premium went up simply because of all the external factors.

MR WOODS: But that's because of the base premium changes.

MR COWLAND: Base tariff, plus the F factors.

MR WOODS: Yes. Those would be picked up under this methodology.

MR COWLAND: Hopefully, yes.

MR WOODS: It's a separate question then, as the variability that relates to the individual homes and I want to, in some way, ensure that that is captured as well and that there are appropriate incentives in a subsidy design structure.

MR COWLAND: We have five homes, so we can compare and we do. We have exactly the same occupational health and safety programs. We intermix educational staff so they're not getting exactly the same. There's not one person teaching in one nursing home and then another person, so there could be a difference in teaching ability. We have regular monthly conferences of all of our directors of nursing coming together with our occupational health and safety people. We have occupational health and safety committees at each nursing home that are very active and yet we have considerable differences between the nursing homes in actual outcomes and we thought, at one stage, it was because one was a particularly older design. The two worse are the oldest one and the newest one.

One has narrow corridors, lots of communal shower areas, another one has very wide corridors, lots more single-bed wards, much easier to access toilet facilities and it has, in fact, a worse workers comp record than all of the others.

MR WOODS: Having dismissed the design factors, what have you then pursued as being some of the reasons for this?

MR COWLAND: I think it comes back to they're not exactly dealing with the same; each situation is separate. You have different people in the nursing home, with different behavioural problems. It's easier for a lady to say pick up Isobel than it would be to stop me falling, and that sort of mixture of residents within the nursing home you cannot control and I think that's one of the external factors that we've tried

to say has - combines to it. One of the homes is smaller and therefore they have a lot less staff on at any one time, so you can introduce all of the lifting procedures, but if someone is falling, there's only one member of staff there and no matter what you do, the natural reaction is to try and help that person and, with all the procedures you put in place, you won't stop that happening. A lot of the accidents happen around showers and toilet areas, corridors and those sorts of things, and the more you try to help people in the activities of daily living, the greater you increase the risk.

MS FREAN: And the less the funding you get.

MR COWLAND: In fact, yes. Paul might be able to answer that better than I, but I understand the better you make the person, the less money you get. The more hours you put into helping them, the less subsidy you potentially get in the future.

MR WOODS: Do you have a suggestion? I notice you offered a recommendation to us that is different at the margin to that which is in your submission of September and so that's a further reflection and refinement, I take it, on what was included here. I mean, the WorkCover one remained the same, but the detail of the capping procedure varied slightly.

MR COWLAND: We took into account, as you were saying, some incentives to people, but also to alleviate the situation of a really bad couple of years or whatever that can be difficult to come to grips with.

MR WOODS: Thank you for that further thinking through and reflecting on those issues, and I'll look closely at your revised recommendation on the - - -

MS FREAN: Could I just make a very brief comment. The recent significant changes to the legislation in New South Wales is intended to more finely tune the experience of the organisation with the premiums. The legislation is still not wet on its pages and the time-lines that have been set into place have curious linkages to the political election cycle. There is a lot of work that must be done in partnership to ensure that the new system works. We, obviously, are committed to participating and making the new system work, but I think it's going to be - the general view is that it will be about 3 years before the new system beds down. That's assuming it's not changed again in the meantime. But I think, potentially, the arrangements that are going to be put in place will provide a better linking, but the resourcing - whether the industry will be able to meet the resource implications within the time-frame for it to work, is something that obviously we are looking at and we're concerned about and I think a radical change in funding coming from the Commonwealth end would exacerbate our capacity to respond to what, as I said, has the potential to deliver better sensitive calculations of premiums, etcetera, at the state level.

MR WOODS: Thank you for that. Can I turn now to the benchmarking exercise. You were creating distinctions between unit costing and benchmarking, which you describe as being better able to take into account quality of care. Can I just clarify though that the exercise that you are going through is still - not still, but it is an

assessment of inputs and their costs but that you are trying to identify their relationship to at least a minimum or perhaps the actual outcomes in terms of quality of care.

MS CAHOUN: I think that's a reasonable statement I guess in a broad analysis of what the project is trying to do, yes.

MR WOODS: So it's not actually establishing a quality of care benchmark, but it is trying to more fully understand the inputs and their relationship to that quality of care.

MS CAHOUN: It's trying to do both. It is certainly trying to identify and better understand the relationship, and in the first generation of benchmarks I think there will be a limited capacity to do that, but in fact you have to start somewhere in the industry; in fact, it needs to start at some point in terms of analysing its data. But the project is also attempting to examine methodology that will in fact assist the industry to measure quality of care, identify best practice within the range of activities that happen in aged care and hopefully in that process be able to further down the track more accurately identify the links between the financial and organisational performance levels and the quality of care or client outcome issues that need to be addressed.

So it is in fact doing both, and the exploration of the methodology around quality of care is new and I'd say embryonic to some extent, but nevertheless our response in consultations from the industry is that they are very interested in it as a potential to give them a better handle on quality of care and in that process hopefully identify the common ground. One of the issues that I think arises around accreditation is that any accreditation process, any process that's based around standards, is in fact by its very nature based on minimum standards. It's the minimum level that you need to get to to in fact be considered okay.

What that implies is that while you can achieve a sign-off, that a facility has got to a reasonable level, it doesn't in any way define best practice and doesn't in fact help to define the difference in performance between one organisation and another. Some measure around quality of care will hopefully identify that differential and down the track hopefully be able to identify what is the level of practice that in fact works best in the industry rather than what is the minimum level of practice that gets you past that accreditation line and in that process hopefully be able to create those links between the financial and organisational aspects of benchmarking as well.

MR WOODS: Thank you. You went on further then to express the view that the accreditation process would not provide an indicator of quality of care, as I understood your comments. Could you elaborate on that for me.

MS CAHOUN: I think it's probably better to say it won't provide an accurate indicator of quality of care and won't be able to provide enough information for organisations to in fact bank their financial and organisational performance against it.

MR WOODS: There is a distinction, however, between a management tool - and I understand the value of your exercise for that purpose, which requires a much finer graining to assist proprietors and staff to deliver quality of care - and that which may be necessary to assess whether the quality of care output being delivered meets an approved minimum national standard.

MS CAHOUN: Yes.

MR WOODS: I take it your exercise is primarily designed for the former, for the managerial perspective and therefore accreditation as such would meet those managerial needs because they need obviously to go further. Does that necessarily draw the conclusion that accreditation or some progressive refinement of that may not be sufficient, however, though to assess whether the quality of care meets national minimum standards?

MS CAHOUN: I think accreditation has the potential to give you some measure and some concept around national standards I guess in that sense. What it won't assist the industry in doing is identifying what is the level of care and service we need to provide to our residents and how in fact does that relate to how we spend our money and the kind of inputs that go into the system. The two in my view are intrinsically linked. The identification and development of quality levels of care and their measurement and the development and measurement of financial and organisational activities are totally intertwined and I don't think accreditation in its current format can actually get you to that next level, but it certainly will give you an indicator that the broad processes that set up the framework for quality of care to happen are in place.

MR WOODS: Thank you for that.

MS FREAN: If I could just quickly add the managerial outcomes, if you like, that we're looking for from this project are just as much about being able to define the ability of the organisation to deliver what it would consider to be having regard to industry standards best practice and then being able to compare that with the resources available to provide that, much of which come through obviously the RCS, which as has been previously discussed, is a relative funding tool and not an actual funding tool. One of the things that we are keen to better understand and be able to demonstrate to the recipients of care and obviously to the funders and taxpayers is what that gap might be, and I think that point was made by Robyn in the first instance.

So the motivation is about how can we as a community move towards and demonstrate what we're able to deliver in terms of best practice and move away from this notion of minimum practice, and the challenge in any funding methodology is to allow that achievement of best or better practice to provide the incentive for that to occur, balancing obviously with the resource implications for government of doing so, but there are other vehicles for freeing up the ability of providers to supplement that gap which, at the moment, we don't believe the current legislation provides.

MR COWLAND: I think it's very important, commissioner, because especially our staff have a 24-hour 7-day a week association with our, if you like, customer, and they're not really interested in minimum standards. They're trying to achieve better standards all the time, and I don't actually know of any nursing homes, but I'm sure there might be some, that are actually trying to achieve minimum standards; they're always trying to achieve better. I think the expectation of our customers in the broadest sense, which is our residents and their relatives, is much higher than any minimum standard that we would like to set.

MR WOODS: I understand that fully. It's essential that the funding be at least able to achieve minimum standard and provide incentive for higher levels of care and higher levels of efficiency in delivering that care; it certainly has to go both ways.

MS CAHOUN: Commissioner, could I just also add that the methodology that we will trial in the pilot and that we've been working on around quality of care doesn't view accreditation as extraneous to the process; it sees it as an integral part but just one part of it, and the methodology in fact works around, in the first instance, identifying that the facility has those broad processes in place which meet the outcome standards as prescribed in the accreditation guide, but then requires the facility to also self-evaluate against its individual protocols that in fact support that broad ability to meet the standard and then to go one step further and to do some evaluation of individual outcomes against clients, and in that process hopefully down the track we'll be able to identify through the pilots whether or not the industry is able to get to a better picture of its own performance and what in fact is an appropriate level of performance around quality of care.

MR WOODS: Thank you for that. One further issue I'd like to explore with you is in your correspondence of 10 November you stated that ASA strongly opposes the introduction of a productivity discount and that productivity efficiencies are difficult to demonstrate in the industry. Can I also note that in your submission of September you drew to my attention that homes can have differing financial outcomes, and on page 7 of that submission you noted that one country-based 25-bed nursing home incurred an operating deficit of 27,300 while another in the same area with 29 beds recorded a surplus of 58,400 and another 28-bed country facility recorded a deficit of $1183. I don't know whether you'd have a view, but presumably they're all meeting an appropriate standard of care.

So clearly there are different financial outcomes between homes and they're in the one jurisdiction, so they're getting the one standard level of RCS funding profile. I mean, they may have different residents and obviously would have variations, but at least in terms there's some standardisation of dollars per resident in those homes - breach of the RCS categories. You also then on pages 15 and 16 helpfully identify a number of areas where cost efficiencies have been achieved in homes, and I found that a very interesting and useful presentation of case studies.

What that leads me to the conclusion is that productivity efficiencies can be achieved in the nursing home sector and the question then is how is that encouraged

and what subsidy mechanism can we have to reinforce pursuit of those sorts of efficiencies that you've demonstrated in that evidence across all homes and who should be the beneficiaries of that productivity, and I accept ACA's point made in evidence to us, that of course it's the resident who should be the primary beneficiary, but then in distributing some of the benefits of that there are also the proprietors, the staff who actually implement the efficiencies and the taxpayer who supports the industry and the care.

I'd welcome your comments, given the evidence and reflecting on the views that you expressed in that letter.

MS FREAN: I might just start briefly on that. I think the sentiments conveyed in our September submission were intended to highlight that historically there has been of necessity a significant amount of achievement of efficiencies and those case studies were there obviously to highlight that. Whether one can draw the conclusion that there are therefore as many efficiencies yet to be squeezed out of the system is perhaps an assumption that you're making, that we - - -

MR WOODS: I'm asking for your comment on it.

MS FREAN: The strong position conveyed in response to your proposal for a productivity efficiency really was a reaction that the system has achieved varying degrees of efficiency and, again, none of this really relates back to a particularly sophisticated notion of quality outcomes. The reason, of course, the association is particularly committed to a project such as that which we've been describing, really is again to get a better feel for the nature of opportunities for continuing to be able to deliver quality care to residents.

Our September submission also, we hope, highlighted that one of the fundamental components to efficiencies - and certainly your position paper uses industrial examples to highlight how those efficiencies have been achieved. One particular example that you do refer to, and then draw a fairly generalised conclusion about, relates to an enterprise agreement that for all intents and purposes achieved efficiencies. It achieved industrial arrangements, many of which are already in place within New South Wales, and any refinement of those sorts of efficiencies in the interests of the taxpayer are extremely slow and hard-fought and I think we've made previous presentations to you about the current endeavours of employers to look at how we might achieve those issues, but fundamentally we believe the lemon has been squeezed, but I might ask John to talk.

MR COWLAND: I don't disagree with that. I think the case studies that we gave were virtually all in the same area and when SAM was introduced, it was introduced at an average rate for the state and most nursing homes, I think, were pretty close to expenditure on that. At that time, SAM was supposed to include a depreciation component and a return-on-investment component, so naturally if anyone was looking to achieve those areas, they had to make savings if they were anywhere near the average cost, hence savings had to be made. As to your earlier question as to how the

system could encourage efficiency, I don't know, I haven't put my mind around that.

MR WOODS: Certainly the initiatives such as you're taking there, where you can then help inform managers of what constitutes best practice examples in various homes, I think, is quite commendable.

MS FREAN: It's probably fair to say that that initiative is driven less though by efficiency than about the need for viability and survival. Obviously, that raises issues about opportunities for industry restructuring and, again, that's something that the industry is already participating in. The incentives in the system, such as those we referred to about workers compensation, need also to complement those sorts of opportunities and be matched by all the things that you highlight in the position paper that relate to the unique situation of particularly small, remote and many rural organisations.

MR WOODS: Thank you. You mentioned in your introductory comments, Ms Frean, that you had some case studies you wished to draw to our attention. Do you want to do that by reading them into the transcript or by way of handing them up?

MS FREAN: I'm conscious of everybody's time and would like to present a supplementary submission, which contains some studies, together with a bit more information on the workers compensation that we've presented. I'll hand that to you.

MR WOODS: Thank you. And please don't be constrained on the time side. I much prefer that we adequately deal with the issues than deal with them within a particular time-frame.

MS FREAN: My comment there is that I'm aware that those that follow us have addressed some other aspects which we haven't covered, which particularly relate to rural and remote and it's really about making sure that you get the opportunity to hear those issues.

MR WOODS: And I will. Thank you for that. I noted that in your summary of recommendations in September your very first one was a recognition of rural and remote, followed by reflections on viability supplement and then state government nursing homes and I figured that, as I read the first three, we had a commonality of view, albeit that we differed a little as we progressed down some of that list.

MS FREAN: Can I just say in relation to the first three in particular - or at least the first two - we have participated in some eight or nine visits, in association with the Commonwealth Department of Health and Aged Care, to regional facilities under the guise of what had been referred to as state alert response teams, with the purpose of identifying the impact of the Aged Care Act on the quality of care and the viability of those predominantly rural facilities. The report from the not so alert team process has taken us several months to conduct this process - we are hopeful will go to the technical review group, which is the national advisory group to the minister early next

month and essentially will incorporate with the departmental support some recommendations to the TRG, along the lines of our recommendations 1 and 2.

MR WOODS: Thank you. Do you have other matters that you'd like to raise during this hearing?

MR COWLAND: No. Not at this particular point, no.

MR WOODS: Ms Frean?

MS FREAN: I would like to take the opportunity, if I could, to put a different hat on.

MR WOODS: Hat away.

MS FREAN: I'm a member of the Council on the Ageing New South Wales board and I'd like to take this opportunity just to say a few words on behalf of the board of Council on the Ageing. COTA Australia is in touch with Aged Care Australia, who is also represented on their board by Trevor Giles, who is the vice-president of Aged Care Victoria. COTA Australia has not provided a submission to the commission, as they support the position and recommendations contained in the Aged Care Australia submissions. They have simply asked me to reiterate today that they, too, would not support any rebalancing of the current funding pool which would be at the expense of the quality of care provided to residents.

MR WOODS: Thank you. We have met with COTA and we welcomed that opportunity to explore issues with them directly and thank you for that comment. On that basis, I will thank the witnesses for the information that we have to date, your evidence today and subsequent information that you will be providing, and I will look through those case studies also with considerable interest. Thank you very much. Could I call the next witnesses, please.

MR WOODS: Could I call the next witnesses, please, from Nambucca Valley Care, Catholic Care of the Aged and the H.N. McLean Retirement Village. Could you please state for the record your names, organisations and your positions.

MR CURRAN: My name is Errol Curran. I'm the financial controller and company secretary of an organisation called Nambucca Valley Care. We run an 81-bed nursing home and a 61-bed hostel in Macksville and a 40-bed hostel in Nambucca Heads in addition to a number of self-care units as well.

MR WOODS: Thank you very much.

MR WATSON: I am Ralph Watson. I'm chief executive officer for Catholic Care of the Aged in the diocese of Maitland and Newcastle. We operate three nursing homes, eight hostels, a range of community care services and retirement villages across the Newcastle region and many regions of New South Wales.

MR COOK: I'm Paul Cook, chief executive officer, of the H.N. McLean Memorial Retirement Village at Inverell, which incorporates an 80-bed nursing home, two hostels, one of 53 beds, and one of a dementia specific a hostel of 13 beds, and also self-care units. I also wear another hat on behalf of the rural remote facilities within this part of the world and certainly throughout rural New South Wales.

MR WOODS: Thank you very much. Opening statements?

MR CURRAN: Commissioner, thank you for your time today to hear from us. Briefly today I want to touch on three issues - indexation and efficiency, workers comp briefly and the differences in costs we experience compared to the metropolitan areas. Firstly with indexation - on 1 July 1996 the rate of subsidy we received for a category 1 resident was $105.76 per resident day. Today it is $103.59 a day. For a category 2, $95.29; now it's $93.59. Based on our current resident mix and the loss per resident day in funding, if we were funded at July 96 rates today, we would receive 147,000 in additional subsidies.

In addition, since 1 July 1996 we've incurred roughly 5 per cent award increases in the charitable sector, a 2 per cent increase to the Nurses Award in May this year with another 3 per cent timed for January in 1999. We've had an increase in the statutory super rate from 6 to 7 per cent, and the workers comp base, as you're probably well aware, over that period in time, not allowing for costs of claims movement, is roughly about $25,000 up from July 96 levels. So in addition to not having funding for $147,000, we are also faced with increased costs of $180,000 since July 96, which is a $328,000 change in the financial wellbeing of the nursing home.

Comparing 1998 to 1997 financial years as the reforms came in in October 97, salaries held static that year and for this financial year compared to last year we've reduced it, by necessity, by 2 per cent, even though the award rates went up by 2 per cent in May of this year. What that firstly illustrates is that indexation hasn't been appropriate to cover our costs but in addition can I also just mention the change

in the subsidy on 1 July this year. We received a $1.80 per resident day, which equates to about 53,000 per annum. Out of that we then have to fund a superannuation increase of about $26,000 because of the increase in the statutory rate, and we have another award increase for the nurses due on 1 January of 3 per cent, and a 2 per cent charitable sector award due any day, an increase of 2 per cent as well. That equates to about 70 per cent per annum. In addition, as alluded to by the previous witnesses, the F factor will increase our costs, holding the costs of claims the same at $10,000. So we receive $53,000 in extra income but our costs go up by roughly $100,000.

What I'm saying to that is firstly on 1 October last year there was a 3 to 4 dollars or 3 to 4 per cent decrease in the rates. However, the COPO index has been inadequate in dealing with cost increases. There is reference in the position paper to retaining COPO until such times as a better system is implemented. That is of concern to our organisation because we feel that the only way to go now is to decrease staff numbers to continue to be viable. We have held all of our other costs, apart from workers compensation and superannuation, at either the 1996 level or below 1996 levels.

COPO will not be adequate to fund the increases we feel we will be facing over the next 10 years. To that end I'm suggesting that the commissioner consider perhaps using maybe the award increases that will be flowing through to the sector over the next few years, or if the commissioner feels that enterprise bargaining is the way of the future for the industry, that will be tied in somehow to the average weekly earnings rate because if the workforce as a whole is embracing enterprise bargaining, that should be reflected in the average weekly earnings increase.

There is also reference within the paper whereby the commissioner makes reference to the fact that if we go to a national subsidy rate, the differences of 2 to 3 per cent either side of an average rate is not really that significant in the scheme of things. Every 1 per cent reduction in nursing home subsidies to us means a $26,000 reduction in our nursing home subsidy per annum. So if it's 3 per cent, that would be $78,000 per annum. In addition, we have the costs of accreditation, both implementing accreditation by 2001 and the audit, which we are at this stage not being funded for, and with the advent of an increase in personal space by 2008 we will require significant - maybe not significant - but extra funding to compensate for increased wages to staff the extra area - cleaning, electricity, etcetera.

In relation to workers compensation, I support what ASA have mentioned to you today. Just suffice to say that there's another comment in here whereby the department have said there's not enough incentive for nursing homes to reduce workers compensation costs. To our organisation, the incentive for us is to get below the average. In that way we know we are fully funded. That was the system that was in existence prior to the reforms and we feel that it is a necessity for us - and we have been below the average for the last 2 years - to continue to strive to be below or at the state average for workers compensation.

With the decrease in funds for both income and the increasing costs, our organisation, and I would assume other organisations, have had to devise efficiencies to survive. As Isobel said prior to me coming up here, how far can the orange be squeezed any further? It will be squeezed but it will be at the expense of staff in our organisation. As for regional differences, Paul will be presenting that in greater detail so I won't go over what he's going to say but suffice to say this organisation, if we were located in the metropolitan area, would save probably in the vicinity of $30,000 per annum in such things as telephone, freight, staff training and car expenses.

MR WOODS: Can I just get those earlier numbers of the additional costs that you've been incurring in the last 2 and a bit years and the reduction in funding compared to funding structure?

MR CURRAN: Certainly - income first?

MR WOODS: Yes.

MR CURRAN: 147,000 if we were being funded at 1 July 1996. So that's 147,000 we would be getting extra. In addition it's $100,000 in costs; the reason being that we had a 4½ per cent increase in the Charitable Sector Award since - - -

MR WOODS: Yes, I remember the components. It was just the sum of 100,000.

MR CURRAN: 100,000, roughly - around that figure.

MR WOODS: And that came up to 247. Thanks.

MR WATSON: Thank you, commissioner. I'd like to comment on several things: firstly, the setting of average funding rates; secondly, some comments about the productivity discount; thirdly, some comments about workers compensation; fourthly, comments about the amount of volunteers and voluntary input into nursing homes; fifthly, some comments about restructuring opportunities that might create productivity improvements; and finally - and I didn't come prepared - but I will make some comments about accreditation that I hope you will find interesting.

Back to average funding rates, the first thing I want to say is that the differences, be they 2 per cent, 3 per cent, 4 per cent, 6 per cent or whatever, of each jurisdiction from an average rate is in fact not really reflective of reality because each jurisdiction itself is an average figure. So in fact we're not talking about whatever the figure is that people may determine through that process as the worse scenario for nursing homes in any given state, we're actually talking about a much worse percentage. So what it is, I don't know, but it will be much worse than 2 or 3 per cent. I've done a little bit of research on the impact of a 4 per cent loss on five nursing homes; three of my own, one that's run by the Baptist Church - Maroba in Newcastle - and another run by the Upper Hunter Village Association, the Scone and District Nursing Home. In total these five nursing homes have a total of 360 beds, so roughly an average of 70 or 80 beds each, although there's a bit of variability actually,

but that's the average.

When you look at the current financial position of those nursing homes, four are making surpluses and one is currently making a deficit. When you apply a 4 per cent loss to their income, in fact all five drop into a deficit position - and I've got the actual figures here which I can provide later, if you wish to have them. Now, I'd like to comment about the productivity discount and I did raise some comments about this in my letter to you.

MR WOODS: Thank you, I have read it with interest.

MR WATSON: I am pleased you've read that. What I wanted to say is that the commission quite rightly has rated the importance of quality and equity as primary considerations in your proceedings. I believe that, given that we do not yet know exactly how much money is required to provide an acceptable quality of care, that any suggestion about a productivity discount at this stage is based on a number of assumptions. In my letter to you I mentioned three and I've since found another one.

MR WOODS: As you describe them - acts of faith.

MR WATSON: I did call them acts of faith, yes. I won't repeat the first three I have there, seeing you have them in front of you, but there is another one and that is the more efficient providers who would in your paper hopefully take over from inefficient providers who fall by the wayside, the assumption is that those more efficient providers will meet accreditation and certification and appropriate quality standards. So there's a fourth assumption.

MR WOODS: It won't be long before all who are providing will meet those standards, if those standards are applied in that manner.

MR WATSON: Indeed, yes, they will need to do that. I'd like to make some comments about workers compensation. I don't want to repeat what's already been said and I have three things to say. Firstly, I want to give you a little case study which relates to one of my units which is a community care service. I appreciate that it's not a nursing home but I believe that the same issues and quantums of money would be applicable in a nursing home. This particular community care service has an annual budget of $500,000; 1 year ago its workers compensation premium was $9700 which was 2 per cent of its total budget. It had, late in the financial year, a back injury. The person was returned to work just after the end of the financial year but unfortunately there was a $60,000 estimate put on the cost of that claim. That resulted in the premium going from 9700 to $117,000. So the premium has gone from 2 per cent of the total budget of that service to 23 per cent of the total income of that service. I think it demonstrates the irrationality of the current workers compensation system. That's my first point.

The second point I want to make is that you asked John Cowland the question, "What proportion of workers compensation experience is directly attributable to a

provider or a management or whatever?" and in fact I have a belief that it's very little. Here in the Hunter region we notice a great disparity between the workers compensation claims of different districts in the Hunter region. Now, I put on my hat from when I was part of the area health service, and if you happen to be in the coalfields community which is Cessnock and Kurri there was always an inordinately high workers compensation experience in that sector compared to other parts of the region. It seems to have something to do with the culture of the local community, so the point I'm making is, that one of the factors that is most important in workers compensation is the culture of a local community or local district which obviously is beyond the control of any particular provider.

The third point I want to make about workers compensation is probably the most important and that is, any good statician or epidemiologist could run a proper scientific study to determine the contribution that each of the variables make in a workers compensation experience. I believe that if we are serious about getting to the bottom of this, then we need to commission somebody to do such a study. If such a study were done my gut feeling is that it would demonstrate that in fact the contribution of management is less than 50 per cent, and probably much less than 50 per cent.

I want to make some comments about volunteers. I've got information here from Anglican Care in Newcastle, as well as Catholic Care of the Aged. I won't bore you with all the detail, except to say that it looks like in nursing homes there is something like 1 to 2 thousand dollars per annum of voluntary input per bed per nursing home. Now, this voluntary input comes from two sources; one from members of the community coming forward and volunteering, and the other from members of staff staying behind after rostered hours or taking work home.

The sorts of things that the volunteers from the community do are things like sewing, mending, putting on buttons, ironing, supporting individual residents in activities who otherwise may not be able to participate, special cleaning, reading, chatting, driving and a whole host of other things. I guess - - -

MR WOODS: And fundraising?

MR WATSON: Well, I didn't mention fundraising -yes, but I've only looked at actual care or support within the nursing home.

MR WOODS: Yes, thank you.

MR WATSON: Now, that data comes from, as I say, two organisations. I'd like to make some comments about restructuring because in your paper you have looked at productivity discounts as a means of making the industry more efficient. I would like to suggest to you that there are better ways to do it, and I think we need to be looking at restructuring how we deliver care, and I give you two examples: one is the nursing home packages which are well-known in the industry and I won't therefore extend upon that.

MR WOODS: Extend upon those - - -

MR WATSON: The other one I would like to suggest to you is a concept that we're developing and no doubt others have similar things. We call it self-care plus which means that we design and manage self-care developments in such a way that it encourages and enables people to stay in such accommodation well into where they would have formerly have been in a nursing home. Now, I won't say anything more about that except to say that it obviously overcomes the problem of finding capital funding for nursing homes and indeed hostels. It may have other ways of producing productivity improvements as well.

Now, as I said, I didn't come to talk about accreditation but I have to say something. I've actually been involved with accreditation for 20 years, the last 15 years as an accreditation surveyor for the Australian Council of Health Care Standards. I would say that I agree with much of what has been said, not all, but I agree with much of what has been said, particularly where Robyn was talking about whether or not accreditation can prove, if you like, or demonstrate quality. What I would say, the way I would put it is, that there is variability in the reliability, the repeatability of an accreditation survey or an accreditation audit.

What I think we have here in the aged care system is a new arrangement or a new system that is going to need time to get itself going, which is perfectly obvious. But I think the other thing that needs to be said is that there needs to be built into that process ongoing evaluation just to see how well it is getting to real quality. There are lots of things that can be done to improve the current system as it is set up and one would hope that over time they would occur. Thank you.

MR WOODS: Thank you very much. I have read your letter of 6 November and there are a couple of points that I would like to pursue on that, but we'll go through your statement first.

MR COOK: Great, thank you, commissioner. First of all, the main issues I'd like to address are staffing issues, education costs, operating costs and multipurpose services, but with a specific emphasis on rural and remote - I separate those two because I notice in your summary for supplementary funding it relates specifically to special funding for small, remote and rural homes. I think the evidence that I can produce today will indicate that it not only applies to the smaller facilities in country areas, but also to the medium-sized facilities, and when it comes to efficiency of size I think it's an important factor.

We heard this morning the difficulties of attracting staff both in the metropolitan area and country areas. I'd like to demonstrate that that is even a much greater difficulty in rural and remote areas. For example, registered nurses are almost unprocurable in some areas. In our case alone, as an example, we've been advertising for the past month throughout the north-west region and New South Wales regional areas for a registered nurse. We have received two applications; one from a 19 year

old student still in university and one from a 64 year old registered nurse who hasn't worked for 25 years.

MR WOODS: Sorry, what's the location of the position?

MR COOK: Sorry, this is in Inverell.

MR WOODS: Inverell, yes.

MR COOK: This is a dilemma that we have faced for many years and the situation is growing more difficult, particularly with education for registered nurses being in more remote universities. Even though they may leave our country towns to go off to university, very few of them ever return. So we finish up with a scenario that we have registered nurses who have usually been out of the industry for many years, having raised a family, and they come back to work because they're usually supporting their husbands who are on the land or are working in rural-based type industries to earn more money.

So you have not only the consequence of not being able to attract sufficient registered nurses, but it's the quality of the registered nurses. Bear in mind also that refresher courses are almost totally unavailable in country areas. You usually have to go into the metropolitan areas to resource refresher courses. The same applies also to enrolled nurses and assistants in nursing. In actual fact, in our situation, we have had to employ a full-time educator.

We are accredited through the College of Nursing as an enrolled nurse provider and we are also accredited with VTAB, essentially so that we can provide training for certificate 3 level, assistant in nursing training, as there is no other source of skilling staff sufficient for our needs, bearing in mind we have a nursing staff of numbers of around 70 and overall staffing needs of around about 130 people. So it's a fairly significantly sized facility for a remote area.

The other great difficulty we have is attracting the more professionals of staff, for example director of nursing. We had a vacancy about 4 years ago. We advertised throughout New South Wales and Queensland. We had five applicants. Again the quality of those applicants was reasonably poor. In actual fact the person that was appointed only remained with us for 6 months. We had a very recent experience where we required an accountant. We were offering a salary of $50,000 plus. Again it cost us almost $3000 to advertise throughout New South Wales and Queensland. We had 14 applicants, the quality was reasonably poor. We got down to a short list of two and they were both locals. Again they're both fairly young, they will need a lot of additional training to bring them up to speed. I talked with some of my colleagues in the metropolitan area and if they were to advertise for similar positions - one in particular at Rooty Hill required a professional and they had 150 applications. So they have a much greater pool from which to select.

The other problem I feel that we suffer from - and this is not just specific to

rural and remote - is that we do have a reputation for hard work because it's a physically and emotionally draining form of employment, particularly for nursing staff, and many of them would prefer to perhaps work in the public hospital system where the pressure is not so great. On education costs, as I mentioned previously, we have had to employ an educator which is an extra cost of $55,000 a year, primarily to provide skills-based training for our staff as we find the costs of sending staff off for external education is prohibitive because of their replacement costs, travelling costs, accommodation costs. A lot of them being married women with children are reluctant to leave home particularly on their own. Most of them are fairly fearful going off to a larger centre.

We provide preceptor training for the University of New England which is another reason why we need a reasonably good base of education staff. Also with the expectations of accreditation, not only are we increasing the skills of our staff for our own needs but there is an expectation that all assistants in nursing and personal care assistants that work in hostels, within a reasonable period of time should at least have a minimum education standard of the certificate 3 level of training. We've committed ourselves to upgrade all of our staff in that area, that is 40 staff members, and that's going to be over a 3-year period at a total cost of around about $145,000. That's to take them off the wards, to give them the required amount of training. Obviously they have to be replaced whilst they're receiving that training. So it works out at about $48,000 per annum to upskill that level of staff.

Then of course, we have to provide education from a regulatory compliance point of view for staff members who are part of an occupational health and safety team. That is not available in Inverell, it either means going to Armidale or Tamworth and that costs approximately $1200 per participant because it's a 4-day course. Then you obviously have turnover. As people leave someone has to replace them and of course that's an ongoing cost. For 10 members of the occupational health and safety committee that's quite significant. We also have to provide fire safety training for an accredited fire safety officer which means a trip to Sydney for a 2-day course, which amounts to a thousand dollars.

As far as operating costs are concerned, this is another significant area where rural facilities without exception pay much more than the metropolitan area; for example, fire protection. There is a regulatory requirement that we have early warning fire systems throughout our facilities. If we have a malfunction of our system - we have a contract and those people come on site once a month to test the equipment, and you also have a major service each 6 months. But if we have a malfunction of the system which requires the service agent to travel from Tamworth to Inverell, it's $55 an hour travelling, $55 an hour labour which is also included in the travelling time and $30 for the service. That, all round, costs us about $500. Now, we can't afford to have a section of our nursing home not protected if there is a malfunction. We tend to get a lot of thunderstorm activity in our area and we are forever having to have attention to that fire alarm system. So that's another significant cost.

Mixing valves is another. It is a regulatory requirement that those mixing valves are attended to. You have to have a major service at least once every 12 months. There are no qualified plumbers in our area so we have to bring someone in from outside; another significant cost. Fuel costs in the metropolitan area - the average fuel cost is 65 cents a litre. In country areas - Inverell is a probably a little bit more fortunate because we're in a zone closer to the Queensland border where it is a little bit cheaper, but it's 76 cents a litre in Inverell. So it's 12 cents a litre more. So for all of your travelling for education, for acquiring provisions, etcetera, it has an impact.

Our communication costs are quite significant. Once you get outside of the boundary of the Inverell shire it's STD, so even if you want to ring Armidale or Tamworth or places further afield, which is - well, it's virtually an hourly occurrence during working hours because you're ordering equipment, spare parts, food and other related services. Also with our computer remote support, that is an additional cost. It's costing us approximately $20,000 a year for all our communications costs.

I compared that to a colleague in the metropolitan area - Our Lady of Consolation at Rooty Hill and their all-up communication cost is around about $4000 a year, so again it is much more significant. Our council rates appear to be higher in country areas, and in fact there is a clause whereby you can gain some exemption because you're a charity, but they can then turn round and charge you on a per closet basis, and by that I mean toilets, so we finish up paying $14,760 per annum where our friend at Rooty Hill pays $9391. So that it is a significant cost and it's up to the generosity of the council, and our council say that they need every dollar they can get, so whether you're a charity or not - and they apply the same reasoning to the local schools.

Freight costs: this is a difficult one to isolate because much of the goods that we have to bring in from outside are the cost of the item - the cost of the freight is actually included in the item. So it has been difficult to isolate that, but we're averaging a straight-out freight fee for a range of goods of around about $250 per month, and that's only the freight costs that we can absolutely identify; food costs obviously, because everything has to be freighted in and just for food alone it's cost us in the last financial year $176,000. I haven't been able to compare that adequately with the metropolitan area but I would assume that because of the freight costs that we would be paying proportionately more.

The impact of a possible 4 per cent reduction - and I've got my own figures and that of a smaller facility at Armidale which has 28 beds - if there was to be a 4 per cent reduction in funding, that equates to about 25,700, and in our case with a total of 146 beds we're looking at about $150,000 a year. The last point is on multipurpose services, and I don't know whether you're particularly familiar with multipurpose services, but this is - - -

MR WOODS: I've been brought across them. I haven't actually visited a site where one is operating, but I understand how it works.

MR COOK: Okay.

MR WOODS: Wilcannia I understand has a multipurpose service.

MR COOK: Yes, Baradine has one. There are quite a number around New South Wales. Our main concern there - whilst it doesn't affect us personally, we have a great concern about quality of care. Multipurpose services have a set funding on the basis that if they're categorised as a nursing home-type resident the Commonwealth will pay that multipurpose service at the same level as the resident classification scale of level 3. If it was a nursing home-type resident it's based at category 7 - hostel, sorry.

MR WOODS: Hostel, yes.

MR COOK: Our great concern there is that inevitably, whether they come in at that level or lower, their level of frailty will increase, and already many of those multipurpose services are finding that that level of funding is becoming inadequate, so it means two things: they either seek to transfer that person to an even more remote location to get them into a nursing home, which defeats the purpose of multipurpose services, or the standard of care suffers, and unfortunately we fear that the latter may be happening where we could get to the point of having ghettos. By virtue of the way in which they are structured they tend to fall outside the majority of the regulatory requirements that our industry has, even by way of accreditation. Thank you, that's all I have.

MR WOODS: Thank you. I appreciate the detail in which you've put forward your comments. There are a couple of matters that I'd like to pursue a little further. Mr Watson, you mentioned five homes, of which four are currently in surplus and one in deficit. Could you give me an indicative range of the size of the deficit and the size of the greatest surplus, just to assist.

MR WATSON: Yes, I can. The greatest surplus would be 93,000 - that would have been at the end of June 98. The greatest deficit is going - I haven't got the final figure here, but it's somewhere in the vicinity of two or three hundred thousand dollars.

MR WOODS: Current operating deficit, or is that post 4 per cent adjustment.

MR WATSON: That's post 4 per cent, yes.

MR WOODS: What is it at the moment?

MR WATSON: Again, I don't have that figure.

MR WOODS: Right, okay.

MR WATSON: Yes, I'm sorry about that. I can get it.

MR WOODS: No, that's fine. I'm just looking for broad orders of things. I was particularly curious to know that you've picked a 4 per cent - and on the assumption that New South Wales, in your homes in particular, would be at the worst end of the average. If they were at the positive end of the average and were doing better than, would that be enough? How would that affect - - -

MR WATSON: All I'm doing there is saying some homes will be at that end. I mean, I don't know where these five sit. All I'm saying is some homes are going to be in that position.

MR WOODS: Yes, I understand that point. There is of course the other side of the average as well, that those who are doing currently better than average, their surpluses would be enhanced through such a process.

MR WATSON: That is - - -

MR WOODS: If they're funded at average and were doing better than average, they would retain the surplus under that subsidy structure.

MR WATSON: That is true, but unfortunately presumably under this system they're going to be 50 per cent, or something like that - worse off.

MR WOODS: Yes, we just need to keep recognising both sides of the average, not only the worse case end of the average.

MR WATSON: Yes.

MR WOODS: I noticed, Mr Curran, with your figures, that your home had absorbed in effect about $250,000 worth of financial impact and a 3 per cent reduction equates to $78,000, which is something less than a third of the impact that you've actually been able to absorb in the last 2 years.

MR CURRAN: Sorry, I don't quite understand.

MR WOODS: Well, you've absorbed a financial impact into your home of nearly 250,000 at the moment.

MR CURRAN: That's correct, yes.

MR WOODS: You were saying that a 1 per cent impact on subsidy would mean $26,000 further impact on your home.

MR CURRAN: That's correct.

MR WOODS: So I'm just trying to put what a 3 per cent impact on your home

would be, which would be $78,000 on that basis, compared to what you've already been able to - - -

MR CURRAN: Yes.

MR WOODS: Or what you've already suffered by way of impact, which is nearly 250,000. So it's just a way of putting into context the relative impact of changes in subsidy levels. Mr Watson, in your paper - and thank you for that, I found that particularly helpful - you drew attention to three and then added today a fourth argument or an assumption I was making in relation to the productivity discount.

MR WATSON: Yes.

MR WOODS: I do continue to note, however, though that there are variations in performance of homes and the challenge is to devise a subsidy that encourages all homes to move progressively towards best practice and to become efficient while still delivering an appropriate level of care, and that is the essence of some of the task before us, to come up with such a scheme, so I'd appreciate any further comments you have.

MR WATSON: I would just reinforce what was said by the ASA representatives, that the benchmarking exercise has the potential in a proper scientific way, or more scientific way, to move us towards efficient and hopefully quality services at the same time and, as I said in my paper, I believe the best solution to productivity improvements is actually in looking at different models of care.

MR WOODS: Yes, and I was quite interested in both the nursing home packages, which you referred to, but also the self-care plus, which you elaborate on there, as another way of looking outside the current square, which is clearly of interest to us. We've had a number of witnesses come before me in this inquiry who have looked outside of the square and I intend to devote a little space in the final report to just canvassing some of those points so that everyone can benefit from the thinking that has been put before me, so I'll take that into account and thank you for that.

In rural and remote - and I appreciate you drawing the distinction between the two and I find that helpful - could you also comment on the nature of care being delivered? I'm conscious that in a number of rural and remote areas there can be separation of the resident from their community, their family; in some cases it's because they are the last remaining member of family still in that community, the partner having passed away, the children having moved outside of that area - or else they are coming to that care from many hundreds of kilometres away from a community environment to there. Could you, from your own experience - and all three of if you so wish to comment - help the commission understand what that involves in terms of providing a more "whole of life" care for the residents?

MR COOK: In our region we have a number of quite small hostels; in fact, I would say most of our country areas are reasonably well-served insomuch as they have

hostels of nine beds up to 14, 15, 20, 30 beds that I suppose in economic terms find it very, very difficult to survive. However, if they weren't there it would mean total relocation of those people to a larger centre, and in actual fact that was happening and our particular facility tended to be that receival point and we were more than happy to see those facilities developed with total encouragement from the Commonwealth at that stage.

MR WOODS: What size hostels are we talking about there? Are we talking sort of 15 to 25-bed type facilities?

MR COOK: Yes.

MR WOODS: And sponsored by organisations or cultural groups that are based on those local communities.

MR COOK: Yes, they're predominantly community-based facilities, community-run facilities.

MR WOODS: Yes.

MR COOK: Some of them are actually under the auspices of the local councils and they probably are in a better position, because they can outsource some administration and other areas of management, which the community-based ones do tend to struggle with. It may well be in future that there may be forced amalgamation of some of those facilities.

MR WOODS: At least in an administrative sense and not in an operational sense.

MR COOK: Yes. It is a great concern, however, the impact of the new aged care legislation, because most of these small facilities do not have registered nursing staff and the staff working in those facilities do not have nursing qualifications, so that in itself is a tremendous impact. Only last week, we received a draft from our local regional Department of Health, which indicated that because of the new aged care legislation, that they would be introducing a charge on those smaller facilities if they wanted to utilise any of the Department of Health services, so that will be a further impact on the viability of those places. I'm saying, for example, a community nurse coming in to give an insulin injection, doing a dressing, giving advice on continence management, podiatry for severe diabetics, etcetera, so that is going to have a tremendous impact on, again, the viability and management of those places, because there is no way that they could afford to employ a registered nurse.

There is obviously, a time when those facilities then have to move their residents on, because they can't take any more than a required number of people before requiring a registered nurse.

MR WOODS: Yes, I understand that tiering process.

MR COOK: So there is an impact. The other is the education and, fortunately, we do have a tremendous networking and I would say that most country areas would do, but it is particularly strong in this region, where we tend to be supportive of the smaller facilities, particularly for skills-based training, whereby our facility does tend to provide education to those outlying centres.

MR WOODS: Thank you. Workers compensation, you were present while other witnesses were discussing that matter and the interchange we had, but are there any particular issues you want to draw to my attention, other than what we've already discussed?

MR COOK: Only on the basis that one of the speakers this morning indicated that fact of the no-fault-type claims, that it doesn't matter what amount of training that you do give, and I would without reservation say that virtually every facility in this region has got a very active occupational health and safety program in place, however, our incidences of workers compensation injuries, if anything, are increasing. Anecdotally, I suppose, in our own particular case, just to give you an example of this difficulty, we've got a major claim under way at the moment of a registered nurse who is claiming a neck injury as a result of pushing pills out of a Webster blister pack. Now, that potentially could run into a significant amount of workers comp premiums for us in the long term.

MR CURRAN: Just in relation to the previous submission from the ASA, you were referring to incorporating something into a basic subsidy for the basic tariff premium. What about the claims side of things, in light of what Paul said? Really, we're quite held hostage to the WorkCover Act, whereby it's no-fault insurance. What about that other side?

MR WOODS: That's what I was exploring with the previous witnesses, to how much of that can be related to the occ health and safety practices of the home in question and how much of it relates to unavoidable events that threaten the viability of a home, and how do you devise a subsidy where there is incentive to pursue good practice, but recognition that homes shouldn't go under because of large claims that affect their fundamental viability and it's a matter of trying to achieve some balance and I'm not suggesting that balance just lies in the middle between the two, that it may be towards one end or the other, but they're the essential criteria to look for in trying to devise a premium subsidy arrangement. Yes, Mr Watson.

MR WATSON: There needs to be a multiple regression analysis, done by someone with statistical background, into the causes of workers compensation cost and that sort of analysis will indicate where the balance of factors lie in terms of, you know, what is within control of management, what's caused by all sorts of other things? That's what needs to happen.

MR WOODS: Thank you.

MR CURRAN: On page 43 of the position paper, there's a reference to subsidies

based on average costs, and I just quote:

> Providers using a more expensive mix of inputs would still face pressure to improve their efficiency or exit the industry. Over time, this would put downward pressure on the average benchmark cost.

MR WOODS: Yes.

MR CURRAN: Couldn't you have the same analogy with workers compensation as well? The cowboys of the industry in terms of OH and S, they also will face the same demise.

MR WOODS: If we're looking at a subsidy that isolates workers compensation, however, we then have to treat it within its own parameters, whereas that was referring to the subsidy relating to general operating costs overall. So I don't think you can translate one completely and simply to the other, because workers compensation has the two elements of a base premium which also differs between jurisdictions and within jurisdictions will differ over time and, as it was also pointed out, differs between whether you're grouped or ungrouped, so there is that level of complexity to deal with and to ensure that because those elements are outside of your control, that they are adequately reflected in both the input bundle of costs and the indexation process, then there is separately the marginal element which relates to some element of control that you may have overperformance through your occ health and safety practices, but recognising that even in those cases, there are still events and instances that are outside of your control that can threaten your viability.

I don't think workers compensation lends itself simply to the same methodology. The underlying principles are similar, but I think it may need to be devised and I'm interested in the recommendation that was put to us to ASA to explore a little further.

MR WATSON: If we were building on that ASA recommendation, what I would suggest is that that percentage that, in essence, the provider has to pick up out of their own funding ought to be equal to the percentage after study that it is determined that a provider can actually control.

MR WOODS: Yes. And it would have to be based on some analysis to come up with an appropriate figure.

MR WATSON: Rather than - at the moment it can be as high as 80 or 90 per cent, which is clearly inappropriate.

MR CURRAN: As I said earlier, for our organisation, what drives us with workers compensation is to get below that average, because then we know we're financially disadvantaged.

MR WOODS: It's a very powerful motivating force.

MR CURRAN: Indeed.

MR WOODS: Thank you. With those community hostels that you were referring to, presumably they look upon your nursing home and others in the region then as the next stage, so that ageing-in-place won't be occurring in those, because they trip the RN requirement in particular, although they may or may not also have other facilities and services that can provide support for the very frail aged. Do you therefore have to, in your planning of your future, take into account your broader hinterland, so that when you're looking at accepting your next resident, be cognisant of a wide range of feeder groups coming in.

MR COOK: Obviously, we do, because geographically we cover a very large area as well, and the fact that we also have a dementia-specific hostel unit, which tends to have - there are only two of those in the entire north-west region, so we tend to have a tremendous drawing power for that. But certainly, we do have to factor in that once they get to a certain level in those small hostels, then we will actually be the receival point, I guess, ultimately for those people. That, in itself, creates a lot of social implications for the residents and their families, because it does mean that they are much further away. We're talking about towns that are within a 150-kilometre radius.

MR WOODS: You talk about you cover a very large area. How far out west do you go?

MR COOK: The nearest nursing home west of us is Moree, which is 230 kilometres away.

MR WOODS: I visit Moree at least twice a year. Do they then pick up back out through Bourke and Tibooburra and place?

MR COOK: I would imagine so, yes.

MR WOODS: Although they might follow transport routes more, back down towards Broken Hill or Dubbo.

MR COOK: Towards Dubbo and that area, yes. But certainly, they would have another large catchment, although there is a nursing home at Narrabri, which would take some of the pressure off. We are called upon to care for people from quite remote - in fact, in our village, we do have relatives' units that are available, like motel-style suites for those people to visit.

MR WOODS: Do you charge motel-type rates for them?

MR COOK: No. $10 a night.

MR WOODS: Bed and breakfast?

MR COOK: No, it's fully self-catered. It's just like a motel-style suite and it's really just a service to encourage relatives to visit as often as possible.

MR WOODS: Yes. And strongly endorsed, from our travels and experiences, that it's very important that they have somewhere to stay that they also feel comfortable with and know and that it's on site or nearby. Thank you for that. Gentlemen, are there any other matters that you want to raise before me while we're on evidence?

MR COOK: Just one again on the rural remote issues compared to the metropolitan area - and it was mentioned earlier today, about the ability to be able to outsource for laundry, for food.

MR WOODS: Yes. I don't guess there's too many cook-chill in-services that you're drawing upon.

MR COOK: There's not, no. So, again, all the facilities in rural and remote areas, regardless of their size, have to be totally self-sufficient.

MR WOODS: Although we've come across some instances where the base hospital can provide some of those facilities.

MR COOK: It doesn't happen very much these days, because they keep jacking their costs up to a point where it's just - - -

MR WOODS: You make your own commercial judgment.

MR COOK: Yes.

MR WOODS: But certainly the opportunities for contracting out and the lack of competition is a significant factor in how you can operate.

MR CURRAN: Just in relation to efficiencies and the indexing of the rate, less some sort of efficiency bonus or gain, you've heard from myself about how we've absorbed so much in terms of loss of funding and increased costs over the last few years. I feel that whilst we always have to strive for continuous improvement and looking to do things better, that we are starting to reach the end as to how far you can go. You can only feed a resident as quickly as they can eat. You can only walk them as quickly as they will walk. How far do we go?

MR WOODS: I do understand those points and I have visited nursing homes and I'm very conversant with the fact that we are actually dealing with people and people need to be dealt with with dignity appropriate to their circumstance.

MR WATSON: Can I just raise one thing?

MR WOODS: Yes, please.

MR WATSON: My own organisation, and I know this would be so for many others in the not-for-profit and charitable sector, any surplus we make is retained within the organisation to plough back into services or to meet the needs of the financially disadvantaged. I just make that point. So that if we do make a surplus, it's not frittered away, it's used productively to benefit our customers and the community.

MR WOODS: I understand that point. Thank you for raising it. Any concluding points you wish to raise?

MR COOK: Just one more point. It came up this morning, as regards - well, I suppose the fact that we do have to provide a service for not just elderly people in some of the rural remote areas. We have taken people in their thirties and forties, who reside in our area who are totally incapacitated with various forms of disabilities, primarily because there is nowhere else outside of the metropolitan area.

MR WOODS: We met a similar person in Tasmania, who was late twenties, who has a life expectancy of another 30 or 40 years or more.

MR COOK: So that has an impact on the social design of your facility.

MR WOODS: They have very different needs in one sense and very similar needs in another.

MR COOK: Yes.

MR WOODS: And they will be there for a very long time, in all probability.

MR COOK: Yes. And, you know, it also has an impact on addressing the social needs of their loved ones.

MR WOODS: Yes. Thank you. Thank you, gentleman. I've greatly appreciated the opportunity of being able to discuss those issues. Thank you also for the written information that Catholic Care of the Aged provided. At this stage, then, I'll draw to a conclusion these hearings and thank people for coming from around the region to help the commission understand the regional aspect of its issues, plus the broader issues as they've been brought up, both by regional representatives and by the state representatives. Thank you.

AT 4.22 PM THE INQUIRY WAS ADJOURNED ACCORDINGLY

INDEX