COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

Reference: Aged Care

TUESDAY, 22 FEBRUARY 2005

ADELAIDE

BY AUTHORITY OF THE SENATE

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COMMUNITY AFFAIRS REFERENCES COMMITTEE

Tuesday, 22 February 2005

Members: Senator Marshall *(Chair)*, Senator Knowles *(Deputy Chair)*, Senators Humphries, Hutchins, Lees and Moore

Substitute members: Senator Allison for Senator Lees

Participating members: Senators Abetz, Allison, Barnett, Bishop, George Campbell, Carr, Chapman, Colbeck, Coonan, Crossin, Denman, Eggleston, Chris Evans, Faulkner, Ferguson, Ferris, Forshaw, Greig, Harradine, Lees, Lightfoot, Ludwig, Mackay, Mason, McGauran, McLucas, Murray, Nettle, O'Brien, Payne, Tierney, Watson and Webber

Senators in attendance: Senators Humphries, Knowles, Lees, Marshall, McLucas, Moore

Terms of reference for the inquiry:

To inquire into and report on:

the adequacy of current proposals, including those in the 2004 Budget, in overcoming aged care workforce shortages and training;

the performance and effectiveness of the Aged Care Standards and Accreditation Agency in:

(i) assessing and monitoring care, health and safety,

(ii) identifying best practice and providing information, education and training to aged care facilities, and

(iii) implementing and monitoring accreditation in a manner which reduces the administrative and paperwork demands on staff;

the appropriateness of young people with disabilities being accommodated in residential aged care facilities and the extent to which residents with special needs, such as dementia, mental illness or specific conditions are met under current funding arrangements;

the adequacy of Home and Community Care programs in meeting the current and projected needs of the elderly; and

the effectiveness of current arrangements for the transition of the elderly from acute hospital settings to aged care settings or back to the community.

WITNESSES

Committee met at 9.00 a.m.

DEMPSEY, Mr Robert Neale, Chief Executive Officer, Aged and Community Services South Australia and Northern Territory Inc.

FISHER, Mrs Marcia Janet, Chairperson, Aged and Community Services South Australia and Northern Territory Inc.

CHAIR—The Community Affairs References Committee is continuing its inquiry into aged care. I welcome representatives from Aged and Community Services South Australia and Northern Territory. The committee prefers all evidence to be heard in public but evidence may also be taken in camera if such evidence is considered by you to be of a confidential nature. Witnesses are reminded that the evidence given to the committee is protected by parliamentary privilege and that the giving of false or misleading evidence to the committee may constitute a contempt of the Senate. The committee has before it your submission. I now invite you to make an opening statement which will be followed by questions from the committee.

Mr Dempsey—Aged and Community Services took the opportunity offered to it by the Senate inquiry to make comments in relation to the five questions that form part of this inquiry. I will go through each of those questions and highlight some pertinent points that we raise in the submission. I point out, however, that the submission was written in either June or July last year and since writing this document there have been some changes which affect the theme of what I put forward in the submission. At those relevant sections I will highlight those points and we can note them accordingly.

The first question is about the adequacy of the current proposals and especially those in the 2004 budget to overcome the aged care work force situation. I would like to address that in three veins. The first is in relation to community care. Community care is the sub-branch of aged care which is looking at helping people to remain at home—that is, offering care and support services to those people who are remaining in their homes. The overarching theme behind it is to keep people out of residential aged care. One of the issues that we have within the industry is that in the 2004 budget there were very little if any initiatives designed to work towards the community care work force. The majority of it was focused towards residential care.

We do have some concerns with the community care work force. The majority of these people are working in unsupervised situations. They are going out to people’s homes and offering them a variety of services. This creates a unique series of circumstances for these people, for most of which they are relatively poorly paid. As I put it in my submission, the average wage that the people in community care get is somewhere between $14 and $17 per hour. The vast majority of the work is casual and in some cases the services are brokered or on a contractual basis so there is no employment relationship. As I outlined, there are concerns with respect to the occupational health and safety of these people going into people’s homes and working unsupervised. They have to be very multiskilled because the work that they do could encompass a variety of tasks.

One of the things that we are now seeing is a reluctance of people to take up work in the community sector. I get a sense from within my own membership that the community care work force is in—I hate using the word ‘crisis’—peril of leaving a good number of people in their homes without ongoing support if we as a nation do not do something to enhance the benefits that community care workers get to make it an attractive field of endeavour for workers to work in. That is the community care aspect.

With regard to the residential aged care response that I put in my submission, I will focus first on the formally registered people—by that I mean the registered nurses and enrolled nurses. In the Hogan report, which was a precursor to the budget, Professor Warren Hogan suggested that the government increase the number of registered nursing places at Australian universities by 2,700 people over the next three years, with 1,000 first year places commencing in the 2005 academic year. He believed that was necessary to overcome the massive shortfall there is in the work force at present, particularly in aged care.

The government's response to that, as I assume you are aware, is that the government provided for only 400 additional places in 2004-05, increasing to only 1,090 over the four years, which is a bit less than half of what Professor Hogan had recommended. My understanding of the work force is that there are more people leaving the work force than there are coming into it and that the average age of registered nurses working within the aged care sector is about 47 years—so it is ageing at a very rapid pace. Clearly, we are not getting the younger registered nurses coming into the work force. We are getting some, but not as many as we need to replace those who are leaving.

It has been our experience—particularly here in South Australia, but I suspect in other parts of the country—that it is fine to increase places at the universities to take on more people but, sadly, there is no guarantee that these people will ever end up in the aged care sector. Indeed, it is my belief and the belief of a good number of my colleagues that the majority of people who are coming out of the universities are being snaffled up by the acute care sector—the public hospitals and the acute private hospitals—before they ever get a chance to get into aged care.

Part of the reason for that is that the work is getting harder. There are many more reporting requirements and an expectation that people will participate in non-clinical activities such as quality related activities and so forth and they are having to look after, or supervise, greater numbers of people. A 40-bed nursing home, for example, could have, effectively, one registered nurse and a team of enrolled nurses and/or care workers—which puts a lot of pressure on the registered nurse, and at a higher level than they are being paid. The other factor is that registered nurses in the aged care sector, arguably, are generally paid less than their counterparts in the acute private sector, which again is keeping them behind the eight ball.

The situation is inherently far worse in the rural and remote sector. Being responsible for the Northern Territory, I was in Alice Springs recently talking to some providers. They have permanent agency staff working in their environment purely because they are unable to attract full-time employees of their own. That is a poor reflection of what we are now facing. I understand that in rural South Australia hospitals and nursing homes have been able to attract nurses but have not been able to retain them. They lose them very quickly.

There are some other work force issues I wanted to touch on. We tend to focus on registered nurses and care workers within aged care but we also have a large problem attracting physiotherapists, podiatrists, dentists, speech pathologists and dieticians to residential aged care. It is endemic of the work force generally—there are simply not enough of these people to go around. The federal government's Medicare Plus initiative, the Aged Care GP Panel initiative, was a fantastic initiative. We looked forward to that initiative increasing residential aged care's ability to attract doctors to the nursing homes, not only to see residents but also to give education and training to the staff. But the pick-up rate on that has been incredibly slow and frustrating. There have been some fantastic developments—some really exciting and innovative developments—but they tend to be relatively isolated to selected regions, and the other divisions are quite slow on the uptake. I see that as a big problem as well, because this initiative is for a timed period, and I fear that the time will run out—as will the money—before we see any true benefit.

I now move to the second question: the performance and effectiveness of the Aged Care Standards and Accreditation Agency in assessing and monitoring care, health and safety, identifying best practice and implementing and monitoring accreditation. This is one of the aspects of the report I wrote last year which has arguably changed the most. A good deal of my submission relates to the accreditation of the agency—in particular, along the lines of the JAS-ANZ, the Joint Accreditation System for Australia and New Zealand—in that our argument was that the agency was not accredited itself but was acting as an accreditation agency for other organisations. As you would be aware, the agency has now become an accredited body. So that aspect of my submission is perhaps not as relevant today as it was when I wrote it.

I have some additional comments in relation to the agency. Some aspects of my report outlined the concerns of my members at the time—the comments and concerns that were being expressed by my membership of just over 200 members. Some members felt intimidated by the agency and believed that the term 'support' visits was a misnomer. What they really felt was that the accreditation process put undue pressure on a facility at a time when they are really working hard. Since that time, I have conducted an extensive survey of my members and have found the situation to be quite the contrary—and I am not quite sure whether it is because of a change in time—in that there was overwhelming support for the agency and the accreditation process. There were, however, a few comments in relation to subjectivity versus objectivity—that came out on a few occasions—and consistency in approach. For example, one team of assessors can go into a home and conduct a survey and find that it complies with every standard, and some time later another team will come through, nothing will have changed within the home itself, but it will be found to be noncompliant. So there were concerns about how this could be the case.

I also said in the report that there were concerns about the quality of assessing within the agency itself. The agency is now looking at these issues and, I understand, conducting regular quality assurance on itself to ensure there is greater consistency between the assessors and the work they are undertaking at the time. In summary, a lot of the comments I raised in June or July of last year, when this document was prepared, are perhaps not as relevant now as they were at that time. I get a sense that the relationship between the agency and my members is a good one.

I will move to the next point: the appropriateness of young people with disabilities being accommodated in residential aged care facilities and the extent to which residents with special needs such as dementia, mental illness or specific conditions are met under the current funding arrangements. I do not think that there is any argument within the industry that it is not necessarily appropriate for young people with disabilities to be accommodated in residential aged care facilities. However, it is our experience that in many cases there is little or no other alternative. This is particularly true when you are dealing with people living in rural and remote regions. In cities there are some other options and some other alternatives available to young people with disabilities. That may not be the case in rural and remote regions. For instance, some time ago there were about 62 such people in South Australia, at least, between the ages of zero and 49, 135 people between the ages of 50 and 59, and 184 people between the ages of 60 and 64. With our ageing population the coincidence of aged people with a disability has to increase and we have to find ways of dealing with that.

In South Australia the state Department for Families and Communities together with Commonwealth Department of Health and Ageing are looking at this issue and are putting practices into place to prevent the unnecessary movement of younger people into aged care. There is an assessment process in place—I think, through Julia Farr Services—and as far as possible alternatives are now being sought to prevent young people from going into nursing homes because there are no other alternatives. I think that is a tremendous way forward.

Clearly, a lot of this comes around to Commonwealth and state funding. When somebody is in a residential aged care facility they are funded by the Commonwealth—at least, ostensibly—and yet if they are in another facility, a state government facility, or a disability related facility, the funding is by the state government. So those discussions do need to take place in terms of who ends up funding these changes. But generally there are good moves to overcome this issue. From our perspective clearly younger people in nursing homes suffer isolation and lack of peer support. Also from the point of view of the older residents in a residential aged care setting, it is not always good for them to have young people there in residence either, so there is a bit of a misfit. But I do think there are good things in place there to make progress. It is probably not happening as quickly as it needs to and more work needs to be done in that area.

Then there is the issue of the adequacy of the Home and Community Care program in meeting the current and projected needs of the elderly. I have to say that from my perspective—and I believe that of my colleagues in aged care—the Home and Community Care program is sensational in the sense that it reaches and touches so many people and provides an incredible service. Without it people would otherwise be put in a very difficult situation. My own mother, for example, has just turned 84. She gave up working for Meals on Wheels just a year or two ago, having spent 40 years working for that organisation. She is now a recipient of Meals on Wheels. She remains at home with that support and the few other aspects of support which she gets. I think that the Australian society is wonderful in so much as we do have these support infrastructures in place to enable our elderly citizens to remain at home. In my report I have highlighted some statistics, which I am not going to go through, which show the tremendous outreach that HACC programs do have.

They are the positives. On the negative side, from investigations that we have done there are a number of people who receive less than 10 minutes a day. Is that good? Is that bad? Truly, we do not know. Whilst 10 minutes may be an appropriate time for someone who has low-level need, as the circumstances change they need more time and what we are not seeing are the processes in place to increase the time that people have in terms of care and support in direct correlation with their increasing needs.

One of the vagaries we have is that when somebody is put on a program or receives a service, it usually takes some kind of significant event for the services that they receive to change in direct proportion. That is one of the things that we have to think about with community care generally: just because we are keeping people at home for longer and with support mechanisms in place, what are the support mechanisms to monitor them to ensure that they are still able to remain at home and that their circumstances have not changed to a point where they need more extensive care? Often, the trigger point is when there is an untoward event—a major fall, a fractured neck of the femur, a cerebral vascular attack or some other medical or physical problem. We do need to watch that.

The other thing is that we tend to package aged care programs. Home and Community Care, as you would be aware, is funded 60-40, Commonwealth-state, but we also have the Community Aged Care Package and, more recently, the Extended Aged Care at Home Package. They add valuably to the whole community care network but there is not necessarily a link between them. So we have found that, particularly in some regions of Adelaide, there is an unwillingness to pick up Commonwealth-funded community aged care packages, possibly because people are not sure what it is that they can get. Perhaps there is a lack of information or, alternatively, it is because they feel they are getting a better degree of service or support with the HACC program. That is an area that needs to be looked at as well.

I also put in the document that there was a concern about the relationship between the state and the Commonwealth regarding the management of HACC. Again, since this document was submitted, the Minister for Ageing has announced ‘The Way Forward’—the government’s response to the community care review. Since that time, state and Commonwealth HACC officials have been meeting, on two or three occasions thus far, and are looking at ways of redefining the HACC agreement. Providing that that all goes in accord and there is agreement between the various parties, it will go a long way to resolving a lot of those Commonwealth-state conflicts.

While I am on that, many providers who are recipients of smaller HACC grants—for example, $10,000—are finding that the reporting requirements attached to the HACC funding are extremely onerous. What has to be remembered is that a number of these organisations are small, provider based volunteer organisations, many serving cultural or religious areas and serviced by volunteers. They do not have the support mechanisms in place to be able to undertake this extensive reporting option. We, as the peak body, have raised this on numerous occasions with government and, whilst there is an acknowledgement that this is the case, there does not seem to be an awful lot done at the moment to try and overcome this issue. What it does highlight is that there are some organisations now saying, ‘No, it is too hard, don’t worry about it, we won’t take the money.’ If you look at it in terms of the services that these small organisations are offering to their specific client groups, it is quite an injustice, in my view.

Regarding the effectiveness of the current arrangements for the transition of the elderly from acute hospital settings to aged care, what I have written in that document is pretty straightforward. South Australia has done a lot of work in regard to work on this particular issue, particularly with the Acute Transition Alliance, City Views and the Advanced Community Care Association, which has been working fastidiously in collaboration with the government to reduce the number of elderly people in hospital—dare I use the term ‘bed blockers’—and to put them into a more appropriate environment.

Having spent about 25 years in the public health system, I am ashamed to say that I do not believe that our public health system looks after the elderly very well at all. It is very much mechanistic in its treatment of the elderly. You go in there, you get whatever it is wrong with you fixed up and then what happens after that is something of a blur. It does the elderly a great deal of good to get out of that public arena and back into more familiar surroundings as quickly as possible. As I said, we here in South Australia, between aged care and the acute care setting, have done a lot of very valuable work in that area. It is not without its problems but it is a good start and hopefully we can enhance that in the future. They were the main points that I wanted to raise in my opening statement. If you would like further clarification I would be happy to provide that.

CHAIR—Thank you. You adjusted your submission considerably in respect to the accreditation agency. You refer to an extensive survey that you did of your members. I am wondering if that survey might be made available to the committee.

Mr Dempsey—I am certainly happy to provide that survey to the committee. Having undertaken that survey, I also provided a copy to the Adelaide branch of the agency and forwarded on to them the comments and the report for their information. My understanding is that the agency's Adelaide office also sent a copy of that to their national office for their records as well. In my view at least the relationship between our body and the agency is a very positive one. When issues come up we try to work through them.

CHAIR—I think that would be useful to us. Do you have any concerns about the level of documentation required by the agency?

Mr Dempsey—Yes, I do. One of the problems that we find these days—and it ties in with the work force issues, really—is that nurses really are averse to overdocumentation. Everyone acknowledges that you must keep care plans and pathways and the appropriate documentation that is needed to look after residents. But what is happening is that we are going to an overkill of information. The parties need to come together to find a way of working out exactly what is needed and being very specific about that and trying to get away from just accumulating masses of information for the sake of exactly that, particularly if it does not have any ongoing relevance to or bearing on the situation. I accept that we need certain information in terms of identifying clinical indicators and perhaps adverse events. But there should be a balance. Some places tend to go overboard.

Partly the reason for that is that there really is a lack of definition in terms of specifically what is needed in order to achieve particular outcomes. What you tend to find is that some places will just do everything and document to the nth degree. That does not necessarily mean that is relevant. So there is a bit of a lack of clarity there. We have tried to address that on a number of occasions by providing information sessions to our members. The agency has tried to do that as well through its education programs. But there is still a fair degree of information collection which is an impediment to the work force, in that nurses want to be clinicians and not necessarily paper managers.

Senator KNOWLES—I just want to carry on from where you have left off there. You also mentioned the reporting options for home and community care. We have to look at any adjustment to those reporting options, both in residential care and home and community care, against a backdrop of unbelievable scrutiny such that, if one thing goes wrong, it is not an individual who is blamed; it is the institution and the care giver—whether it is home or community care or whatever. The liability is sheeted home and the whole sector is put under a microscope and criticised. Accusations are made that the whole sector is falling apart and that the standard of care for the members of the community most at risk is substandard. I can see that there is a balance there where you can get to a situation where it becomes too burdensome. How do we strike that balance against that backdrop?

Mr Dempsey—Senator, I think the two aspects that you highlighted are perhaps a bit separate, and I will approach each of those. With the HACC program, one of the aspects that I suggested to government was that they have a long form and a short form of accountability. In reality, in my view, for some of the organisations which are smaller and receiving smaller sums of money a la the $10,000 amounts, I think the risk factor is actually quite small. I guess you have to look at it from a risk management point of view. These are organisations that are providing some support services, not necessarily clinical services but aid and assistance to members of their local community—again, volunteer based—and the money may be used to transport people around—a variety of things; it does not really matter.

I do find, and it is being reported to me, that the accountability for this $10,000 is becoming overly onerous, to the point where many of these providers are just thinking that it is just not worth the effort. Therefore I think that if you look at this from a risk management point of view, there should be an avenue to provide a long form of accountability and let us say, arguably, that that could be for organisations receiving more than $30,000, $40,000, $50,000 in HACC funding. But for those receiving less it could well be a short form basis, with some generalised reporting so that government and other officials have a degree of comfort in the sense that the money is being used appropriately and fairly. So that is that aspect.

The other aspect that you raise is a very valid concern with regard to residential care. One of the aspects that we tend to find in our line of endeavour is that for the many good things which are done on a daily basis and for the number of people—20,000-odd in residential care—that we look after on an ongoing basis, we get tremendous accolades from families and friends for the help and assistance we are providing to those people. And, with all due respect, a lot of that is as a result of the government’s initiatives around quality and care and it has had a profound impact, in my view, on the industry. But, sadly, one thing goes wrong and it makes front-page headlines and that tarnishes the industry. What we do not see is a blended mix of the good and the bad.

I do take your point. The agency is there, whether we like it or not, in a regulatory capacity. They are provided for within the act and the regulations are there. In accordance with those regulations and the act the agency must undertake its work. I guess what I am coming at is that I think that perhaps both government and the industry itself need to look at what is fair and equitable and try to balance out the impost of over-regulation versus the fact that we have a work force which is very adverse, or becoming very adverse, to large increases in administrative overheads.

Senator KNOWLES—I do not blame them. I think we all are!

Mr Dempsey—True.

Senator KNOWLES—I want to move to the area of providing care for people in their homes. You mentioned that meeting the demand has been made more complex by an increasing demand for home based dementia services. How do we meet those needs into the future?

Mrs Fisher—There are a lot of initiatives at the moment. Dementia is one of the most difficult things to look after in a community setting. One of the reasons why there are more dementia clients coming into residential aged care is that most people can cope with a person at home who has a physical frailty; but to care for somebody with advanced dementia 24 hours a day is exhausting. There is a lot of technology coming on the market now, and I believe that is being used; but again that is very expensive. It is a double-edged sword. You can look after people well, but you cannot look after people on a shoestring budget, and I think this is the crisis point.

There are things like automatic alarms, so if somebody goes out of a house you know it. Apparently there are even things like monitors for the fridge—how many times it is opened. If it is not opened during a 12-hour period, that alerts you that there is perhaps a crisis and somebody is unwell in a home. It is giving support to carers, because you just cannot leave somebody with dementia in the home on their own. Quite often we are talking about older people with older spouses or families that work and have to give up their income to care for them. Basically quite often it is providing support to the family more than the person with dementia—who is quite blissfully unaware of what is going on. We really have got to look at more support for carers: education and also a lot more respite care, so that people can access respite either in the home or away.

Senator KNOWLES—I have one final question. With the dilemma that is being confronted now with caring for people in their home, there are better models around than trying to keep people in their three-bedroom home on a quarter-acre block, where they can actually go and get three meals a day prepared for them, instead of one meal on wheels, get their heavy laundry done and things like that. What have you done about progressing forward those other options that are available to people now in the community—particularly in the low-income areas, where their options might be greatly reduced?

Mrs Fisher—I believe that HACC actually supplies most of the options for this. There are a lot of day care programs being accessed by clients through HACC.

Senator KNOWLES—I am looking more at residential care. My colleagues will probably get sick of me quoting this, but I think a perfect example is Village Life. Are you aware of Village Life?

Mrs Fisher—Yes.

Senator KNOWLES—People actually go and get their three meals a day, and they get their monitoring. They are people who would otherwise be able to live at home but just cannot manage the house or the garden. It takes the burden off the family and the carers. What do you think about options similar to that that could be extended throughout the community by other providers?

Mrs Fisher—I believe Village Life is a private business. We are basically involved with more of a residential and community focus. That is a different arm of business. Quite a few of our members do run retirement villages and, as you say, the options for the future are expanding. But I believe what we would have to do is get away from a core business and go into a different arm of business to do this, from our association's point of view. A lot of places are looking at more short-term options—transitional, three-monthly type care to get people back on their feet. The Housing Trust are also looking at a lot of options for older people at the moment where they can provide low-price housing and linkages with aged care providers to provide that support you were talking about.

Senator KNOWLES—But that is provided by the taxpayer as opposed to someone providing it for themselves.

Mrs Fisher—Yes. As I say, this is basically away from our core business, which is a different area.

Senator McLucas—Thank you very much for your submission. A couple of issues come out of it. You talked about some of your more remote and isolated places having permanent agency staff on their books. What is the cost differential for that?

Mr Dempsey—The cost differential is enormous. The mark-up on agency staff can be as high as 20 per cent to 30 per cent over and above the normal casual rate, because agency staff are generally paid at casual rates. So it is normal rates plus 20 per cent to give you your casual rate and then 20 per cent to 30 per cent as well—in some cases it is 40 per cent—where people are sent out into the community. On top of that, the receiving facility is expected to accommodate the agency nurse for the duration of their tenure at that facility and, I understand, feed them as well—I think that that is free of charge. So the benefit of paying an enormous amount of money for a qualified staff member is that you have a temporary resource who is predominantly from the city—someone who is looking at going out and doing a month-long stint. They generally do not have a good understanding of the residents and, in the case of outback Australia, a lot of the cultural issues, particularly with the Indigenous population and the people who are in those facilities. It is very complex. But the act requires that we do have registered nurses in a home, and if that is the price that you have to pay so be it. But certainly a lot of our members are losing a great deal of money. Part of that is in direct correlation to the fact that they are so dependent on agency staff.

Senator McLUCAS—You said just a moment ago that someone might be there for a month. Is that about the average stint you would do in the bush?

Mr Dempsey—The stints can be one, two or three months long. I am aware of one agency in particular that does place people into very remote places—for example, I am aware of one that went up into the Gove Peninsula in the Northern Territory. During the wet season, once you go up there you are effectively there for the duration. The only way in or out is by helicopter, as I understand it. Generally they are a month long. That is long enough for people, but some people do go up there for extended stays.

Senator McLUCAS—You also talked about the GP aged care panels. Whilst you thought they were a good idea, I share your concern about the level of actual take-up. Do you have any data on that? It is an issue we have actually tried to progress as well to get some information about what is really happening.

Mr Dempsey—It is difficult. I think that each of the divisions is in a different state of progress, and that actually does make it difficult. I do not really know whether the state based body which is trying to coordinate all the activities is doing a good job or not. It is very difficult to say. I have one division here in South Australia—the Adelaide north-east division—which is extremely proactive and very involved and focused. Arguably, it is probably leading the innovation of this initiative. But for some of the other divisions, my understanding is that there has been very little progress made. Again, the corollary of that is that as a result of this initiative, and particularly in the north-east region, residential aged care facilities have now found that their relationships with the GPs, particularly those which are on the panels and are attending the residential aged care facilities, are great. There are tremendously innovative things happening in relation to medication management and care planning and so on and so forth. But for other areas, of course, that is just not there.

Senator McLUCAS—Are they not the same people that were doing that anyway? I suppose that is the question. That seems to be what is happening in places that I am aware of.

Mr Dempsey—I think so. I think it comes down to the willingness of the GP to undertake that. I am aware that there is a shortage of GPs. I am aware that in some regions GPs are not taking on new clients or new patients because their books are full. And so then their time, or the availability that they have to actually go out and visit residential aged care facilities, is extremely limited. This is of course true for country regions as well. So for those regions there has been little benefit.

Senator McLUCAS—Finally, I am interested in your comments about the linkage between HACC and the community aged care packages. I suppose I am a little concerned about your comment that there was an unwillingness to take up CAC packages. Can you expand on that a little more?

Mrs Fisher—One of the reasons there is an unwillingness is that there is a cost, if you can afford it, that comes with CACP. Although a nominal amount goes with the HACC package, pensioners looking at the two will probably decide on whether they can manage on a lower level package and not pay. Although it is not a high amount, it is if you are on a pension. It can cost just over $30 for a CAC package, whereas you might donate $5, if you can afford it, for a HACC service. It is sometimes a little bit more if you have professional services like physio or podiatry. Certainly if a person is getting support in the home and if they can get the service and cope, it is cheaper for them to stay on a HACC package. As I say, it all comes down to money for people and, if you are on a pension, it is a struggle.

Senator McLUCAS—It has also been put to me that for an older person there has been a period of negotiation with HACC and that there are a suite of services that they have been able to arrive at. If you move to CACP, the Community Aged Care Package, what you might be delivered in terms of services is less than what you would have been able to access under the HACC package and that moving from one to the other can deliver you less in terms of real service.

Mrs Fisher—I believe that has been happening. What happened was that, up until a couple of years ago, not much monitoring was going on of clients. When people started looking at the different services people were accessing, each HACC program seemed to be basically running autonomously through an organisation or domiciliary care or an aged care provider or a local organisation. People did not know what other people were doing. Somebody could be accessing domiciliary care to get showering; they could be accessing a local community club to have social events and transport.

Apparently some people are accessing several services, which does not seem right in one way. But, if you look at in another way, if that is keeping that person at home it is a pretty cheap option, rather than having them move into residential care or become sick or have a fall or not cope. So there are two ways of looking at it. My personal point of view in dealing with aged people is that, if we can give them minimal support services to keep them well, it is better for everybody in the long run—everybody wins.

Senator LEES—Going back to your comments on the survey that you did on accreditation, you found quite a high level of acceptance and support of the agency. Does this at all relate to services becoming computerised? When I have visited nursing homes, I have found the happiest ones to be those with everything down on computer—particularly one here in Adelaide; it is now almost totally computerised—and that has basically reduced the amount of work that individual nurses on duty have to do. Is that starting to pick up now? I have talked with other nursing homes which say that the agency will not accept the computerised model of recording. Where are we up to with that?

Mr Dempsey—That is a very good question. In fact one of the issues that our association is working on at the moment is in relation to that very issue and the RCS validation process, not only with the agency but also with the Department of Health and Ageing. As you quite rightly said, a couple of organisations have invested heavily in clinical IT systems in an endeavour to streamline and gain efficiencies in the whole administrative clinical process—

Senator LEES—And keep their staff happy.

Mr Dempsey—and keep their staff happy. One of the things that has come out of that is a disconnect between that progress and the current reporting auditing requirements of both the agency and the Commonwealth. Our association has written to both bodies. I have had a response back from the state office of the agency to say that it is an important issue and that they have referred it on to their national office for a nationally consistent approach to it. I do not have any further information on that one. The second one was the response from the Commonwealth. That was in two veins: one was verbal and the other was in writing. One was that it was okay as long as we can print off the information that they need—which seemed to be at odds with the whole process of going down electronic records.

Senator LEES—I have met nursing home staff who were looking at doing paperwork for an hour, or two hours in some cases, after they finished their normal shift, just to try to keep up with the amount of paperwork. It seems that it is one reason why nurses simply leave the industry and head back into the public hospital system. There are also more jobs opening up for them with GPs, as we now have the items in Medicare for nurses. Could you give us some more details as to exactly where you are up to in this regard? I see it as an area where we have the capacity to make some recommendations and really get some major improvements and streamlining of the process of accreditation and accountability. Is there any correspondence that you are comfortable releasing to us or any information that you have sent to your members and responses from them?

Mr Dempsey—I can certainly provide that information to this inquiry. I do not think there is anything in there which would be in conflict in any way, shape or form. I will make a point in that regard: I think the costs associated with this IT development for the larger organisations which are going down this path are quite large. Part of the reason for that is because there is a tremendous amount of research and development going on. It is fairly embryonic, as I understand it, and it is certainly not ready to be rolled out to the wider aged care population.

Senator LEES—Apparently, one nurse in this particular nursing home had basically been relieved of other duties and when he came on shift was just doing this. They were looking at on-selling the knowledge base that was being built up as a package for other nursing homes. But their problem was: what is the Commonwealth going to accept? What is the agency comfortable with? How does it all fit? Those questions are still out there somewhere.

Mr Dempsey—At this stage we do not have a definitive answer on that.

Senator LEES—Could you demonstrate to us where you have been and then we can perhaps look at where we go from there.

Mr Dempsey—Certainly. As I said, I have written to both the agency and the Commonwealth and I have not had a definitive response back at this stage.

Senator LEES—We can keep following up some of those lines of inquiry.

Mr Dempsey—I am certainly happy to provide the correspondence that I have at this stage.

Senator LEES—Thank you.

CHAIR—Thank you, Mr Dempsey and Mrs Fisher, for your submission and for your participation today.

Mr Dempsey—Thank you very much indeed.

[9.53 a.m.]

HEARN, Mr Richard John, Chief Executive Officer, Resthaven Inc.

CHAIR—Welcome. The committee prefers evidence to be heard in public, but evidence may also be taken in camera if such evidence is considered by you to be of a confidential nature. Witnesses are reminded that the evidence given to the committee is protected by parliamentary privilege and that the giving of false or misleading evidence to the committee may constitute a contempt of the Senate. The committee has before it your submission and I now invite you to make an opening statement, to be followed by questions from the committee.

Mr Hearn—Thank you for the opportunity to be here today. By way of background, Resthaven Inc. is a Uniting Church agency. It is one of the large service providers in South Australia in both residential and community care services. The bulk of our funding is from the Australian government in the Aged Care Act related services, and other funding is a combination of state and federal funding through the Home and Community Care program. There is also an element of our funding from client resident fees.

Resthaven employs over 1,100 staff. We have over 400 volunteers. The average age of our work force is approximately 47 years. Work force shortages in the aged care sector is a key concern to Resthaven. We have been particularly focused, as a topic of concern, on nurse shortages over the last five to six years. In recent years we have observed issues in other job categories, such as personal care workers, home support workers and allied health professionals such as physiotherapists. A lot of our emphasis on work force issues has been by way of a focus on nursing, but in more recent times these other job categories have been of concern to us as well.

To elaborate on some of the issues in my submission, I just want to focus on a few matters with respect to nurses and the specific budget strategies. First of all, I think it is important that additional places have been provided in the budget. I think that is an excellent outcome. I do not want to be critical of the fact that extra resources have been provided. My concern, though, is about more than just this budget; my concern is that we have been raising this issue for many years. I do not think either state governments or federal governments have really understood the key aspect of this and the potential domino issues that are going to develop in the future. So, with respect to the budget initiatives specifically for nurses, I think it is significantly under the amount that is needed. My understanding from state government statistics is that some hundreds of extra places would be needed to be offered in this state for the training of nurses to meet the retirement levels that are occurring in nursing.

With respect to related issues in other job categories, I notice the aged care work force vocational places that have been offered, which are very important as well. The issue of the 1,500 enrolled nurse medication certificates does not seem to have specific relevance to South Australia. I think that is more relevant to the Victorian system and possibly the New South Wales system. Again, it is not easy to comment on the supply-demand issue in the personal support area because we do not keep statistics in the state or nationally to give us a good grasp of what the issues about demand are in that area.

A related issue to work force outcomes has been well argued in the sector with regard to our indexation system, called the COPO indexation system. A very important outcome of the last budget was the introduction of a conditional adjustment payment, CAP. The 1.75 per cent each year for the next four years is a very much appreciated outcome. Resthaven has just completed a nurses EB. We offered the 1.75 per cent in our wage offer as well as the indexation outcome of two per cent in year one of our EB, so we offered 3.75 per cent. So the total amount of that CAP payment has now been used by us for wage issues. As an example, we have just resolved the first year of our current EB, and the first-year outcome for nurses in the state government's EB is six per cent. So, on one hand, I do not want to be critical about what I think has been a tremendous outcome that the Australian government and parliament have offered us in the budget in terms of quantum increase, but our real dilemma is that the state government is the major employer of nurses in each state and in its responses to nurse issues it has been offered significant wage outcomes. It is the price leader and it is the major employer. So we have a real dilemma in relation to still competing for nurses from a wage perspective. I acknowledge, though, that is only one of the aspects of work force issues that we need to contend with.

Related issues to work force matters that I wish to emphasise include the issue of the increasing difficulty that aged care residents who move into aged care facilities are having with their doctors not following them to aged care facilities. This is a great concern to us. We think that a related issue to this is the fact that doctors are given a disincentive in the Medicare rebate system when they attend aged care facilities. Their first consultation fee is approximately what they would receive in their surgery. If they have successive consultations, the fee is discounted. In an environment where there is a shortage of doctors and an overwhelming demand on their surgeries, there is great incentive for them to remain in their surgeries where they have fixed costs. We believe the MedicarePlus strategies have not responded to that issue.

Flexibility between existing job professions is another area that is critical for the wider community, nationally and in this state. It is difficult to know where we should have leadership here. I think it is a shared responsibility for service providers, government at the state and federal level, and unions. At this particular point I think we are too set in historic views about where proper regulation should occur. There is significant need for leadership and for all the stakeholders involved to have greater flexibility with respect to nurses being able to dispense medication and order clinical tests through nurse practitioner roles, not just being employed by doctors but working in consultation with doctors.

I believe there is a great need for nurses to be able delegate to non-nurse workers issues of medication. Controlled substances acts nationally in this state allow us in our own homes, when we are the carer, to provide enormous levels of medication management and dangerous drugs to ourselves, our children and our disabled children but, when you move into an aged care system, the regulations and the issues of risk mean that there is a significant limitation. We are heading for a domino impact due to the shortage of nurses. The reality is that those limitations will unfortunately be seen in the media to be a criticism of some service providers and they will not be aware that the agency or the department had raised this issue as being part of a wider work force shortage issue.

Overall, I think the accreditation agency play an important role and do a good job. The previous system, managed by the department, was also reasonable, but the accreditation agency continue to improve their outcomes. I am not in favour of a rating system. I cannot imagine that the state acute hospitals will be rated—for example, think about the five acute hospitals in this state and rating them in stars. I think the community would be concerned as to why we would rate hospital systems. In aged care, there is the important issue of minimum standards. I think the agency is managing to minimum standards. It is important for all the elderly that we ensure that they get at least minimum standards, and I think that is where the regulatory focus should be.

There is a staff concern about paperwork. There is the counterbalance that the government has to regulate its standards—I understand that—but we need to search for a balance in the way we can produce the best outcomes. Resthaven had the opportunity in the last accreditation round to apply for a higher level of standards acknowledgment from the agency. In wrestling with our concerns about staff sensitivities regarding the paperwork issues and the focus away from resident care to going through a process of an award, we chose that we would not submit to the level of requirement that the agency currently has for that type of rating. I think it is dangerous for us to go in this direction. If there are going to be ratings, they should not be based on additional paperwork processes to prove that you are at a higher level.

I have talked in my submission about the transition from acute care. I would just reemphasise some of the programs that are occurring in South Australia. In the last four or five years, the relationship between the state and federal governments has been the best I have seen in my 20 years in aged care. It is tremendous how the governments and the bureaucrats are working positively to try to find better outcomes. I know that, in the scheme of things, it may not be evident to the public but they are working well. I think the transition places in the federal budget are an outcome of that good work, and I applaud the government for those 2,000 transition places.

There are some significant state based programs evolving in this state with the Acute Transition Alliance, which comprises aged care providers, and the federal government—for example, a city view step-down facility run by the Aged Care and Housing Group—and state and federal government funding. The Advanced Community Care Association, which has state based funding, is doing a lot of work in the area of hospital avoidance and has developed a program in residential aged care facilities. Where an Australian government funded aged care facility identifies that someone may have to go to hospital, the state government is using the Advanced Community Care Association to provide additional funding to help them stay in their facility rather than go to hospital. It is an excellent program.

CHAIR—Mr Hearn, I do not want to restrict you in any way but I am conscious of the time, and the committee will have some questions for you.

Mr Hearn—I appreciate that. I am concerned that, in commenting on issues such as this in your task, we can give undue negative focus to matters because of the nature or focus of the questions. This then affects the images associated with working in aged care and providing services to the elderly. The aged care work force is comprised of thousands of dedicated and caring individuals, staff and volunteers who work very hard and make a caring and positive difference to the quality of life of our elders. The Australian government and the parliament should invest funds and effort in ensuring that there are positive images of working in aged care and working with our elderly which can be emphasised through the media. It is important that young people understand the value of respecting our elderly and it is important that the government takes a leadership role in encouraging that work in the community.

Senator HUMPHRIES—We have heard comments by some agencies and providers that there is not enough money in the government’s announcements in the budget last year to make up the shortfall in nurses’ salaries between what nurses are being paid in the aged care sector and in the acute care sector. Others such as the ANF have said to us that there is enough money there but the providers are not committing to use that money to redress that shortfall. Will Resthaven be using the money that it receives, for example, under this 1.75 per cent conditional payment to raise nurses’ salaries or will you be using it for other purposes?

Mr Hearn—First of all, there are some obligations with the awarding of that money that relate to training and some other conditions such as work force surveys. However, we have just completed an enterprise bargaining agreement for three years with the ANF, who have agreed to the terms with us. That is based on three years at 3.75 per cent. The starting point for this year has two per cent from the COPO indexation that we received in July last year and the 1.75 per cent. We have projected that outcome over the next two years. From our point of view we are clearly using the money for those purposes. If you wish to consider the issue of add-on costs, offering 3.75 per cent in specific wage outcomes will cost us 4.9 per cent in costs. So we are definitely using that money to flow on. I do not agree with the ANF’s generalisation; I think there is much more pressure in the system than the comments you alluded to imply. It is still an issue for us. We are desperate to provide for a proper work force, but we also have to manage our business and to ensure that we do that prudently. The community charges us with that obligation. We are trying to balance all those issues.

Senator HUMPHRIES—After you pay that 3.75 per cent, how far short will nurses in your system be compared to nurses in the acute care sector?

Mr Hearn—A factor related to this is that public benevolence institutions have access to salary sacrifice, which was a very important initiative by the government some years ago. That is a critical component for us to be able to argue in this three-year period, that we are within five or six per cent of the acute care outcome in terms of value to our nursing staff. Our concern is that, following this three-year period, we would have already offered that balancing option. The state government EBs are six per cent in year one and—I may not have mentioned this—16.5 per cent in the three-year period. If they have a similar outcome in their next EB in three years time we will struggle significantly to be within that five or six per cent of outcomes that are being given to nurses in the state system.

Senator HUMPHRIES—We have heard lots of reasons why nurses are not choosing to go into the aged care branch of nursing. The reasons are not just to do with there not being enough training places for them—or so we are told. Are you confident that if there was a significant increase—for example, a doubling, as Professor Hogan suggested—of the number of training places for nurses then people would take up those places?

Mr Hearn—Yes, I am confident people would take up the places. The statistics I have seen suggest there is about a 30 per cent non-finish rate in nursing, but I believe that there is a fairly high rate of non-finishing in other tertiary courses as well. A dilemma in aged care, and for nursing, is that many graduate nurses wish to get a foundation in the acute sector—and I can understand that. From our point of view the issue is to maximise the supply in the system to try to move away from the dilemmas that occur when you have a severe shortage.

Senator HUMPHRIES—Could you explain the comment you make on page 4 of your submission about simplicity of programs in the service system. You say:

> Contracted service providers should be required to only refer to these community programs by their established service names—not allowed to develop program titles in order to distinguish their service from others.

I do not quite understand what you mean by that.

Mr Hearn—A real dilemma in the HACC and the Aged Care Act systems of service delivery is that, particularly in the HACC arena, we all provide a unique name to try to emphasise why we are providing a unique best outcome that should be funded, to start with, in that competitive funding round and that clearly sets us as being something special. We try and balance that, and we have been watching that for many years. The consumers and their relatives face a crisis when they suddenly come to grips with an ageing frailty issue that is not something they would have dealt with before. When they start to change roles in that process they are faced with this enormous array of names to describe programs. There is just not a clear link. My view is that we should be a bit more autocratic about this for the benefit of the community to ensure that the consumer understands what is available. Then the issue is trying to negotiate access to what is available.

A number of issues arise because people just do not understand what program is available and how it links. There should be systematic way of showing how programs go from a minimal level of service, which is particularly focused in the HACC arena, to advancing levels of dependency and need in the Aged Care Act arena. I think it is important to simplify the terminology and to have three or four names that everyone has to display and portray as: ‘This is the program we are funded to provide and this is what we are doing.’

Senator McLUCAS—I understand what you are saying about dressing something up rather than telling people plainly what is being provided. You may have heard us speaking earlier with the previous witness. We were talking about the interface between the Home and Community Care Program and the community aged care packages. He described the lack of linkage between those two programs. I accept that you provide residential aged care services. Do you have any comment about not only the name of the program but what you might get out of those programs?

Mr Hearn—We have been doing some work within Resthaven, because our community service programs involve HACC funded programs and aged care related programs. We are trying to understand the service system in terms of three levels of care. One is an entry point—a low level of care, which is about domestic support type service, but very important.

Senator McLUCAS—Through HACC.

Mr Hearn—Yes. Then you move to medium care, which is like a community care package, and then to the EACH program, the higher level of care. Then we link somewhere for people who need a level of residential care. So my view is that the emerging issue of three levels of care is where we should go. I think we should be more disciplined in ensuring that all programs adhere—

Senator McLUCAS—That sounds very logical, but my experience from some care receivers is that when you move from what you are describing as that first level of care, which is a HACC funded program or suite of services, into the community aged care packages, or CACPs, at that point there can be a reduction in the level of services that are provided. Is that your experience as well?

Mr Hearn—No, that is not the general experience. But given that the HACC program is evolving and we are still maturing in that program, I know that there has been a period in the HACC program when some very high levels of care have been offered to people with a disability et cetera. So I think the general view is that that is not the norm. I think the issues around the linkages, when you then need to go from a low level to a medium level, are about the availability of that package when you need it. In certain areas where there are very high densities of elderly, there are some very large waiting lists for community care packages.

Senator McLUCAS—On another completely different issue, you commented about nurse practitioners and their suitability and the desirability of the sector to be employing more of them. I think you have made a fairly compelling argument about it. But what is the blockage? Why aren’t we doing it?

Mr Hearn—I understand there are probably three graduates in South Australia that have that qualification at the moment. Organisations like Resthaven have not developed enough insight yet to feel that they could be one of the leaders in that process. The other issue is in the relationship between how possibly the AMA define how that system should work versus whether there are other models that could also be of benefit that do not only have those practitioners working as employed staff of a surgery. I think there are models that would be very attractive to nurses where they are practitioners in their own right, but there is an obligation in specific areas of their work where they would need to consult with a doctor when a certain risk management aspect needs to be further considered.

Senator LEES—Do you have any young people with disabilities in Resthaven?

Mr Hearn—No, when you say ‘young’, that would be someone under 60 years of age?

Senator LEES—Yes.

Mr Hearn—We do not have anyone specifically in our services. Occasionally over the years we have had an elderly person who has a disabled child who is in need of care. We have wrestled with the issue of our mission to work with the elderly and how we support that person, and then there is the dilemma that if the person passes away we have a very young person in an environment where the average age is 85. That is in residential care. I think the issues about young disabled and the issues of the elderly are very difficult and complex. I think we need to find a range of alternatives. My particular interest is with the elderly. I personally believe we should ensure that the elderly are offered a range of options to stay at home at the same levels of cost that are offered to some younger disabled, which they do not have access to as well, as part of that whole issue of helping people maintain themselves in an appropriate environment.

Senator LEES—Are you approached at all to accept younger people?

Mr Hearn—We have been approached a few times and then the issue for us is working through how we best assess, particularly for residential care, what we believe is the most appropriate outcome in that community environment for that applicant versus the people that we care for.

Senator LEES—I turn to your comments on step-down facilities. I have had a look at what is being done, particularly out at Flinders. While some argue that the process is about helping people back into their own homes, it seems that the focus—I suspect because of time pressures—is on just moving people through and getting them into nursing homes. What is your experience in terms of what the focus is of those facilities? I think it is a tremendous innovation in that people are not now stuck in a big public hospital in an environment that must be quite terrifying if you are not well and are actually looking for some peace and quiet. But what do you feel the focus is of, for example, City Views?

Mr Hearn—From the collective discussions I have had and from my understanding of City Views—we have a place that we have offered in that project—my sense is that there are two types of step-downs that we need to be considering. One is the type that City Views has currently become in that stays are relatively short. But the feedback the City Views group has is that those people are better prepared for a residential care environment, having gone through that process, and that environment is more skilled in specific aged care areas. There is another type of service where people need a longer period of convalescence and it is not in aged care at this stage and it is not in acute care. I think that needs to be coupled significantly with the rehabilitation service, which seems to be missing in the system at the moment. We need to consider how we can create that second option as well where, if someone had rehab or was in a slow-stream area for three to six months, the likelihood of them going home may have significantly increased. But I do not have any direct experience with that model.

Senator LEES—Once people are moved into nursing homes and their own homes are sold, even if they have rehabilitated quite well after, say, a hip replacement operation, there is really no going back. Is that your general experience? Once people are permitted to a nursing home do you see many of them going back to their own homes?

Mr Hearn—We are quite a large provider of high-care services. In our view it is a rare not because they do not have a home but because once we admit a person at the level of care that we are dealing with—RCS 1 and RCS 2 in particular—they are extraordinarily frail and there are not sufficient services in the community, within CACP and EACH, to help them. But we have seen some move from a specifically high-care area in a nursing home to a low-care environment in a hostel.

CHAIR—Thank you for your submission and your presentation today.

Proceedings suspended from 10.21 a.m. to 10.32 a.m.

PRICE, Dr Kay, Senior Lecturer, School of Nursing and Midwifery, University of South Australia; and Key Researcher, Centre for Research into Sustainable Health Care, University of South Australia

CHAIR—Welcome. The committee prefers evidence to be heard in public, but evidence may also be taken in camera if such evidence is considered by you to be of a confidential nature. Witnesses are reminded that the evidence given to the committee is protected by parliamentary privilege and that the giving of false or misleading evidence to the committee may constitute a contempt of the Senate. The committee has before it your submission. I now invite you to make an opening statement, to be followed by questions from the committee.

Dr Price—Thank you for this opportunity. You have the paper I presented which was published in the *Australian Journal on Ageing*. With their permission, I have presented it to this inquiry. I repeat that the reason we undertook the study was to understand why there was an aged care work force shortage when in fact there were unemployed people. It did not seem to me to be reasonable to have unemployed people—particularly mature aged people—and a shortage in that area, so we set about exploring why. Clearly, there were views that were coming from the mature aged people themselves about why they would not work in aged care. At the end of the day, the reasons that were coming forward were that, even if we did improve the image of aged care work for people, there were still many difficulties in getting people into the aged care work force. Important in all of that were their views and changing those.

But even if we could work to change that view, mature aged people said over and over again that they were not being employed because of their age. I extended the study to employers in aged care to try to understand why it was that age was an issue for people to work in aged care. What came through from the aged care employers was this notion of the ageing person being at risk of injury so, as an employer, they had a responsibility not to employ them because occupational health and safety laws would say they were putting somebody at risk of injury.

What was happening, as far as we were able to explore—and I have not been able to explore this at a national level, which is where I hope to go—was that occupational health and safety laws themselves were being used as the argument as to why we cannot have ageing as a natural event. Ageing itself now is being put as something problematic. It brings about problems which are at risk, then, for the individual. The risk is actually that there will be insurance problems for the employer if they employ somebody who may get an injury delivering direct care. Rather than changing the environment in which the person would work by extra lifting machines and much more appropriate staffing ratios to residents, it is being put back onto, ‘They are at risk of injury, we must not employ them because of that in a direct-care role. We will of course employ them in finance or where there is a desk job.’

So even if we were to go to a full-employment situation, which I know people are saying is looming, the aged care work force will be depleted of the human resource that they require, not only because of attitudes of people to work in aged care but because of the way everyday legislation at the local level is being used to preclude people who are ageing naturally and who may have some difference in their capacity to be productive and efficient—namely myself at this moment—from being able to work in an aged care direct service role. Until we change that legislation it does not matter what other effort we make, we are still going to have a problem. That is where I would like to leave it with the committee and take questions.

Senator KNOWLES—Dr Price, this is a really big problem that the industry has been facing for a long time. Repeated government attempts to try and solve this have had limited success. Part of the problem is that it is always put down to wages, that nurses in this sector are not paid enough so you cannot attract them. From my experience over a few decades of sitting in this committee and listening to various people, it is more than that—it is much more that people do not necessarily see it as an attractive option. If we get more people into nursing school and get more nurses qualified it helps the community generally, but most of them are going to be hived off to the acute sector. It is not just wages. How do we resolve the other problems of making the sector an attractive option to younger people coming out of nursing schools?

Dr Price—I take your point that it was not just money for these people; it was about the environment. With colleagues from my research centre our theoretical work is exposing that it is more a societal issue, not just the residential aged care sector. It is more than that. It is about how we have blurred the concept of mortality and immortality together in our society. No longer do we believe that we are ever going to die. We have this notion that we can live forever. We are having perpetuated the view of ‘active and healthy ageing’, that you can keep active and healthy and that natural ageing will not see you change your productivity and efficiency from when you were younger. The consequences of that are massive when you look at how it influences how legislation and work practices are developed. People are not stopping to think about how they think about what influences they get. We are getting views perpetuated in the work force that ageing is not a good thing and that if you age you end up in these horrid things called residential care facilities—I am being sarcastic here; I do not want to be seen as someone who thinks that they are like that at all, because I am very much an aged care advocate.

For me, the problem is how we are addressing this concept of ageing as natural. We are not allowing it to be a natural event. Everything has got to work to keep everybody active and healthy, in the sense that active is full-time employment and healthy is no injuries and at no risk. But that is not what is going to be a consequence of natural ageing. Everything is made to look unattractive: it is going to be heavy work, people need to be lifted, there is not enough money in the sector and there are not enough resources for lifting machines. Consequently, people are put off by the thought, ‘I don’t want to put myself at risk. I know I’ve got an injury so why would I want to work there?’ That is what people were saying. They understood that the area was deprived of resources or was not given enough resources and that the issue was more about the provider making money. That is what they are thinking. Consequently they are saying, ‘Even if I wanted to work two days a week, they are not letting me do that. I would need help and assistance.’

Senator KNOWLES—How do we deal with that perception? The lifting issue, for example, is just as serious, if not more so, in the acute sector. There are lots of heavy patients who need lifting in the acute sector and there are no lifting machines at all. We are dealing with perception and we are dealing with reality. From your perspective, how do we overcome that perception in order to encourage more people to go in there?

Dr Price—Certainly the way that I am trying to do it is to ensure that people understand what critical thinking is. I have just finished summer school with undergraduate students and critical thinking was something that most of them could not do. They now realise what it involves and they are on a learning curve towards being able to think that way. It is about understanding that they should not do something if there is not the equipment to do it. They should be critically thinking through this and having the courage to stand up. Unfortunately, most people in certain roles in which they are subordinate take the direction of the person who is in charge. Quite often, that person says: ‘Of course you can do it. You don’t need this. You don’t need more staff. You don’t need lifting machines or whatever.’ So these subordinate people will do it and the fact that they are still doing it means that they are not going to change the situation, because nothing is coming together to stop what is happening.

Senator KNOWLES—I understand that. However, I still come back to the perception. I am a young person, leaving school: I want to go into nursing. What is going to change my mind during my nursing course so that, instead of at the end of it going to the acute care sector, I choose to go into the aged care sector? The perception of the aged care sector is that you are just dealing with a bunch of grizzling geriatrics and you can have a better life in the acute care sector. In fact, to go and deal with the older folk in our community can be incredibly rewarding and a loving and really life changing experience.

Dr Price—I do not know where you get that feeling that undergraduates do not want to go work in aged care. I do not agree with that. Our undergraduates do want to go work in aged care. They are given a positive view about ageing and they are given lots of challenges relating to it.

Senator KNOWLES—In answer to that, I get the impression, from the evidence we are given, that a lot of people go off into the acute care sector because it is more attractive.

Dr Price—Most people in aged care are not nurses—that is one of the biggest problems. Most people in the aged care sector who care for our older people in residential care facilities are support workers and care workers—people with no more than certificate III. We do not value ageing in our society and we do not put nurses towards it. The facilities do not make the options open. They want to make their money. They will argue the funding is not there. I am not into discussing whether it is or not, but the number of positions for registered nurses in aged care is generally only one a shift if you are lucky and none on the weekends.

We now have a hospital avoidance program here in this state which says: ‘Mondays to Fridays you might have an RN but on the weekend, when you do not, we can broker a deal and get an RN to come in just for that one hour or moment when you need something done that, normally, an RN would do.’ For the care of the resident, who is viewed, by the way, as aged and not useful or productive anymore, they bring in an RN for this short moment, they do not have any enrolled nurses and they have care workers who have not got the experience and skill and who are not able to stand up for themselves and say, ‘I will not care for this person after that RN administers that IV medication.’ At the same time, the RN does not understand that legally she or he is being put at risk by coming in and delegating care after administering the IV medication.

That program is supported by our state government—a hospital avoidance program to keep people out of acute care. To me the attitude is: these patients are the human waste of old age and we do not have to bother. I am being very sarcastic but I am afraid that is the view out there: they are old so we do not need qualified people to care for them—they are going to die anyway. There is nothing about quality of life or the rights of humans. It is not the fact that there are not enough nurses—most nurses that I know really enjoy aged care.

Senator KNOWLES—It is getting them in there.

Dr Price—If they go into acute care first, that is not a problem to see how to care for sick people. Aged care people living in residences have a lot of complex illness. Complexity as we grow older is a given; uncertainty as we grow older is a given; unpredictability is a given. So it is harder in lots of ways to do caring for the older person in residential care than in acute care, where it is very much structured, with the surgery and the medicine and lots of medical staff. That is not there in aged care, where we limit the number of RNs, we limit the number of ENs and we put in care workers with only a certificate 3 at the most—and we expect to get a work force. Why should an RN go into a work force where he or she knows that they are going to be the only one on for 60 residents? Why should somebody? We have to stop it at some point. There should be many more. There is a one to five ratio in acute care: why isn’t there that ratio in aged residential care?

The argument we get told is that it is too expensive. Why is it too expensive? Are our older people not worthy of the expense being put onto them? This is that whole notion that this is a view that is being given to people in society. Once you get into residential care, it seems that the view is you are never going to get out; it is your road to wherever. And we have set up fear about that. It should be a great place for people to have their last years, but we are scaring people in society, particularly unemployed and underemployed people who could come into aged care if they were given the appropriate training and given the right resources. But the thing is that we know they will go into aged care and they will generally be left alone with four, five or six very difficult people to care for supposedly only needing personal care.

Senator McLUCAS—Thank you for your paper. There is a lot of information in there. The point I want to explore is the comment you make in your paper about people wanting employment but not seeing the need to have training. You say 16 per cent of the survey respondents expressed an interest in undertaking the necessary education and training. What do you put that down to?

Dr Price—Most of them put it down to not being able to afford it. The VET programs have to be paid up front and there is no HECS arrangement like there is for undergraduates where you paid it after you start earning. We got back comments like, ‘If I have to pay the electricity bill versus pay for a course, I have to look after my kids and I will pay the electricity bill.’ It was an issue of them making some choices. The other part of that is that there were those who did not believe it would do any good anyway because at end of the day they are still older and they would not be seen to be employable.

Senator McLUCAS—You use the word ‘older’. Are we talking about people who are 40?

Dr Price—Forty-five and older.

Senator McLUCAS—That is older, in their mind.

Dr Price—They argue that it is in the mind of the person who is in the position of employing, that that person is arguing that that is older. Anyway, I think the WHO or somebody says that once you are over 45 you are old anyway. The definition—

Senator McLUCAS—No, that is definitely wrong.

Dr Price—That is related to developing countries that have dreadful death rates. But there is a view of what is old that really needs to be challenged. To me it is associated with productivity and efficiency: ‘As you get older you are not going to be as productive or as efficient and therefore you are going to make us have to employ more staff to get the productivity that we need to be able to deliver the care we need.’ Yes, that may be the case, but that is natural ageing and we are not seemingly coping with that in our society. That is naturally going to occur. You only have to think about footballers. I do not know whether you follow the football, but in the AFL young blokes are having shoulder repairs and knee repairs. What are they going to be like at 50? They are going to have such complex care needs and they have not even thought about the immobility. They are just out there waiting to play football. So our lifestyle and technological advances have made up for that fact as we get older. You only have to be 45 and older and you are limited sometimes in doing what a person can do who has not got the injury level or the complexity of the care needs you have. It does not make you any different; it just makes you not as productive or as effective.

Senator McLUCAS—Just a bit older.

Dr Price—Yes. If you understood how I had this injury that you see, you would laugh—it is a big joke. All I did was walk into a tree.

Senator KNOWLES—The tree jumped out and kicked you!

Dr Price—That is what I am arguing. If I had had a 100-metre racetrack in front of me, I would have been fine, except it was a tree, not the track. We have to challenge perceptions. You can say it is in university, schools and VET—in education—but it is also in society. It is how legislation has been set up. Occupational health and safety was not put there to stop people from getting into the work force—it was to help and protect them in the work force—but it is actually able to be used to stop people, particularly mature age people.

Senator McLUCAS—You say that that is the barrier that the potential employers identify—it is their comment—but is there any real evidence to support that?

Dr Price—If you look at the statistics, you will find there is no convincing evidence that the older you get the more injuries you will have. But there are injuries as you get older. Let us say that at 60 you are doing direct care work in an aged care facility, you have no lifting machines—nothing to help you—and staffing levels are low. The likelihood that you will suffer a rotator cuff tear is high, given the natural wear and tear on our shoulders as we age. So you have that and it is put down to age. The attitude is, ‘They’re old; we shouldn’t have them there.’ It is not put down to the fact that there were no lifting machines and not enough to staff to help. You cannot age in that way. But, I am sorry, we are going to age in that way. Do you see what I am trying to say? It is about how we come to accept how we will ‘naturally’ age and, therefore, how we will adopt the work practices accordingly.

When Kevin Andrews was Minister for Health and Ageing and I made that comment to him, he said, ‘Everybody will have to employ older people. They’ll just have to employ them.’ We say, ‘Yes, they will but we won’t have enough to put into aged care services.’ There will still be human resource depletion there, because we have not tackled the reasons why people will not work in residential care. Senator Knowles talked about some of those reasons. But it is also about attitude, how we have come to value the concept of being older. We baby boomers are going to be the worst old age people ever, yet we do not understand that what we are setting up for our old age is not what we are going to want. We will want total freedom when we are older and total rights to make our own decisions, yet all the way along we are putting in place legislation that is going to take away all those rights, because everybody will have some way of saying, ‘No, you can’t do that because of this.’ I want euthanasia brought back in—they could put me down! If I can walk into trees, I am a hopeless case!

CHAIR—I remind you again that sarcasm does not read too well in *Hansard*.

Dr Price—Can we delete that?

Senator McLUCAS—In your undergraduate nursing program do you have a specialised component that looks at delivery of aged care services or the delivery of nursing in aged care?

Dr Price—Yes, while we have a continuum—while it is across the lifespan—the focus is on the care of older people. It is also a huge focus of our research agenda program in our centre. My PhD student, who is sitting here in the public gallery, has just completed an honours project which, even in that small project, shows there are problems with the way textbooks present ageing. There is a lot of stuff we have to keep tackling, and we have to keep raising that with our academic colleagues to make sure they challenge that—that people do not accept what is given and what is written—because there are huge problems. Textbooks put down ageing as a decline—you are no longer functional; it is a negative—rather than saying it is a naturally occurring incident.

More can be done. All I am saying is that, at the Centre for Research into Sustainable Health Care, our focus is on ageing and aged care work and we continue to look at that. Pamela Alde, a PhD student, is now looking—to pick up on Senator Knowles’s point—at the view of ageing being perpetuated by the curriculums and how beneficial it is in stimulating people to work in aged care. At the end of the day, there are people who will argue—and I do not have evidence to dispute it—that it is the way people are taught. But I would like to go outside the square and say that it is also the way we in society think.

Senator HUMPHRIES—You say there is evidence in the survey that people believe they will face discrimination on the basis of their age if they seek to train in the health sector to work in, say, aged care. Do you have any comparative data in other sectors? Are you aware of that kind of problem elsewhere?

Dr Price—I do not have any comparative data. The point we are trying to make is that there would not be any reason to suspect that in any direct service role there would not be comparable views. As you would appreciate, the difficulty with research is that you first have to get the funding to be able to put it together. One of the things we were seeking to do was to go across sectors to see whether employers had similar views, particularly in direct service roles like teaching and in the police force, and whether there are the same implications there. But I do not have any data I can give you as evidence.

CHAIR—Dr Price, thank you for your submission and presentation today.

[10.57 a.m.]

BOOTH, Mrs Jean, Chair, Aged Care Lobby Group

JACKMAN, Mrs Grace Joy, Member, Aged Care Lobby Group

CHAIR—Welcome. The committee prefers evidence to be heard in public; but evidence may also be taken in camera, if such evidence is considered by you to be of a confidential nature. Witnesses are reminded that the evidence given to the committee is protected by parliamentary privilege and that the giving of false or misleading evidence to the committee may constitute a contempt of the Senate. The committee has before it your submission. I now invite you to make an opening statement, which will be followed by questions from the committee.

Mrs Booth—I am very pleased to have the opportunity to give evidence before you this morning. I am also very pleased to follow Dr Kay Price. I feel that I am possibly going to upset some people in that I am going to present a rather more negative view, perhaps, than the somewhat self-congratulatory view I have heard this morning. None of the following views is intended to downplay the positive improvements, which have been brought about by accreditation, in many aged care facilities; nor are they intended to disparage real efforts that have been made by the majority of aged care providers.

The government designed the legislation on the basis that it was dealing with people of goodwill but, unfortunately, there are instances where this is not the case. Despite the fact that the accreditation system was intended to provide better outcomes for aged care residents, the lobby group has received reports from staff and residents’ representatives that in too many instances the system is failing residents in both the profit and the not-for-profit sectors. This is due to a provider element seemingly intent on ignoring the spirit of the legislation. We feel that the view from Canberra of the interface between aged care staff and residents differs from reality.

One of the greatest obstacles to the satisfactory working of the system is a reluctance of consumers and their representatives to complain, either through the internal complaints mechanism or directly to the Department of Health and Ageing. They may feel that, although the cause of complaint affects that resident’s quality of life, it is not sufficiently important in itself to warrant a complaint. Yet, taken in conjunction with other complaints, it may point to a problem within the facility. Equally, older people are reluctant to say anything to the assessment team. This reluctance is related both to the fear of repercussions and to the recognition that the staff are often run off their feet, and the resident does not wish to be a bother.

Those providers who fail to support their staff and do not offer staff incentives find it hard to attract and retain staff, resulting in what are perceived as staff shortages and a lack of resident care. The Aged Care Lobby Group believes that fresh educational measures must be taken to support residents and their representatives who wish to complain about some aspect of customer service. At the same time, staff who wish to become whistleblowers should be protected for seeking improvements in residents’ lives and not black-listed for evidencing instances of inadequate care.

Whilst initial accreditation depends on documentation, an important part of subsequent accreditation depends on the triangulation method, referred to on pages 11-14 of the *Audit handbook for quality assessors*, dated April 2003. This concerns documentation, observation and interview. When information is only available from one source, there is insufficient reason for the assessment team to question that particular accreditation standard, and therefore no action can be taken. However, if further evidence is forthcoming by one of the other means, the team has reason to look further—hence the importance of properly documented complaints. The number of residents and their representatives stipulated to be interviewed during the accreditation process is a minimum of 10 per cent. The lobby group believes that this minimum should be increased.

There are insufficient instances of management by walking around, resulting in a lack of supervision of care workers. As Dr Price pointed out, the majority of people looking after residents in aged care facilities are care workers. The lobby group has received reports of both physical and mental abuse of residents in high care on the part of care workers. In relation to item 2, on page 2 of our submission, the casual observer cannot assess the quality of care by looking at the built environment. Different facilities, each with a three-year accreditation period, may have completely different standards of care. Unfortunately, there are no nutritional guidelines in the outcome standards—item 2.10 merely uses the term ‘adequate’. As one provider said, the requirement to provide food and drink is not related to any quality standard. As mentioned in item 3, on page 2 of our submission, there appears to be a lack of cooperation between the departmental complaints resolution unit and the agency in South Australia.

Our recommendation 4, on page 3—that the unit should become an independent body—may not provide a solution. Perhaps the unit should become part of the agency. The department carries out its own monitoring, but the findings are not always conveyed to the agency. There appears to be a degree of overlap in this area, since this process seems to duplicate agency support visits. Additionally, it is not always clear from accreditation reports whether the assessment team is aware of the number of internal and external complaints about a particular facility. Some facilities only record written complaints.

Consideration should be given to having the initial two- or three-year accreditation visits carried out at short notice, in the same manner as review audits, instead of giving the providers a lengthy period of notice. The time presently allowed could permit records to be rewritten if a provider considered that necessary. Finally, certain facilities in South Australia with poor records of resident care have obtained more bed licences. This surely makes a mockery of the accreditation system.

CHAIR—Thank you. Mrs Jackman?

Mrs Jackman—As a lobby group for carers, our concern is about the standard of care and quality of life. Included in that, we must look at some of the anecdotal evidence that comes up not only in accreditation but in everyday complaints. I want to preface what I have to say by saying that every day you live you have one day less to live. People in nursing homes, while we may contemplate and plan to do things with the rest of our lives, can only contemplate how much longer they will have to live in the conditions of boredom and misery.

Accreditation is the tool used to assess the standards of care and, while it does that to some degree, it needs some refinement. It is too subjective. It relies on what is written by the provider and statements by relatives and residents. My colleague has dealt with that, but I would like to table for this committee the issues of concern included in the annual report of the Aged Rights Advocacy Service. It deals with the nutritional needs of residents, the splitting up of couples, the security of tenure and difficult behaviour. I am not suggesting that you may not have read it, but I think it is a useful document to look at.

Fear of reprisal and victimisation is a very real fear in nursing homes, particularly in smaller ones owned by some of the private providers. Professor Gray, on page 91 of his report, says:

> To the extent that the Agency does not assess actual care delivered, but infers it from the information provided by residents, staff, families and relevant documentation, its capacity to provide objective information around care outcomes is limited.

I think that sums up the results of accreditation standards.

I now want to focus on standard 2 matter indicator 2.10, which concerns the food given to residents in aged care facilities. Matter indicator 2.10 deals with 'nutrition and hydration'. It says:

> Residents receive adequate nourishment and hydration.

When the accreditation people go around they observe the food on the plate, the food that is provided on the days that they are there, and if that looks adequate then they pass. I suggest that there should be a special committee looking at assessing nutritional needs and the types of food that people are offered, which is apart from the accreditation people. The committee should have people who are informed about the nutritional value of food, its texture and its presentation. If you look at the residents that you find in aged care facilities, many of them are poorly nourished and many of them, because of the types of food that they are presented with, have swallowing difficulties. That means that many of them have to have vitamised food. The quantity of food they are offered is smaller and the deterioration in their general health is rapid.

You can say that there are speech pathologists and nutritionists and dietitians that come in, but if you knew what examinations they make and the tests they provide then you would find that they are inadequate. I am not suggesting that their qualifications are not all that they should be, but there are practical issues regarding the feeding of elderly people. I believe that food is a habit: the time you eat, what you eat and how much you eat. Ask those people who have a problem with obesity; their habit is to be eating all the time. That does not happen in aged care. Many times food is put in front of people who are tired, who have some problem with dexterity and take longer to eat, or who may not be able to eat and then the food is cleared away before they have even had anything to eat. I have a relative in aged care and I take that relative three meals a week at least.

The type of food that is provided is something that also should be looked at. In the residential care documents you will see that the provider undertakes to provide fresh fruit and so on. Most people never see fresh fruit in a nursing home unless it is brought in by relatives. For elderly people, and for us all, food is a celebration and we hang our day on what we are going to have. If we cannot eat during the day we are wondering what we are going to have for dinner. That is one of the real pleasures that most aged care facilities do not provide. Yet, in better ones, food is a celebration and there are pancakes on Shrove Tuesday and different things on St Patrick's Day and so on. But this is not the norm; it is rather the exception.

The other thing I want to talk about is staffing. I must say that I could have stood up and applauded Kay and what she had to say. I guess that I should refer to the report that you have no doubt all seen entitled *The Care of Older Australians: a picture of the residential aged care workforce*. It was the latest study done by Professor Sue Richardson with her associate. In the second paragraph on page 58 she says:

> On many indicators, nurses are less content with their jobs in aged care than are PCs and Allied Health workers. They are less enthusiastic overall about their job than the other two occupations. They are also a little more likely to say that they do not expect to be in their current job in three years time—

which is an alarming thing. This was published last year. It goes on:

> Forty per cent of nurses say they spend less than a third of their time in providing direct care to residents, and they are the most likely to resist the amount of paper work that they have to do. There is an opportunity for facilities to look closely at the way in which nurses' time is used, especially in the light of the importance to staff of their having sufficient time to provide good care in the sense of satisfaction that they get from their work.

I table that second paragraph as part of my comments.

CHAIR—We have a copy of that report.

Mrs Jackman—Good. Let us look at—

CHAIR—Mrs Jackman, I do not want to restrict in any way what you want to tell the committee, but I do want to ensure that we have enough time for some questions.

Mrs Jackman—There is just one other point and that is that most of the care in aged care is provided by personal carers. When you look at the personal carers it is easy to see why care is not what it should be. Personal carers can go to do a TAFE course with year 10 qualifications. They have a 16-week course—seven weeks of lectures and nine weeks of practical work—and they have to have a mature St John Ambulance certificate at the end of the course. Is that adequate to provide someone with the skills to look after elderly people? Most of them, at year 10, are immature and they have a very narrow knowledge base. How can you educate people with that sort of base? Many of them do not know what they do not know. I suggest to you that that is the problem in most aged care facilities: looking at the prerequisites that are needed to look after elderly people. I will conclude with those comments and leave it to the senators to ask questions.

CHAIR—Thank you.

Senator HUMPHRIES—The committee heard evidence in another jurisdiction of a problem with residents who complained or used services like the complaints resolution service to complain about standards in homes being deliberately targeted by staff for doing so. The punishment ranged from things like being deliberately left in urine soaked beds to being the last one called to have a meal and things of that kind. Is there evidence of a problem of that kind in South Australia?

Mrs Booth—Oh, yes, and the repercussions can be very subtle. The Aged Rights Advocacy Service says that you go in and say that you wish to make a complaint, and you tell the director of care that you do not expect there to be any repercussions. But, because of the lack of supervision of care workers, these things can be so subtle as to be barely noticed, but they do affect the residents' quality of life. I get people ringing me up all the time, and I tell them, 'You ought to complain about this.' They say, 'Oh, no, I can't. I'm afraid of what they might do.' And I say, 'What worse things can they do than they are already doing?'

Senator HUMPHRIES—The complaints resolution service has a capacity to anonymously complain. Do you encourage your members to use that aspect of the service?

Mrs Booth—I tell them about it, but I do not think the department takes anonymous complaints quite as seriously as it does complaints that they have a name to and they can go in and find out about a specific problem. Another thing is that some members of my group have given up complaining to the department, because if you complain regularly you are regarded as being over-fussy, a grumbler, a whinger and also suffering from a guilt complex—which most of us who have put family members into nursing homes suffer from. They tend to slightly downplay the severity of complaints, and also they want chapter and verse; and sometimes you cannot give them chapter and verse as to what actually happened.

Senator HUMPHRIES—You talked about problems with poor nutrition in meals provided. Are you saying this is a problem in isolated cases throughout nursing homes or that it is widespread and exists in most nursing homes? Give us an idea of the proportion of the problem.

Mrs Booth—I could not say for sure that it is widespread. There are certainly some facilities where it is happening where the providers possibly should not be licensed to provide aged care. There was a complaint made on a phone-in line—the liquor trades that cover some workers held a phone-in—where one cook rang up and said that she was allowed $2.50 a day per resident for food. And somebody else left his job at a facility because he could not perform miracles with three-quarters of a tin of baked beans. He was pursued for breach of contract in the tribunal by his former employer. There were other instances where there was no food in the kitchen and somebody was given money from petty cash to go to the supermarket on a Saturday night to see if they had any pies and pasties left over. Pies and pasties are not suitable nutrition for elderly people—certainly not for tea time, when you are going to bed with heavy pastry in your stomach. In the old days, in smaller homes, residents who were unhappy and unsettled at night could be settled by the staff member going to the kitchen and providing a piece of bread and butter; but that cannot be done now. In many cases the kitchens are locked and the night staff are not going to bother anyway.

Senator HUMPHRIES—Finally, would you say that the most serious problem is that the accreditation standards that we set are not set high enough or not in a detailed way, or is it that they are not enforced as they now stand?

Mrs Booth—I think they are enforced as far as they can be. It has been suggested to me by a member of a team that the triangulation method of having to prove something is a problem. Because of fear of repercussions, relatives and residents are not likely to tell the team that there is anything wrong—particularly if a staff member or the DON are likely to overhear them. I would like to see the nutritional one, particularly, beefed up. I think the standards are fairly good, and I also do not agree completely with the tale that the paperwork is too much. I think some providers, in their desire to get every single penny that they might be entitled to, make sure that everything is overdocumented. And most of the paperwork, I understand, relates to the RCS rather than the accreditation process.

Senator LEES—Going back and looking specifically at nutritional standards, is dental care an issue? Do residents here in South Australia have an issue with the lack of support for dental problems?

Mrs Booth—Oral care is often lacking and as a follow-on from oral care lacking there are dental problems. I did note from a trawl through the internet of accreditation reports that one person had not seen the dentist in 18 months in a facility when he should have done. Oral care is something that is often lacking. Older people may not be too keen on strangers opening their mouths and poking about in them.

Senator LEES—Looking at some of the issues around accreditation, would spot checks solve a lot of these problems? For example, I was informed of one home in South Australia where the food improved remarkably just for a short period of time.

Mrs Booth—Yes. Unfortunately, the assessment team does not eat the food that the residents eat.

Senator LEES—This was actually the wife of a person who was having issues with the amount of food. They were not able to get the accreditation team back in to do a spot check, because that is not the way it is done.

Mrs Booth—No. The review audits, I believe, can be done at 30 minutes notice. The department fairly recently introduced what I call ‘the flying squad’. They can go in. They can actually knock on the door. There is one home sanctioned in South Australia because it did not admit the team, which was somewhat silly. I would really like to see accreditation carried out at much shorter notice.

Senator LEES—Have you had any evidence in South Australia of the spot checks actually happening on any sort of regular basis?

Mrs Booth—In certain facilities, yes.

Senator McLUCAS—Thank you, Mrs Booth, for your comments about the complaints resolution unit becoming a separate entity and a more independent entity. I do agree with your comments that this may not solve it in and of itself. It has been put to me previously that essentially the function of the complaints unit is to resolve issues. The first step that they take is a mediation process. People have said to me that that is the wrong way to deal with complaints—that complaints should be useful information that will change practice and that a mediation role is just the wrong way of dealing with them. What is your view? Senator Lees said, ‘Mediate for more food.’

Mrs Booth—It is rather difficult to mediate with your jailers. If the climate in a particular facility is more concerned with matters other than the care of the elderly then it is very hard to bring about change. I know of at least two instances where directors of nursing who attempted to bring about change were dismissed.

Senator McLUCAS—What sort of change?

Mrs Booth—Improvement to meet the accreditation standards and to go beyond the standards. There are homes in South Australia that go well beyond the standards and really provide quality of life for residents. While they are supposed to be the residents’ homes, too many of them, particularly the newer facilities, have all the comfort of a hotel lobby. You find the elderly are virtually—perhaps self-imposed—prisoners in their private rooms with their ensuites. It is all terribly sad. That is not how people should end up in their lives.

Senator McLUCAS—I want to pursue this issue of the complaints resolution system. Do you have any other comments about how else we could change the system so that it would actually be useful not only for the people who are receiving care but for the care providers as well?

Mrs Booth—Some homes have very good internal complaints mechanisms which make it unnecessary to go to the complaints resolution unit. The reason people tend to go directly to the complaints resolution unit is that they have tried to bring about change through the internal complaints process and have not obtained any satisfaction. In a way, the department’s resolution unit is often a last resort and because of that it is perhaps less effective than it could be.

Senator McLUCAS—The person has already been through the process internally?

Mrs Booth—Yes. Sometimes I feel that complaints are not always passed on to the agency when they should be.

Senator McLUCAS—Yes, you make that point in your submission. Thank you.

CHAIR—Thank you for your frank submission and presentation today.

Mrs Booth—Thank you.

[11.26 a.m.]

HARLEY Mr John Maxwell, Public Advocate, Office of the Public Advocate

CHAIR—Welcome. The committee prefers all evidence to be heard in public but evidence may also be taken in camera if such evidence is considered by you to be of a confidential nature. Witnesses are reminded that the evidence given to the committee is protected by parliamentary privilege and that the giving of false or misleading evidence to the committee may constitute a contempt of the Senate. You will not be required to answer questions on the advice you may have given in the formulation of policy or to express a personal opinion on matters of policy. The committee has before it your submission. I now invite you to make an opening statement which will be followed by questions from the committee.

Mr Harley—I give evidence today as the Public Advocate in South Australia. I am not a public servant; I am a statutory officer in the same way as the Ombudsman, the Solicitor-General, the Auditor-General and, in the past, the Director of Public Prosecutions. The appointment that I have requires me to report to parliament once a year, and I am not responsible to a minister. In my role as public advocate I have four functions. One is that of an advocate; the second is that of an investigator; the third is that of an educator; and I have forgotten the fourth so it cannot be as important as the other three.

I am the guardian of last resort and that is the capacity I am going to be talking about today. If a person suffers from a mental incapacity, and that can be a result of a mental illness, intellectual disability, neurological disorder or brain damage—usually from motor vehicle or workplace accidents—and is unable to make decisions for themselves and has no family or friends prepared to act on their behalf, then I get appointed for the purposes of making healthcare and lifestyle decisions for them.

The cases I get are usually the more difficult ones. Sometimes there are family and friends available but the trauma of trying to deal with the authorities and service providers is such that they feel they do not have sufficient power and authority to get things done. Very often I get appointed by default. I am generally and colloquially known as guardian of last resort. Sometimes we try to ameliorate the problem of private guardians by accepting an appointment jointly with them so that we can empower them to deal better with the authorities than they could if they were on their own.

Most of the comments I am going to make are anecdotal, because I have a very limited ability to conduct any research in my office. It is an extremely small office and I do not have anyone on my staff to do research into the areas in which I am supposed to have authority. The only time I am able to do research is when I have social science or law students allocated to me for periods of time during the year for work experience and I give them a discrete area of work to assist them in my role. Most of the work we do is taken up with guardianships, because of the number of guardianships we have. At the moment, we have something like 270 guardianships and some cases can be very complex and most time-consuming.

People are put under our guardianship mainly for the purpose of placement. They may, for example, be in an approved treatment centre that is a psychiatric facility or they may be in an acute care hospital to which they have been admitted because they have brain damage as a result of an accident; their placement in community facilities may have broken down and they have been admitted to an acute-care hospital for treatment of the symptoms they have developed. Then comes the very difficult time of trying to place those people in the community. I have confined my submission mainly to our attempts to place young people in the community. As a result of the lack of suitable facilities, younger people are being placed in aged care facilities that are unsuitable for them and unsuitable for the other residents of the aged care facilities.

I referred you to two cases. One was a young man of 25 who has been placed in the nursing home section of a country hospital, simply because there are no facilities for him elsewhere in the community. Options Coordination, the service provided by the Intellectual Disability Services Council in South Australia, did not have any suitable facilities for him. Particularly in country areas, that is always a problem. In this case, the young man's family lived in the country town, and it was appropriate that he be placed near his parents. So he was left there, but he was in a facility that we considered most inappropriate but the best of a number of bad alternatives. You can imagine what it would be like for a man of that age to be placed in a facility with people who were much older than him. The services and resources within that facility would be quite inappropriate for him, and no doubt his behaviour would have caused distress among some of the other residents.

The other case I referred to in my brief submission was that of a 57-year-old woman who had a brain aneurism, as a result of which her behaviour was very aggressive. Again, it was most inappropriate to have placed somebody with aggressive behaviour in a nursing home where there are people who are frail and aged. The type of care that would be provided in an aged care facility would not be appropriate for a lady with those difficulties.

There is an organisation which I am sure has given much more eloquent and detailed evidence than I will give regarding the number of young people within Australia who are being placed in aged care facilities, and I will not add anything to what it would have said. I just refer to the figures that we ascertained from the Department of Health and Ageing. There are 241 people aged under 60 in nursing homes in South Australia, and 69 of those are aged under 50. In discussions that I have had with people as to whether it was feasible for there to be some special facilities for these sorts of people it was suggested to me that there really is not a big enough core group of clients sufficient to maintain a full-bed facility just catering for people of those ages. In any event, to put all those people together, if there are gross behaviour problems with them, would probably not be ideal.

The point I really want to make to this inquiry is about my concern for those people and the fact that there does not seem to be any coordinated or planned approach to ascertain how these people can be properly accommodated in society, and preferably not in large institutions. That, as we all know, is not necessarily the best way to accommodate some people with behavioural problems. Certainly there needs to be a much more coordinated approach from both the Commonwealth and state governments as to how these cases are going to be satisfactorily coped with by our society.

Senator KNOWLES—So what now? What is the solution, other than saying that the Commonwealth and state should get together, which they allegedly do under the Commonwealth-State/Territory Disability Agreement? What now?

Mr Harley—If they get together they do not seem to come up with solutions. Certainly my experience is that that is not happening.

Senator KNOWLES—Funding is allocated. What is the attitude of the state government to providing accommodation for the younger disabled in South Australia?

Mr Harley—There is a major lobby group at the moment pressuring the state government to provide far greater funding for people with disabilities living in the community.

Senator KNOWLES—But the CSTDA has been in place for many years now. It should not be a matter for a lobby group to now say, ‘Isn’t this a good idea?’ There should be results on the board. I am concerned as this inquiry goes on that we are not seeing any results, that the state governments have essentially dropped the ball in providing accommodation for the younger disabled. What is the attitude of the state government here to doing something rather than just talking about it?

Mr Harley—I cannot speak for the state government but there have been further statements and policy announcements made by the state government where they are giving notice that there will be further funding in the state budget. If you were talking to parents and carers they would be saying that it is not enough and that it has been too long in coming.

Senator KNOWLES—That certainly might be the case, but I am interested in what has actually been done and what is going to be done to address this problem. Is there anything on the horizon here in South Australia to which you could point us and say: ‘This is an innovative approach,’ or ‘This is something that has not been done in the past and this would help resolve this problem’?

Mr Harley—No.

Senator KNOWLES—You cannot get more precise than that. What is the average time of your guardianship for some of the people you are looking after?

Mr Harley—In recent times I have had to become guardian of children. Previously, it was my policy not to accept guardianship of children. But because of the inadequacy of the child protection laws here and the inadequacy of services provided for children with mental incapacity and gross behaviour disorders, I have accepted two so far. I think the act will be amended to enable me to make it quite clear that I do have jurisdiction over children. What we try to do is become involved only for as long as we are required. Guardianship is an intrusion upon people’s civil liberties, and the amount of our involvement should be the most limited possible but sufficient to enable good outcomes for the person involved. Sometimes we will come in to a case—particularly these difficult placement cases—as the guardian and will remain there until such time as we can get a good outcome for them. Once that is completed and there are no more decisions for us to make, we will withdraw and seek a discharge of the order. Some of them run for quite a long time and others are just short place orders.

Senator KNOWLES—So you are potentially making medical decisions, lifestyle decisions and placement decisions on behalf of people?

Mr Harley—Yes.

Senator McLUCAS—Thank you, Mr Harley, for your commentary. This goes to a slightly different area than those covered in your submission. We have had discussion with a number of witnesses about the complaints resolution service. I do not know whether, as the Public Advocate here in South Australia, you have had experience using the complaints resolution unit. If you have, do you have any comments for us?

Mr Harley—We do not use it a lot. As a general observation, in my experience Commonwealth departments and instrumentalities regard themselves as ‘nearer to my God than thee’. I find that they produce educational material and make decisions without adequate consideration of what the law is in South Australia or what the policies are in South Australia. I know that there is a degree of discussion between the state and federal governments, but our involvement with them is very slight. For example, some of their standards have rules about who is entitled to medical information, and they will give advice to hospitals and nursing homes that they do not have to give information to carers; that, if carers want information about their family member in the nursing home, they will have to come to the Guardianship Board and get a guardianship order so that they can see their parent’s medical notes.

We try to deal with that by negotiation with the nursing home, and very often they will say, ‘The accreditation people have told us that this is what we’ve got to do.’ That is quite contrary to the principles of the Guardianship and Administration Act that I operate under, which was that informal arrangements are the best way to handle these matters. It is only if informal arrangements do not work that orders have to be obtained. The Commonwealth tend to have their own agenda and very often it is an agenda driven from the eastern states so that often, if they consult with anyone, they consult with the New South Wales or the Victorian government and they do not bother to talk to us about it.

Senator McLUCAS—You have had experience having to gain an order to access medical records.

Mr Harley—Yes.

Senator McLUCAS—You said you prefer to use informal methods and, I dare say, that is usually far more productive but this situation got to the point where you had to—

Mr Harley—In one case I know the Guardianship Board refused to give an order because they said that they were using the privacy principles as well as another device to stop this family member getting information. Once you looked at the law, there was no need for an order. Those people had gone to the dispute resolutions scheme and they had appealed to Rob Knowles’s body and he had said that the resolution committee had come to the right decision but on the wrong grounds. It was not reversed, so then they came to the board to get an order and the board said, ‘No, you shouldn’t need an order to get that information. It would be contrary to the principles of our act to make an order just for that purpose.’

Senator McLUCAS—I cannot imagine a circumstance. This is the child of a person in residential aged care?

Mr Harley—No, it was the child of a person that was in the nursing home. I suspect the daughter had been difficult, but the response to her being difficult was that they just refused—

Senator McLUCAS—Was to be more difficult.

Mr Harley—to give her the information. That really goes back to evidence we heard before today about reprisals and that in those subtle ways—in fact, not so subtle ways really—there can still be reprisals.

Senator McLUCAS—Nursing homes in those circumstances have ultimate power, don’t they? The resident or the resident’s family have diminishing power depending on the state of the relationship if it gets to that point.

Mr Harley—There are difficult families. I spend 90 cent of my time and am often in these cases because of the families. It is not the poor protected person that is the problem, it is often the families. We get guards at board hearings.

Senator KNOWLES—Is that conflict within the families?

Mr Harley—Yes.

Senator LEES—You commented about the parent group that is advocating for people with disabilities and has had some success in getting at least some promises that there will be some greater accommodation options. One of the claims they are making is that there is a growing group within their organisation of quite elderly carers for whom it seems the only alternative as they need care is to take the young person with disabilities with them. Is that something that you are starting to see here in South Australia?

Mr Harley—Certainly in discussions I have with IDSC frequently there are not only those sorts of cases but also those to do with the Aboriginal community, particularly up in the Pitj lands. There are quite a few people there with brain damage as a result of substance abuse and at the moment they are being maintained in the community only because of the goodwill and the care of their parents. But the information I get is that all those parents are getting old and the stage is going to come when they can no longer provide that level of care and then there is going to be a real problem with placement of those people.

Senator LEES—There is also your role in that. Once parents, really for their own preservation, need to move on and look after themselves in their old age, whether or not it is in an actual facility—perhaps it is moving into a hostel or indeed a smaller house that they can actually cope with—does your office have a role with the person with a disability by stepping in and trying to look at advocating for placement? What are your options in South Australia?

Mr Harley—The options are case by case. There is no ordered plan. We do have in South Australia now an exceptional needs process. That operates in conjunction with a body called the management assessment panel. The management assessment panel is set up by the government.

It has no statutory basis whatsoever but if a person is classified as being one of exceptional needs then their case goes to the management assessment panel, which is an expert panel of three. The composition of the panel changes depending on the nature of the problem but the MAP deals with children right through, with anyone that has got major behavioural problems. It works extremely well. It is very innovative, and that is the only way it can operate. But it has a very small budget and often it works just for the purposes of perhaps putting in a relief worker for a couple of months until a more permanent arrangement can be entered into and an appropriate lead agency can be ascertained to provide the appropriate funding.

Each one of those cases is dealt with on a case-by-case basis. Often I am involved for the purposes of providing the legislative framework for the person to be cared for. It might be that I get section 32 powers so that I can direct that person to live in a particular place so that if they leave that place the police can be used to bring them back. I can give orders as to what care and maintenance they receive and what programs they enter into. That at the moment is being done under the umbrella of the Guardianship and Administration Act, although there is quite a lot of discussion among public advocates in Australia as to whether or not that is the proper role of a public advocate. I am of the view that it is, provided there are adequate safeguards and checks on the use of my power. In other states where it has been criticised I do not think the checks are the same as those here in South Australia.

CHAIR—Thank you, Mr Harley, for your submission and presentation today.

Proceedings suspended from 11.54 a.m. to 1.15 p.m.

PENHALL, Dr Robert Keith, General Manager, Medical Services, Metropolitan Domiciliary Care

TROTTA, Mrs Leah Victoria, Project Manager, Healthy Ageing-Nutrition Project, Metropolitan Domiciliary Care

CHAIR—The committee welcomes representatives of Metropolitan Domiciliary Care. The committee prefers evidence to be heard in public but evidence may also be taken in camera if such evidence is considered by you to be of a confidential nature. Witnesses are reminded that the evidence given to the committee is protected by parliamentary privilege and that the giving of false or misleading evidence to the committee may constitute a contempt of the Senate. The committee has before it your submission. I now invite you to make an opening statement to be followed by questions from the committee.

Mrs Trotta—Thank you all very much for your time today. This is an excellent opportunity for us to expand on some of the work we have been doing. The submission that we put forward to the Senate inquiry was done at a time when the project was in its infancy. Now, seven or eight months on, we have actually got a lot more information. Today we would like to provide you with a little bit of background to the project, highlight some of the academic information that has led to the work we are doing and give you a demonstration of some of the interactions that are going on within the project that highlight the issues that we put forward in our initial submission.

To start with the background, as you are well aware, Australian population projections indicate that the proportion of the population aged over 65 is increasing. South Australia currently has a higher proportion of older people than the national average. Healthy ageing is a significant public health issue for Australia, and particularly for South Australia because of the proportion in this state.

Nutrition and physical activity are the two main areas identified by the World Health Organisation to prevent the chronic disease burden and improve healthy ageing. The World Health Organisation has called for urgent action in these areas. Good nutrition is particularly important for older people to maintain an independent lifestyle for as long as possible and to minimise morbidity and premature death. Poor nutrition is one of the main reasons people become frail and dependent, thus reducing the quality of life and increasing the cost of health care for the individual and the community.

Health care costs increase sharply with age, and many of these costs are incurred treating diet related problems. The World Health Organisation expert report *Diet, nutrition and the prevention of chronic disease* found that the cost to the world of the current and projected epidemic of chronic disease related to diet and physical inactivity dwarfs all other health costs. Strategies for successful implementation of national and local strategies for prevention include leadership, effective communication, functioning alliances and an enabling environment. That is the basis of our project work.

Poor nutrition can lead to an increased risk of falls, fractures and infections, poor wound healing, poor recovery from surgery and longer hospital stays. Malnutrition may also lead to decreased appetite, dental problems—which I know were highlighted earlier in evidence—and depression, apathy and even dementia. Protein-energy malnutrition can be hidden as a cause of weight loss when present with other factors such as cancer, chronic airways disease, Alzheimer's disease, Parkinson's disease, diabetes, depression and particular medications. Nutritional intervention has been proven to be helpful. The main nutritional risk factors are acute or chronic disease, polypharmacy—the taking of many medications—and social isolation.

CHAIR—Mrs Trotta, the committee has been provided with a copy of the paper. I want to ensure that there is enough time for questions. Could you go to some of the key points that you want to highlight?

Mrs Trotta—Absolutely. There is a summary provided at the end. Perhaps we can just mention the points in that. On page 3 there are 10 key organisations that we would like to draw your attention to. I think they are representative of the scope of the problem that nutrition and the lack of services provided in this area in the public arena are having. Those 10 organisations are all working as partners with our project. A number of common things about the lack of Home and Community Care services that support the initiatives that they want to take in nutrition are really becoming evident through the work that we are doing. The scope of the problem that we are presenting to you today is evidenced by the list. The last two pages, with the exception of the academic work that I have put forward, offer some of our key points. I will use my time before your questions to highlight those key points to you.

Poor nutrition is, as I have said, one of the main reasons why people become frail and dependent. There is a lot of clinical evidence to support that. Support for healthy ageing initiatives should be a priority—not necessarily the priority—of both the federal and state governments. The majority of older people are living in the community and not in residential care and that is really important in the way that funding is considered. Certainly, the 2004-05 budget talked extensively about care places but not necessarily about the proportion of people living in those kinds of care arrangements. Nutrition in that community care setting is really central to a healthy ageing approach to the older population.

A network of specialist and generalist nutrition workers is needed in the public health system to initiate support and help sustain healthy ageing initiatives which are centred on nutrition. We are finding that the initiatives the organisations want to take are not able to be supported because the specialist nutrition work force or generalist workers who have some experience in that area are just not there. So it is quite difficult to get some of those initiatives that could be easily implemented off the ground because we do not have that environment within the work force just yet.

We have been working extensively with the Carers Association of South Australia and it has become apparent that the needs of those carers are the same as anybody working with older people in the community. It is important that we highlight the need to support an understanding of nutritional needs of older people at home among that group. That sort of support also requires access to skilled community based health workers and supportive systems for food access. One of the common problems that we are seeing through the project is that, even if somebody is seen by a dietician or a health worker with some experience in the area in the community setting, it is very difficult to get the food into the home or to ensure that it is cooked and stored appropriately because some of those other supports are not there. It is all very well to provide the advice but carrying it out is very difficult.

There is an insufficient nutrition work force that is adequately skilled and actively engaged in the aged care setting. Through the project we started bringing together an aged care nutrition interest group and we have been able to rally about 12 people for that group who see themselves as having the capacity to be actively engaged in the aged care environment, which seems somewhat lacking compared with what is available in the childhood arena. That in itself limits the capacity for specialist information to be provided about best practice dietetic services to aged care facilities or other aged care providers in South Australia, because most of those clinicians we have been able to work with are very much engaged in the hospital setting and they are invested in doing what they need to do on a daily basis to meet their clinical workload. So their role in advocating for what they see as best practice is really limited to what they are able to do in addition to their normal work.

We are not aware of any particular driver in relation to the Aged Care Standards and Accreditation Agency that would encourage that agency to seek professional linkages with dieticians or with other workers who have a specialisation in that dietetic or nutrition area. We have started some discussions with the Aged Care Standards and Accreditation Agency so that we can informally make that link, but there is no particular driver other than good relationships with that agency to say that they need to draw advice from a group who have an interest in that area to determine what best practice is. We are concerned that that means that some of that best practice information—if there is any—is coming from a generalist work force that may not have appropriate experience in that area.

There is likely to be a massive increase in demand for home based services such as meals assistance and other food access services in the future. Certainly, what we are seeing in this state indicates that we do not have anywhere near the capacity in place for dealing with that increased demand. That is relevant to the HACC funding priorities because the number of meals being put out now are—anecdotally—already insufficient for the population that appears to need them, let alone an increasing ageing population in the community.

In addition, by 2006 one in four people over the age of 65 in South Australia are expected to come from a non-English-speaking background. It is unclear to me, in the work that I am doing, how that significant and diverse population will be catered for when food and nutrition needs arise. Undoubtedly, that group of people have a right to access culturally appropriate services. Certainly, there are a number of small ethno-specific meal services within South Australia but they are very much limited and are providing a small number of meals to a small number of clients—in the range of 35 to 100 clients per service—on a five-day a week basis. So not only are the meal services inadequate; they are not diverse enough to meet the population base we will be expecting.

There is a clinical trial going on at Hampstead Rehabilitation Centre, a sub acute care facility in Adelaide, which is looking at nutritional screening using a simple screening tool at points of transition—that is, on arrival and discharge from that facility. We think this is something that should be considered as a standard approach in all facilities, because the points of transition are a time when people can be identified as being at risk and there are often more professional services available to start addressing that need. We are concerned that that is not a standard approach; certainly in our experience it does not appear to be a standard approach in all facilities. We think a way of starting an increased awareness of nutritional risk and management is by formalising it in that part of the system.

Dr Penhall—In fact, that particular study is an example of one of the core aims of the project, which is to upskill a range of workers across the health care system to be able to recognise malnutrition in a screening sense—not in a clinical sense or as a medical assessment, but to recognise, as a starting point, that there is a path you can follow if you are able to pick up that there is a nutritional problem. So the upskilling of a range of workers is one of the core aims of the project.

Mrs Trotta—The three academic papers we have provided to you look at the pathway from the testing of basic nutritional screening in a sub acute care facility through to community managed care and nutritional screening, and screening and management for the family physician. All of these highlight quite significant population numbers who are already malnourished or identified as being at risk of malnutrition. That can definitely be seen in daily practice; the facilities and organisations that I am working with are able to cite large numbers of in-depth circumstances of anything from simple cases through to complex cases, in which people are going home with identified malnutrition or not yet identified malnutrition—but clearly quite poor nutrition—or perhaps malnourished and without the support systems in place for getting anything much more than one-third of their needs through the Home and Community Care system. The Home and Community Care meals service systems that are in place are really only able to provide up to one-third of the nutritional energy requirements for a person on a daily basis, and that is mostly done on only five days of the week, except in extreme circumstances. The food security information provided in the paperwork that I have put forward to you suggests some of the areas to look at for increasing food security for older people, and I think it highlights some of the gaps in the Home and Community Care system for supporting people in their home environment.

We have been doing some work with the divisions of general practice, who I know will shortly be presenting to you on another topic. With their support and the clinical evidence given in the paper from the *Australian Family Physician*, we have been able to establish a pathway process for a group of GPs to start trialling nutritional screening, in a fairly simple form, at the time when they do the seniors’ health assessment, which is already provided for within funds. What they and we are concerned about is that, once that identification is done, other than saying, ‘There is a meals service which delivers in your area five days a week,’ there are very few options for the GP or practice nurse to start laying out options for the client when they go home. So the question is: in giving that inadequate solution, is the person going to be significantly better off after that screening or not?

Dr Penhall—In fact, this was one of the major impasses of the first six months of our project, in that there were a number of groups hesitant to initiate recognising more undernourished people. That was because those groups were not quite sure how they could then respond appropriately to them by way of the range of resources available in the community. We had to get past that process and suggest that we were looking at a series of things that all had to be addressed at the same time.

Senator HUMPHRIES—We have heard a lot of evidence about examples of poor nutrition, particularly in residential facilities in Australia, and descriptions of reasons why that might be the case. What is not clear, at least to me, is the actual extent of the problem: how numerous and how widespread the cases of poor nutritional outcomes are. It might not be easy for you to answer this question, but, if you were going to rate our residential aged care facilities in this state on a scale from one to 10—one being very poor; 10 being very good—where would you put the system in terms of nutritional outcomes for residents?

Dr Penhall—That is very difficult to answer. The evidence suggests that up to 50 per cent of people heading into residential care have malnutrition as part of their presentation. Many of those improve during their early days in care. The reason they improve is because, firstly, they are presented with food and, secondly, they are able to be fed. The residential care system is probably doing well, given that these people are being salvaged by virtue of being in an appropriately caring environment. That aside, we know that in chronic disease states malnutrition is, unfortunately, an integral part. We see that in the acute hospital system, and I suspect we will see it increasingly in the residential care system as the residents become more frail and disabled. So the people who are now in hostels we used to find in nursing homes, and the people that were in hospitals we now find in nursing homes—there has been an increasing debility, frailty, chronicity and illness amongst people in residential care, so I think the problem will become greater without any change of resources necessarily.

Senator HUMPHRIES—You mentioned the education measures that you are engaged in at the moment. They sound very effective in terms of getting a better set of information out there to people who are providing meals and nutritional advice to people in both community care and residential settings. Is the main problem lack of information to providers or is it issues like budgets?

Mrs Trotta—Lack of information is the first part. In the work I have been doing I found all of those organisations take up information very rapidly. In a very short time there has been a significant change, unmeasurable at this stage, in the thinking about and approach to the nutritional problem. By comparison to the budget problems and the lack of capacity within the system to address some of those food security needs, particularly within the community care sector, the education problem is much less of a problem than the lack of resource around meal service provision, the lack of information packages that can be given to families and family carers and the lack of alternatives to going to the supermarket, such as home delivery services for groceries and those sorts of things. To me, it seems that the capacity within the health system for those sorts of actual on-the-ground resource needs is much larger. If some of those things were present, the level of education and understanding that is already starting to build among health workers would be much more appropriately carried out. Their decisions would be much easier to carry out if they had the resources at their disposal to do something about it. By and large, there is a good understanding of the problem. There is not an easy access solution to carrying out what those people would like to do.

Senator HUMPHRIES—You mentioned that education is a pretty important part of overcoming this problem. You say in your submission that there is an increasing trend towards the outsourcing of meal preparation in the aged care sector, with meals becoming a catering function. I assume the effect of that will be that we see fewer catering sources providing more meals to facilities rather than meals being done in the kitchens of the homes themselves. Isn't that an opportunity to target a smaller number of providers with information about nutrition and maybe even, if necessary, about the regulation of standards in those places? That will get the providers to accept what are good outcomes for the nutritional needs of those residents and get better effect because of that outsourcing phenomenon?

Mrs Trotta—Your point about driving the standards for that small number of providers is really important. I agree that a good opportunity is there, if there is a small number of providers, to home in on the level of services being provided. Those services, from what I am seeing, appear to be very much contract driven. So the hospital or health service getting the contract right and being very explicit about what the terms of that contract are in the first instance seems to determine what is provided for the rest of the year, the two years or however long that contract is in place for. Some of the dieticians that I have been speaking with have expressed concerns about having not got it right at the time of the contract and, therefore, feeling that they are locked into a certain provision of services during that time. The second issue is that the contract arrangements and the outsourcing of those meal services has meant that food in some facilities has been seen as part of the infrastructure of the provision of service rather than as part of the health care continuum. Food has moved out of the health domain—as I heard somebody giving evidence earlier—where the night staff say, ‘Is there something that you fancy from the kitchen?’ and into a more structured part of the framework.

Dr Penhall—The third problem is that an individual’s needs are lost in the bulk catering order, and so there is a great dilemma in being able to recognise what needs to be modified for a particular set of clinical circumstances. That is one of the dilemmas of this arrangement.

Senator HUMPHRIES—Isn’t there a generational problem here as well? Without generalising too much, people of an older generation used to like to cook their vegetables almost to mash—that was certainly the case with my mother; I do not know about other people’s mothers. Very often a person might prefer a cake to a piece of fresh fruit. Isn’t it part of the problem as well, where you have to educate not only the providers but also the client base?

Dr Penhall—Yes. Older people develop a large range of fads about what they will eat and what is good and what is not good for their health. Many of those have to be addressed before you can put in place an appropriate nutrition program, but there are other contributors as well as. In 1990 a statistic in the ABS data said that in Australia two-thirds of people over 65 had no natural teeth. That is less now; it is down to about 40-plus per cent. That will alter what people will be able to eat. There are a whole range of issues that will be generational, but I do not think it is ever going to stop people having their food fads. It is not peculiar to that generation; it is just inherent within that generation.

Mrs Trotta—I think, too, food is something that a lot of people have preferences about. Regardless of age, there should be some opportunity to make choice about that. Food choice and food preference is one of the things that keeps people eating—actually having some determination over what they eat. It is not always easy to meet that.

Senator McLUCAS—Thank very much for your submission. I think it will be very useful to us. You were talking about a discussion you are having with the standards agency. We heard earlier from the lobby group about there being one standard, which in their view was not focused on nutrition, which was to make sure that people got something to eat, essentially. Do you think that discussion will lead to a change in the wording of the standard that might look more to nutrition than to food?

Mrs Trotta—I do not think we are having a discussion at a level that will impact on the standard. What we are aiming to do as a group within this state is to encourage the assessors from the aged care standards agency to get a sense of what the dieticians think is best practice in this area so that when they are making an assessment on a facility they are coming from an informed position of what good practice is rather than from a base of assumptions about what is good and what is not. I think the change that we will see out of the discussion is about tightening up the understanding of the assessors by providing best practice information. Ultimately I think I speak for the dieticians' group that has been meeting when I say that they would like to see a tightening of the nutrition-hydration standard to be more specific. I know that was mirrored in evidence at the earlier hearing. I do not think that we will be active at that level. We are really just aiming to do a best—

Senator McLUCAS—It is an education process.

Mrs Trotta—Absolutely.

Senator McLUCAS—Do you think that a recommendation from this committee could change that standard?

Dr Penhall—That would be much more helpful because we certainly do not have weight with those who own the standards.

Mrs Trotta—We are just operating at the local level in respect of the standards, and it would certainly be our position that that could do with some tightening up.

Senator McLUCAS—I know that one of the academic papers that you have provided us talks about how you screen. How do you do that? How does a clinician screen a person for nutrition?

Dr Penhall—There are three ways of doing it. The aim of the project is to put in a simple tool related to whether you have lost weight in the recent three months and whether your body mass index—which is a height-weight figuration—is lower than it should be. We think that is clinically simple and able to be taken on board by a range of persons. From that there are screening tools for dietetic assessment which are more complicated. One of those is what you would perhaps undertake next as you try to understand what action pressed the button behind the issue. The third thing is that you can do a clinical assessment in a medical sense. You can do an examination, blood tests and a range of body-screening things as well. Of course, that is not the aim of the project. The project is to get onto that first arrangement—getting people aware by doing simple things—and then channel what is found to an appropriate response mechanism which might provide for a better clinical assessment. That is the pathway that has been established with the division of general practice.

Mrs Trotta—At an even more community based level, some of that screening information has gone a step further. For example, I have been talking with the Meals on Wheels volunteers and their management group about having spotters within the volunteer community so that there is an awareness of risk factors. We have been talking in quite human terms, I suppose, rather than in clinical terms—things like: have you noticed that somebody's having difficulty getting to the door to receive the meal, have you noticed that they appear to have dropped a size in clothing in the last little while, have you noticed that they appear to be declining or becoming unwell, and do they seem to be sad or depressed? They are things that are not actually asking them to clinically screen but that may highlight a problem so that the welfare system within that organisation can then make an appropriate referral back to the general practitioner to tap into the more clinical screening process. They can perhaps at least do something in the first instance so that problem does not go unnoticed. There are a number of ways that we are trying to approach this: from highly clinical, hospital based points of transition right down to getting people in the community who are working or living with older people to be spotters for high-risk individuals.

Senator LEES—Moving on from that, if you have feedback from someone, say, from Meals on Wheels, where perhaps the previous meal has not been eaten or whatever, where do they then report that too? What is the process of notification?

Mrs Trotta—At the moment, Meals on Wheels are embracing that problem. The work I have been doing with them has been encouraging the Meals on Wheels system—and there has been some uptake of that—to get the volunteer to say, 'We've noticed the food piling up in the fridge,' if they go inside or it appears to not have been eaten and they become aware of that. They are now reporting that to the welfare officer within Meals on Wheels, and the welfare officer will then make a referral. We are hoping to work with them to standardise their process for doing that. The project is about building their capacity to notify the GP.

We are then rolling out this GP tool so that when the client goes back to the GP the GP is aware of the problem and has an immediate way of reconciling some of those issues. If when it gets to that point we still have a concern—if the GP first said, 'You've got a nutritional problem; go onto Meals on Wheels'—then what? We are starting to build some of those bridges and some capacity so that the person whose meals are piling up has somewhere to go. What is not complete is the loop from when you have gone back to your GP, Meals on Wheels has already been explored as an option and it is apparently not working. Higher level physician review is an option, but that is using high-end resources when some other community provision for addressing whatever is causing the pile-up of meals could help.

Senator LEES—I am looking at the other players that you are working with. Is there a link between Meals on Wheels and the Royal District Nursing Service, for example?

Dr Penhall—No. Your question highlights the nub of the project in that we have a range of community organisations where nutrition has not been a focus and most times has not even been looked at. We have been aiming to raise that profile and get each organisation to develop ways in which to upskill—and there could be a variety of responses—and improve their understanding of nutrition and people's needs.

Senator LEES—The doctor, for example, might decide, if he or she is approached by Meals on Wheels, to refer the person immediately to an interested dietician, who can then perhaps do a home visit. Are you involved in pulling all of that together?

Mrs Trotta—Yes.

Dr Penhall—Absolutely.

Senator LEES—Will you be making recommendations—going back to the comments you made earlier—about culturally appropriate services with Meals on Wheels and having choice in the menu? I realise that that can get quite complicated. But some people have had a rice based diet, for example, and then have go to meat and three veg. From watching a lot of meals that are prepared, particularly recently in local hospitals in rural areas, I know that that is basically what the diet is. For many of us that is not our diet. I am talking about not only those of us from a different cultural background but also those of us who are seventh generation Australian. That is no longer the norm.

Mrs Trotta—We will be making some recommendations to the Department of Health in South Australia at the end of this project, because they fund us. The committee members have in front of them some of the emerging issues that are starting to come out of the collaborative work that we have arranged between those organisations. I think it has been quite successful, and they have been very open to the collaborative approach. It is really starting to highlight the common problems. Some of those common problems are very much around food security, provision of community based care and also some of the issues that we have spoken about—standards and having tighter understanding.

Dr Penhall—Our project formally concludes with an evaluation and a formal report. But it will potentially head the way of many projects in that there have been two years of action and it has been specifically government funded. What happens at the end of the jetty, where we find ourselves staring at that intriguing precipice?

Senator MOORE—A lot of these issues and those of nutrition and diet were raised at the poverty inquiry that many of us were working on. I have two subsets of questions. Firstly, do we have enough professionals working in the aged care area, particularly those from a diet or nutrition background, and how do we get more?

Dr Penhall—That is easily answered.

Senator MOORE—No?

Dr Penhall—The answer is no.

Senator MOORE—The second part of that question was—how do we get more? Secondly, are similar projects happening elsewhere? This sounds really positive, taking into account what you have said about the end of any pilot project, which is my pet hate.

Mrs Trotta—To answer your question about whether there enough health professionals—no, there are not enough and that is blatantly obvious to all of the organisations. There is a huge lack in the area. How do we get more? That is something I am exploring a lot at the moment. Tomorrow evening I have an opportunity to speak to the Dieticians Association’s AGM about work force development. One of the key issues I will be highlighting is the chicken or the egg problem. They are so invested in their day-to-day clinical issues that they are not advocating for the sorts of services that they could be providing and they are not advocating for best practice, which suggests that you would need more dieticians in that area. At this stage I am aware of those problems and I am starting to advocate with places like the Dieticians Association. It will also come out in our report, because there will be a particular case study on dieticians and nutrition professionals. But it is not immediately obvious to me as to how that actually happens without the group starting to advocate. They will not start to advocate because they do not have the time to do it. It is the chicken and egg problem. I do not clearly see a way out of that for them at the moment without some extra funding or some extra positions to be made available to start that advocacy.

Senator MOORE—What about other projects, because this is South Australian based.

Dr Penhall—We do not see this as a pilot project. It was formally funded as a two-year research project and is being done under the style of action research. The momentum of the project is supposed to carry forward, and that is the bit that we have been charged with manipulating in some way. As to other projects of a similar ilk, we are not aware of many and there have been a number of national links to us for them to become party to the results of our work.

Senator KNOWLES—I want to address the issue of the massive increase in demand for home based services, including meal assistance, which you raised in this summary. What alternatives are currently in place and what alternatives do you consider should be in place? Clearly the whole notion of just having Meals on Wheels once a day is really insufficient in a nutritional sense.

Mrs Trotta—There are very few alternatives in place. Through places like SACOSS, the South Australian Council of Social Services, and its member organisations—they are mostly church groups, the Salvation Army and those sorts of places, where community lunches are provided for people on low incomes, which I am sure you are aware of through poverty work—there are a number of meal services provided. Anecdotally, most of those that I have seen have told me that the majority of their client base falls in the catchment of our project, the over-50s, and they are suffering some range of complexity in their lives. Perhaps people see that if they are able to get out to those sorts of services, they are a viable alternative to Meals on Wheels. There is no standardisation around what they provide. It has not been provided from the basis of a nutrition service; it has been provided for a host of other reasons and has fallen into that category.

Senator KNOWLES—One of the biggest problems is people looking after themselves at home, isn’t it?

Mrs Trotta—Absolutely.

Senator KNOWLES—They do not want to look after the house, they do not want to look after themselves and they do not want to look after anything, to be quite frank. Invariably they are depressed because they are lonely, not because they have clinical depression.

Dr Penhall—Yes.

Senator KNOWLES—This is why I asked you about alternatives. I mentioned it this morning, which you might have been here for, and I will mention it again: there is a village life option where a lot of those people go and get three square meals a day and they get looked after. Why isn’t something like that being a positive recommendation for a lot of these people who need company, who need assistance and who need nutrition?

Mrs Trotta—If some of those services were available, or there was capacity to start exploring those services and establishing them—

Senator KNOWLES—But they are available.

Dr Penhall—In some regions only and it is for a very small proportion of the population.

Senator KNOWLES—But isn’t it a start?

Dr Penhall—Yes, but—

Senator KNOWLES—If it is a start and it is considered positive, why isn’t it being integrated in the work that you are doing as a possible alternative for the future where these people can be looked after and not have to go to soup kitchens to beg for a meal? We have got to try and look after their dignity as much as anything in all of this.

Dr Penhall—Many of those services range around relocation, so either you are where a village lifestyle is being established or you are part of an arrangement occurring in another community. Those two things are not happening across the community setting. There are no entrepreneurs, no funding and no mechanisms putting these options up. Most people want to stay in their own home. Most people want to care for themselves. The usual reason they do not is that something has intervened. Whether that be lack of energy from malnutrition or depression, poverty, loneliness or immobility—it is a range of things—

Senator KNOWLES—Grief.

Dr Penhall—There is grief, isolation, the inability to use the stove and the kitchen, when you could 10 years ago, the inability to get to the shop and get the resources you want—a whole raft of social problems that impact upon someone managing at home.

Senator KNOWLES—But that is why we have to start looking outside the dots. I am concerned that all we are hearing at the moment is just people going around in a circle. We are not looking at new and innovative ways to deal with this, ways that have been tried and tested and that could be built upon to alleviate some of the problems that we are discussing here today.

Dr Penhall—What you are alluding to is a cornerstone requirement, but that requires a major funding initiative to support it.

Senator KNOWLES—But there is private funding and local government funding out there.

Dr Penhall—We have not seen it, at least not directed at that.

Senator KNOWLES—Village Life have hundreds of facilities around Australia.

Dr Penhall—They do. But they have a particular campus and a particular set of arrangements and that is where it is happening. But that is not where people in suburb X are living. They are not part of that community.

Senator KNOWLES—That might be so, but that is the situation with retirement villages, hostels and nursing homes.

Dr Penhall—Yes, but they are such a minority in the community setting. Only seven per cent of people are currently in residential care. That means 93 per cent are free range. They are literally out there, living and doing their thing. We forget that most people are living freely in the community doing what they want to do.

Senator KNOWLES—But there are a lot of those people who are suffering the very problems that you have described today—

Dr Penhall—Absolutely.

Senator KNOWLES—who are totally unaware that there might be alternatives that could suit them, even if that involved moving from one suburb to another.

Dr Penhall—But that is the big trick: the moving from one suburb to another. People have the right and wish to stay in their own place. What the system has to do is get services appropriate to their needs in their location.

Senator KNOWLES—But we are whistling Dixie in the west wind if we reckon we are going to set up a system in every single suburb—plus in regional and rural areas—right across every single state in Australia that is going to suit everyone. Let us face it: we as a nation are not going to be able to afford to do that.

Dr Penhall—There is a need to do something because we are already seeing the clinical consequences of not doing something.

Senator KNOWLES—Exactly.

Dr Penhall—So it will need to be an initiative that is addressed in a practical way. I do not know that that generally applied answer is yet before us. So what we are trying to do is have an impact upon the resources that are currently available because we do not have ownership of any of the resources that might be available. So it is a major problem in terms of planning, because—as we began in our statement—nutrition and physical activity are the two cornerstones of general health. It is going to be a big issue just to try and get people more active.

CHAIR—Thank you very much for your submission. We look forward to seeing your final report. Thank you for your presentation today.

[1.59 p.m.]

FORD, Dr Peter William, Manager Aged Care, Adelaide North East Division of General Practice

GILBERT, Professor Andrew Leigh, Chair, Adelaide North East Division of General Practice Regional Medication Advisory Committee

LOVELESS, Mrs Belinda Jane, Aged Care Program Coordinator, Adelaide North East Division of General Practice; and Member, Adelaide North East Division of General Practice Regional Medication Advisory Committee

MOREY, Mrs Wendy Louise, Member, Adelaide North East Division of General Practice Regional Medication Advisory Committee

CHAIR—Welcome. The committee prefers evidence to be heard in public, but evidence may also be taken in camera, if such evidence is considered by you to be of a confidential nature. Witnesses are reminded that the evidence given to the committee is protected by parliamentary privilege and that the giving of false or misleading evidence to the committee may constitute a contempt of the Senate. The committee has before it your submission. I now invite you to make an opening statement, to be followed by questions from the committee.

Prof. Gilbert—I will make an opening statement as Chair of the medication advisory committee. You have our submission, and I will not spend a lot of time going through the fine details of that. I will just highlight a few of the points that we as a group would like you to consider. The people you see sitting at the table represent the multidisciplinary nature of our committee. It represents approximately 30 residential aged care facilities that are within the Adelaide north-eastern division or around its boundaries. At our meetings, which occur every two months, we have representatives from most of those facilities, often from nursing but also from other groups of people within the facilities such as management and so on. We also have representation from medicine and from pharmacies on the committee, as well as representation from some organisations supporting transitional care arrangements—for example, from mental health care or hospital and so on out into the community or into aged care.

Clearly, our focus is on medicines, and we take a quality use of medicines perspective. There are sets of guidelines available in Australia about improving the quality use of medicines in residential aged care facilities put out by the Australian Pharmaceutical Advisory Council. The facilities pick up on those guidelines as part of their accreditation process but, as you would be aware, there are very major gaps, if you like, between what is recommended in guidelines and what actually happens in practice. These are some of the concerns that we address in the committee. I have said that we adopt a QUM, quality use of medicines, focus. That notes the primacy of the consumer in these discussions, so our major focus is on residents in aged care and how to improve outcomes for them, where medicines impinge on that. The fact is that, in aged care, that is for most residents.

I should speak briefly about the establishment process of our medication advisory committee. It was a consultative process which arose from both Belinda and Peter recognising a need across the region and consulting very widely, individually with aged care facilities and through workshops and so on. We developed a clear impression that a regional medication advisory committee would be very helpful and that we had common agendas, if you like, or common issues. One of those issues was the effectiveness of the transitioning of people between aged care and hospitals and then back from hospitals into aged care. That interface is a problem for everybody who moves into and out of hospitals but particularly for older people, for whom medicines feature very strongly in hospital admission and discharge.

We were able through the work of the division, facilitated through the MAC, to attract one of the breakthrough collaborative projects to the Modbury Hospital, looking at precisely this issue. As we have reported to you in our submission, an analysis of people moving from that hospital to aged care showed that 100 per cent of those people were at high risk for medication misadventure. That clearly highlights the fact that people are going out to hospitals and being placed back into aged care, probably without sufficient infrastructure to make sure that their care could be maintained and that they were not going to run into trouble from the medicines they were using and add to any other problems they might have.

There are a number of other issues that we touch on in our submission, and it is probably best if you ask us questions about those. In terms of issues such as the work force, one of the features of our discussions at the committee is how we get the right mix of skills in aged care these days—that is looking at both external service providers and people within the facilities. Peter can speak at length about the difficulties medical practitioners have in being able to work in aged care. I come from a pharmacy background and my colleagues tell me it is now becoming almost impossible for them to work in aged care and maintain a practice outside of aged care with the expectations on them. I am sure Wendy will be able to talk from a nursing perspective on the issues of the nursing work force.

I heard in the last submission a mention of the fact that the acuity of care needed for residents now is much different to 10 years ago. When I worked actively in aged care 10 years ago, hostel facilities were designed with long corridors to encourage residents to move up and down and exercise, with common areas at the end. Most residents in hostels now are much frailer and are unable to mobilise in those sorts of ways. So even facilities built brand new 10 years ago are struggling to cope with the nature of the residents these days. Regarding comments about aged care standards, largely from our perspective we hear across the table that the weight of documentation is pulling people away from delivering care and services. That is probably a very broad statement, but that is the sort of comment that we are looking at. We really do need positive strategies to attract external service providers such as medical practitioners, pharmacists, physios and geriatricians into aged care. Have I forgotten anything?

Dr Ford—No, I think that is a very good synopsis.

Senator KNOWLES—Thank you very much for your submission. I am concerned that wherever we go we also get evidence that doctors are reluctant to go to aged care facilities. There have been incentives put in place, but we have also had evidence that those incentives are not working. What really has to be done? Is it just a case of money? Is it a case of computerisation? What has to be done to get doctors to actually fulfil what I would consider to be a pretty major obligation to the aged in our society?

Dr Ford—You have highlighted a very obvious problem. In our division there are something like 230 GPs and only about 40 will attend to the residential aged care facilities. The reasons are numerous, as Andy Gilbert has just outlined, but one of the fundamentals is that if you have an accredited practice it costs you about $100 an hour per doctor to run. If you get a call away from your surgery to attend to one patient—and in that sector generally you are in a bulk-billing scenario for a variety of reasons—you are perhaps going to receive $50. So it will take an hour out of your day and people will no longer do it.

Senator KNOWLES—So it is all to do with money.

Dr Ford—No, it is not all to do with money. But let us put that on the table; that is a major issue. As well as that, there is of course a change in the profile of general practice these days. As you know, there has been a great increase in the number of part-time practitioners, partly because of the feminisation of the work force, and partly because many younger males now want to do some general practice in conjunction with some accident and emergency work—they cocktail their life; they are not prepared to just sit and consult for 18 hours a day. So there is some loss of continuity and this is unfortunate, especially in the aged care sector. Those relationships and that longitudinal interaction are lost. Once somebody goes into aged care now, people will not go there as doctors so the patient has lost out. That is part of the problem, too.

Senator KNOWLES—I would have thought that $8,000 a year to be part of a panel would cover for a few $50 an hour losses.

Dr Ford—You have highlighted a great misunderstanding. Only one person in our division gets anything like that, and that is me. I get that for contributing to this sort of venture. Other people who are involved in local panels for individual residential facilities get something like $600 a year. I do not think that is a lot. That is to participate in, say, quarterly meetings with the staff and the pharmacy—the so-called medication advisory group—at the individual level, to attend to some of the problems we have on a day-to-day basis.

But we would emphasise that some of these problems are endemic throughout this sector and are so trivial it almost embarrasses me to raise them with you. It starts with even getting in the door after hours. It can take 10 minutes to get in the door of a large institution after hours. There are problems around prescribing medications et cetera. Last week—just to give an example of the problem with discharging from hospitals—one of my patients, whom I had admitted to a private hospital, I discharged back to the nursing home in which I was attending to him; subsequently, on the same day, it was necessary for me to attend that nursing home and redo his medication chart. That kind of inefficiency is all through—

Senator KNOWLES—But that would be the exception and not the rule.

Dr Ford—That is the rule; that is the rort.

Senator KNOWLES—Let us cut to the chase. What has to be done to get doctors in to look after people in aged care facilities? You tell me what has to happen to do it. It does not seem to me that money or anything else is going to be any consolation. We need to know from you what is going to change.

Dr Ford—I think you have to attend to manpower or person power; we have to have the numbers to do it. At the moment in all sectors—pharmacy, nursing and medical practice, particularly general practice—we are underresourced. You have to analyse why people will not go into general practice. I think a couple of hundred training positions nationally are not filled because people are not attracted to general practice. It is all very well to be disparaging perhaps about the financial aspect, but at the end of the day people are going to look at that. So that is a factor.

Around this area, we have to have some executive progress. We need to look at some of the work that we are doing—and there are a couple of other similar organisations around the country—and not wait for everybody to reinvent the wheel around all the 116 divisions of general practice and innumerable nursing homes. We need to get on and fix a few things. For example, APAC, the Australian Pharmaceutical Advisory Committee, which has a publication which in many ways provides great instruction and on which much of the sector relies, is behind the eight ball; it is a couple of years behind with respect to computerisation and many of the changes that we would like to see brought in.

We have arguments about how often people should be reviewed. The nurses think it should be one thing and someone else will say, ‘Oh no, the legislation says it should be something else.’ There are all sorts of issues around state boundaries versus federal boundaries that apply to nursing homes. We need to get on and fix a few of these problems, which are so elementary that it is just frustrating.

Senator McLUCAS—Dr Ford, I come back to your patient whom you discharged from hospital and whose chart you subsequently had to go and fix up. Why did that happen?

Dr Ford—That happened because the nurses in the nursing home require a chart from which to administer their drugs and on which to record that administration; that particular chart is not available in the hospital. In many cases, the hospital doing the discharging process is a public hospital and there is no link with the nursing home. But the nursing home requires that chart to be completed and in many cases they call a locum service. When people are discharged at four or five o’clock in the afternoon, you cannot necessarily snap your fingers and get a GP at seven o’clock at night. So the nursing home calls an after-hours locum service, who is probably a South African doctor—no disrespect intended—who has never seen the patient and they will come at two o’clock in the morning to formalise that chart.

Belinda has put in a lot of work with our local hospital, Modbury Public Hospital, in trying to facilitate a chart which will at least give a four-day program that will be acceptable to the residential facility on the patient’s return. First of all, it records transitional treatment administered to the patients—for example, whether they have had their medication et cetera while waiting for their transport—so that it is not duplicated on their return. That gives the GP a chance, without being immediately summoned, to attend to these formalities over the next day or two.

Senator McLUCAS—It seems very simple.

Dr Ford—It does. Just on the subject of medication charts, ultimately we would like to see great changes. In the very recent past and even today there are establishments which have a six-week medication chart. So a doctor may have to go there and redo that chart every six weeks. In many cases this is clinically inappropriate. In our division we have advocated that there should be a six-month medication chart. Such a chart has been developed and refined over a couple of years, and it works extremely well.

One of our other problems is with the prescription of medications. At the present time that chart only facilitates the nurse administering the medication. On the side, somewhere, the doctor has to write a prescription to give to the pharmacist. There are areas where we cannot comply with legislation that affects this area. It is apparently illegal to predate or postdate prescriptions. We get into all sorts of complexities there. Pharmacists are forever chasing up prescriptions owed and so on. I feel that, with some determination and a bit of good sense, we should be able to eliminate the need for prescriptions to be supplied in this context. The chart could in some way become—

Senator McLUCAS—The prescription?

Dr Ford—Yes. And then there could be some sort of auditing process from the Health Commission's point of view—perhaps like the ATO, which has some sort of random system of auditing and self-auditing and so on. At the moment millions of prescriptions are printed every year, and I cannot believe that somebody actually sits down and correlates those with the person et cetera. So there has to be some attention given to that sort of thing. I have about 50 patients in this sort of facility, and I would spend three hours a week doing prescriptions and incidental paperwork.

Senator McLUCAS—Is it also an issue that when the person is in hospital the medication is being provided by the state hospital system and that that medication is not taken with the patient when they are moved back into the residential aged care setting? Can they take a bottle of pills with them?

Dr Ford—Not a bottle. They get about four days supply. That would suit our purpose reasonably well; I do not have a problem with that. It is really just a matter of some coordination, integration and cooperation.

Senator McLUCAS—Do you think the recent residential medication management review proposal will provide the capacity to solve the problems that you are talking about?

Dr Ford—Sorry, I am not clear about your question.

Senator McLUCAS—Remember that we used to have DMMR and then it changed its name. Now there is this new residential medication management review system. Will that assist to solve some of these issues?

Dr Ford—Are you referring to the CMA?

Senator McLUCAS—No.

Mrs Loveless—It is the medication side of it.

Dr Ford—Oh, yes; the DMMR. I think that is a very useful tool. At the moment there is some difficulty around that that Andy might wish to elaborate on. I think the arrangement with remuneration for pharmacists in that area is not clear, because until now it has been on an annual basis per bed. The turnover rate is greater than that in some instances, so the facility is not there. I think that is being negotiated with the forthcoming pharmacy review that is due in about July.

Senator LEES—I hate to suggest that nurses do even more, given the evidence we have had on the stresses, particularly with all the paperwork and approvals and everything that they have to do, but are there some areas where it would actually assist doctors if nurses who are nurse practitioners, particularly, were able to at least operate with you and reduce some of the trips backwards and forwards? You could give instructions over the phone or ratify something with a fax and the nurse practitioner could be the one to do the hands on.

Dr Ford—Are you asking me?

Senator LEES—Yes, as a doctor. Some of the travelling that seems to be involved seems to be a nightmare for you.

Dr Ford—Again, you have highlighted an issue of difficulty and that is how to transmit instructions and so on. There is some conflict around this area. I would like to see the nurses whom we already have, the ones who are there, able to do more. They would perhaps have a formulary of common things that they could have discretion with. Over the next week maybe the GP would attend to review that. I think that the issue of paperwork for nurses is immense. I am told that—and perhaps Wendy will elaborate—a nurse has to do something like a 20-page assessment every eight weeks, or something of that nature.

Senator LEES—Do you have any experience in the nursing home or homes you are involved with where that is now computerised and it is now a system where there is not quite so much pen on paper and nurses can do it far more quickly?

Dr Ford—Some do, I believe.

Mrs Morey—Where I work, we are working towards that. We do not have it yet.

Senator LEES—You are in the process?

Mrs Morey—We are in the process but we have not started it in a practical sense yet.

Senator LEES—Are you developing the computer programs to cope with it?

Mrs Morey—We are looking at an off-the-shelf product that we can customise for our organisation.

Senator LEES—So you are not at the stage of being aware of any hiccups that you might have with accreditation.

Mrs Morey—In the research that I have done on the IT care planning process, I have found that the facilities that I visited in the Eastern States and also in Perth have been through an accreditation round and also a number of validation rounds and have been fine.

Senator LEES—I have found only one nursing home in South Australia that is using it extensively. What is needed? What is the process that we could recommend or someone could recommend to get more nursing homes reducing the paperwork that nurses have to do so that they can take on more of the day-to-day tasks?

Mrs Morey—There is no doubt that the way the nursing homes are funded and the structures around supporting and validating that funding have fallen to the nurse. Often the most senior nurse on the site is involved in justifying the funding. There is some appropriateness in that, but the pendulum has swung right to the side and it needs to come back to a central position. Often there is a lack of IT skill amongst nurses. We do not learn this kind of thing in our training, and we need to develop those skills either professionally or personally outside of work.

IT hardware costs money and a lot of the small homes do not have a lot of money to put into this kind of thing. Another issue is how it is integrated into other services. It is all very well to pop an IT system in place which is a basic word processing system, which you might have seen around the place in Adelaide, but that just relies on someone being a very good keyboard person and inputting sentences about care. I think an IT system needs to have good information in and good information out so that you can run reports that tell you about the care of residents, from which you can track clinical trends, and that you can feed into the medication system.

Senator LEES—So the doctor might visit, and he or she would be able to bring it up and make adjustments?

Mrs Morey—That is right.

Senator LEES—That is where the pharmacy could be tracked through as well.

Mrs Morey—Yes. And you might not necessarily even have to visit. You might be able to do some of those activities that Peter is talking about remotely.

Senator LEES—So, back at the doctor’s surgery, that could just be transferred across and Mrs Smith’s records would be there or in the hospital.

Mrs Morey—Yes. And there is visioning too. You could perhaps pop a camera in. If you wanted the GP to look at a wound and you had good rapport and a trusting relationship with that GP, that GP might be happy to look at that wound via the remote to video access and then prescribe what is required. And then there is a nurse—

Senator LEES—It is happening in remote parts of South Australia already.

Mrs Morey—That is right. In the metro area I can see that kind of thing applying.

Senator McLUCAS—The doctor would not be paid in that circumstance under the current arrangements, would he—or she?

Mrs Morey—So possibly a change is required.

Prof. Gilbert—I think some of the issues we are looking at are actually systems requirements rather than individual professional groups' or organisations' facilities trying to make the move by themselves. The compatibility between IT systems is a major event. If a medical practitioner wants to keep his case notes equivalent to what is in the aged care facility, you need some transfer compatibility mechanism linking into systems that have already been set up by HealthConnect. They are well down the track with the final trials there. Where there is a shared medical record, why aren't we utilising that?

I think some of it comes down to the fact that there are different relationships between different people working in aged care. The medical practitioner and the external pharmacist will have a one-on-one relationship, with responsibility for a particular resident. Nurses in the aged care facility would be looking after groups of residents, with responsibility across all of those in the facility. We have funding models which are not compatible. Doctors and pharmacists are paid per service or whatever it is; the nursing staff are paid a salary from the facility.

It seems to me that we need to move to a system where we maintain the home-like environment in the facility—so I am not talking about setting up health services—but we have an environment where a consultancy fee or some sort of retainer is paid to attract the appropriate services, whether they are medical services, a specialist geriatrician, a physio or whatever it might be, to a facility to look after the residents in the facility across a period of time. That can be very easily established with a local arrangement where yearly care plans—or an appropriate care plan for a clinical time period—are worked out for residents, which do not require the doctor running backwards and forwards to write prescriptions and all those sorts of things. That responsibility can be handed over to a manager of the care plan in the facility.

We do not have appropriate credentialling of care workers. There seems to be absolutely no reason why a registered nurse would drag a drug trolley around for hours and hours on end. The eight o'clock medication round might not finish until half past 10 or eleven o'clock in the morning, and this nurse is being tied up full time, doing nothing else but crushing tablets and trying to get them in residents' mouths. A lot of that work is routine and could be done by an appropriately credentialled person, freeing up the highly qualified nurse to manage care plans and to relay information backwards and forwards appropriately across care plans.

Senator LEES—So do you think doctors would support a system where there was a package, a pool of money per annum per patient, and then it was up to the doctor how, when or whatever, depending on the needs of the patient, rather than this item by item system, and not being paid for a lot of the work that is actually being done? In the last couple of pages of your submission, you list some of the activities that are now unpaid. I guess, if it were a package of so many hundred dollars, on some patients you would be ahead and on others you would be behind, but it would balance itself out.

Dr Ford—I think you could look at some cocktail arrangement there. I still feel that fee-for-service has a place. There are very perverse incentives in giving somebody a lump of money: is it outcomes based et cetera? I could see some situation where there is some moiety, or the sort of work that you refer to, yes.

Senator HUMPHRIES—Some of the points you make on the last page of your submission are, with respect, a little bit obscure. You seem to be criticising the integration of medical and nursing notes. What are you actually recommending to us should be done about that?

Dr Ford—Again, it is a relatively trivial thing in a sense but communication is essential for us to administer our trade. We now have a part-time work force in general practice in many cases. In my own case, I have training registrars in the practice. They come on a six-monthly rotation. I tend to give them perhaps one nursing home to look after, with my assistance. So we depend on our communication. A sort of tradition evolved where the records of the doctor were integrated with the nursing notes, which are, of course, increasingly voluminous for all sorts of reasons. So we tend not to write so much. After three or four months, our notes are archived with the nursing notes. So we lose our admissions summary and all sorts of other communications, which are essential to what we are doing. I am advocating that the folder of records contains a segment which is the preserve of the doctor. It is not that I do not wish everyone else to look at it but I wish for us to have the ability to have a continuous record.

Senator HUMPHRIES—What about the last point you make—that last dot point on the page? What do you mean by that? You say:

> The two most important factors in shortage of medical services to Residential Aged Care Facilities are firstly the current remuneration for General Practitioner consults and secondly the increasing component of part time medical workforce that results in reduced GP availability.

I am not clear what you are saying we should do about that issue.

Dr Ford—These are factors I have mentioned to Senator Knowles. The remuneration is not adequate to attract people. As I mentioned, the bulk-billing rate for me to attend one patient, which might take me an hour by the time I have made the return trip, is probably in the order of $50. It is just not feasible. The other thing is that we would like to see some enhancement of the uptake of specialist geriatricians around the residential aged care facilities. At the moment, they tell me that they cannot afford to go there, for the same sorts of reasons.

Senator HUMPHRIES—So you need more money in the system, basically, for those things.

Dr Ford—More money and more opportunity. I think in South Australia there are very few—I cannot remember the number—geriatricians and there are a miniscule number who would be prepared to visit residential facilities. I do not see them being needed on a day-to-day basis but I would like to see a system that enhances the perception of aged care and aged care facilities and that creates an educational environment around that sector. I think that for best practice we need to access some specialist services there.

CHAIR—Thank you very much for your submission. We could probably talk to you for the rest of the afternoon. If there is anything you feel you wish to add after the questions you have received today, please feel free to send that to the committee secretariat. I thank you very much for your submission and your presentation today.

Proceedings suspended from 2.35 p.m. to 2.47 p.m.

BEDDALL, Mr Phillip, Member, Disability Action

MORRELL, Mr David Stanley, Member, Disability Action

CHAIR—I welcome representatives from Disability Action. The committee prefers evidence to be heard in public but evidence may also be taken in camera if such evidence is considered by you to be of a confidential nature. Witnesses are reminded that the evidence given to the committee is protected by parliamentary privilege and that the giving of false or misleading evidence to the committee may constitute a contempt of the Senate. The committee has before it your submission and I now invite you to make an opening statement, to be followed by questions from the committee.

Mr Morrell—We have no confidential information contained in the submission. I have provided an updated version of the submission to Peter Short, who I suppose has distributed it.

CHAIR—We have it.

Mr Morrell—The major change from the earlier submission is the addition of a profile on South Australians with disabilities. Apart from that, it is pretty much as it was.

By way of an opening statement, I will briefly introduce Disability Action. We provide advocacy directed at social change for South Australians with any kind of disability. We also provide advocacy for individual South Australians who have disabilities—about 400 of those a year—and we have been doing that since 1987. Our work on various accommodation related issues also dates back that far. More recently, we have had an active involvement in the young people in nursing homes issue through some association with the South Australian ‘engine room’, as it has been called, and that is a role that my colleague Phillip has been pre-eminent in.

You will have heard many things said in a similar way by many people presenting submissions, so I thought it would be useful to provide a profile of South Australians with disabilities in order to draw out the things that are somewhat different about South Australia. In essence, South Australia has a higher proportion of people with disabilities than any other state in the country. Our population is also older than most other states. These are matters that you are probably well aware of, but South Australia performs very badly in funding disability accommodation services that might provide alternatives to nursing homes—for example, the first table on page 3 of the submission shows that the spending of South Australia per person who is resident in an accommodation service is the lowest in the country. That may be partly a reflection of lower costs in South Australia, but these figures are quite substantially lower.

Low spending is reflected in low availability of accommodation services. The next table down shows the number of people using accommodation services per thousand of the whole population. South Australia, with the highest national rate of disability, is pretty low in terms of the number of people per thousand of our population using accommodation services. One can only suppose that is an indicator that those services are difficult to get into.

On page 4, South Australians who have disabilities are already steered towards congregate or institutional type care. The first table on page 4 shows that 59.5 per cent of all South Australians using accommodation services are using community based ones, therefore the rest are using institutional or congregate care type services. The other states have a greater preponderance of community based services and a smaller amount of institutional based services. Part of the phenomenon that may be steering South Australians towards institutional based services apart from a general nonavailability of community based ones has been brought to our attention by a colleague who would have been here today, Suzanne Mackenzie. She has mentioned that in her region, Murray Bridge, which is a provincial town about 100 kilometres out of Adelaide, people with disabilities are often never given an assessment by the state government's disability options coordination agencies. Their first and only assessment is with an ACAT team, and they get funnelled straight into the local nursing home, which has expanded its accommodation in order to receive them. It sees it as a market opportunity.

I will digress for a moment in relation to Suzanne. She was meant to be here today to give evidence. She is a woman of 42 and has osteoporosis. When she was 32 she had to fight quite hard to stay out of a nursing home. She managed to do that and is now a very effective advocate and is very committed to the interests and issues of young people in nursing homes. She was not able to get here today because she was not able to get enough support hours from her community support workers. The alternative would have been a $100 taxi ride, which was no alternative at all, so the empty chair belongs to Suzanne.

Going back to the body of submission, the low availability of accommodation services in South Australia is very likely a product of the fact that South Australia's rate of increase in its spending on these services has been the lowest of any in the country. The second table on page 4 shows that the percentage increase between 1998 and 2003 was three per cent for South Australia compared with a national average of eight per cent, and a similar pattern is repeated across most other kinds of disability support services in South Australia. Our state has not held up its end in relation to the Commonwealth-state disability agreement.

These factors produce the second highest nursing home occupancy rate in the country, it would appear, with 98.2 per cent occupancy—a good deal of which will be older people, of course, but some proportion, given the difficulties with disabilities services, will be younger people using nursing homes. And our population is expected to get older. It is also quite possible that many younger people will be leaving for economic opportunities interstate, which will have an adverse effect on the dependency ratio and capacity of the state to pay. That is a long-term projection.

In terms of impact on human rights, we at Disability Action see that as very much the crucial issue. It is easy to get lost in the complexities of nursing homes and the issues around young people in nursing homes but, when it all comes down to it, it is people's human rights that are not being supported. You could argue they are not being actively violated, but they are certainly not being supported and enabled in a way that should be possible in a country that has a national budget of $160 billion and a state budget of $7 billion. There is money there to support these things. For example, in terms of article 3 of the Declaration on the Rights of Disabled Persons, which Australia is a signatory to, being forced to enter a nursing home is no indication at all of respect for one's human dignity. Forcing young people into the company of older people can hardly be mistaken for according the young people the same fundamental rights of citizens of their own age; and I could proceed on through that section and summarise what is said there in relation to human rights. If it is useful I will, but that section was provided earlier. So I am in the hands of you on the panel as to whether you need that summary.

CHAIR—No, I do not think you need to. I think you have laid it out very clearly for us.

Mr Morrell—Then I will move on. I will skip the bit on bed-blockers because I am sure you have heard it all before. I will explain our thoughts on what should be done. I have to say that this is not the kind of detailed critique that could be expected of somebody who has been working heavily in this area for a long time, such as Bronwyn Morkham from the Young People in Nursing Homes coalition. No doubt you have heard from her or will hear from her. The things that we at Disability Action are aware of are that, without the money, a great deal of time, energy and effort is going to be put into trying to patch up a system that fundamentally is not patchable. More money is needed.

There is a campaign getting going here in South Australia at the moment. Mr David Holst, of the Dignity for the Disabled campaign, is after $100 million. I have seen the compilation of that figure and it seems quite well founded. That might sound like a lot—and it is something like almost half again what is now spent on disability services—but in fact it is only 1.4 per cent of our state's budget. To overcome the kinds of problems we are talking about here, 1.4 per cent of the state's budget is not a big ask.

Also, we think that some other things need to be done. Our state, like most other states, has a disability services act, which is more or less a mirror image of the Commonwealth Disability Services Act and is part of the mechanism by which funds are able to be transferred under the Commonwealth, states and territories disability agreement. Those acts set forward a number of disability service standards that disability services are required to comply with, and I would imagine that they are quite similar to standards that would apply in the aged services area. But those standards are not binding; that act is not binding on the Crown. No person with a disability can, in fact, use that act to enforce the rights that the act itself declares they have. We want that changed. We want the act to bind the Crown, and then I think an awful lot of things could be made to change.

It is one thing to have service standards; it is another to have accommodation services held to account against those standards. If the act were amended as indicated, and if there were effective enforcement and inspection regimes in place, we might make some progress. This is something where I think the aged care area is considerably in advance of disability services.

Also, in relation to young people who are in nursing homes, we would urge that for those people who are part of families—perhaps the really younger ones—family reunification programs be got going, that those things be funded with the objective of enabling people to move out of the nursing home and live in, as much as possible, a home-like environment with their mother, father, brothers and sisters in those crucial years when development and growth as part of the family is so essential. That concludes our opening statement.

Senator HUMPHRIES—Do you have a figure for the number of younger disabled people in nursing homes or aged care facilities in South Australia?

Mr Beddall—The latest figure I have is from late last year—there are 70 people in nursing homes in South Australia.

Senator HUMPHRIES—Under what age? Under 65?

Mr Beddall—It is basically under 65, but predominantly, when we are talking about younger people in nursing homes, we are talking about people under 55. I think that is the government's criterion at the moment.

Senator HUMPHRIES—And are most of those 70 under 55?

Mr Beddall—My understanding is they are. They are people who are in a nursing home and who are under the age of 65 and who want to move on to a better option.

Senator HUMPHRIES—Do you feel that it is practical to create an option for the majority of those younger people which is not disability specific? By that I mean: is it possible to create, for example, a generic facility in Adelaide that would accommodate a large proportion of those 70 people with a range of disabilities from MS through to intellectual disability and so forth? Is that practical, or are you looking more at residential settings in group houses or individual homes?

Mr Beddall—We would be looking for residential settings in group homes or community houses, cluster models, rather than the institutional setting.

Mr Morrell—We would also be looking for services that are oriented around the growth and development and maximisation of potential of the person rather than services that are oriented around—as nursing homes are, ultimately—death with dignity and making the last years as good as they can be.

Senator HUMPHRIES—Many submissions have commented on the inappropriateness of young disabled people being in nursing facilities or aged care facilities. I think this is the first submission I have seen which actually suggests some concrete steps that might be taken to change that paradigm. My concern remains that, at the end of the day, this is essentially a political problem. The nursing homes and aged care facilities are there in the community, people need a place to go and they are admitted to those places. If the Commonwealth, for example, were to say, 'No, we're not going to take any more young disabled people in nursing homes,' there would be a lot of political angst and kerfuffle about the fact that these people were being forced out with nowhere to go. I understand the logic of what you are putting forward, but I am not sure if I can see clearly what the political path is to solve this problem, because being heavy-handed on the part of the Commonwealth and insisting that the states shoulder their responsibility will not be an easy thing to do.

Mr Beddall—The Commonwealth does need to have some sort of concrete strategy to actually deal with the issue. It actually also needs a strategy to deal with housing. I think part of the problem is that we have an accommodation problem in this country not only for people with disabilities but for a lot of Australians. One of the difficulties is that, while you can actually sometimes get a bucket of money to provide the support, getting the appropriate housing is also difficult, so getting that match-up between housing and support to work together to assist the person in the community is quite often difficult. It is not necessarily all about the dollars and cents; it is about how it is coordinated and also who takes responsibility for it.

Senator HUMPHRIES—Presumably you would really need to have state housing commissions involved in providing those houses. You would not be able to source them readily from the market, I assume.

Mr Morrell—That is true. State housing commissions—South Australia's is the South Australian Housing Trust—play a crucial role in this. To come back to your earlier comment about Commonwealth involvement and the political path, I can only endorse what you have said about the possibilities of Commonwealth heavy-handedness and the reaction that would provoke from the states. That certainly occurred in relation to CSDA mark 2 when that was negotiated, and the states still talk about it. The political path in terms of getting the support services in place has to come from people operating at the state level lobbying their state governments. The crucial role for the Commonwealth is actually in the provision of public housing and moving somewhat back into that provision even if it is in a targeted way. I am not sure how that could be done. The moving of money out of the provision of public housing infrastructure and into private rent assistance has done a lot of damage. It has caused a lot of reduction in the public housing stock around the country. That hits especially hard those people who really do not have other choices, those people who really cannot source things on the private market, because, for example, they need a house that is accessible or they need one that is available now so the support services can come in or whatever else it may be. So there is a role for the Commonwealth.

Senator HUMPHRIES—Thank you very much for this submission. It is a very helpful one.

Senator McLUCAS—I also thank you for your submission. Mr Morrell, you talked about the $100 million that the other advocacy group has come up with as an appropriate figure. Does that include consideration of the housing needs of these 70 people that are currently living in nursing homes?

Mr Morrell—The list that I have seen, and I have seen this list only in the last few days, did not include specific mention of that group. It included mention of a variety of community based support services but did not say who they were for. I am unable to answer your question until I can actually get to speak to the people involved. I certainly intend to do that and would be happy to pass on the results of anything I might find out that could answer that question.

Senator McLUCAS—Tomorrow we are going to be in Perth and we are actually going to see some quite innovative housing options. Are you aware of Fern River? The MS Society runs an operation called Fern River, which we are led to believe is a very good facility.

Mr Beddall—I have heard about it. I have actually seen it on paper, if that makes any sense. I have not actually seen it first hand.

Senator McLUCAS—I will take some photos and send them back to you.

Mr Beddall—At a glance it looks to be a very good model and also reasonably cost effective in terms of providing accommodation and support.

Senator McLUCAS—The way I see it is that you need an injection of money for the capital and then it is almost really self-sustaining. It depends on the level of the person's disability. Some people need to have an employee living in the group home with the people but others do not. It comes down to the mix of people who are living together in a group home and what support they need.

Mr Beddall—That is a key issue: the more severe the disability, the more complex the care and the cost becomes an issue. Disability Action and other groups would argue that, no matter how severe the disability, we should be striving to improve the lives of those people. Although cost is an issue, we do need to look at innovative ways and programs to actually deal with those complex needs.

Mr Morrell—I am going to risk taking a guess in front of a Senate inquiry, so do not hold me to it: very roughly, if we have 70 people in nursing homes with support needs towards the high end of the spectrum and I were to take a worst case scenario, I think it would be $100,000 a year. We are talking about perhaps $7 million recurrent. The $100 million was a total figure across a whole range of needs, including those of young people in nursing homes. That figure of $7 million that I have just nominated needs to be run down much more closely, of course. But it is in that order; it is not in the order of, say, $40 million or $50 million or more.

Senator McLUCAS—Are there any group homes or alternative types of accommodation settings in operation in South Australia at all?

Mr Beddall—There are some that CARA operates. Julia Farr Services is the main institution in this state. It is looking at devolving and moving its clients out into the community. That is happening at the moment. It is also looking at the issue of young people in nursing homes and trying to assist into the community some of those clients that may have gone into Julia Farr. But Julia Farr is the main one here. There are a couple of others, but that is the main institutional setting here in South Australia.

CHAIR—I think the committee accepts in general the inappropriateness of having people with disabilities in nursing homes. What to do about it is something we will be turning our minds to through the course of the inquiry. In a more general sense, do any of your members or the people you seek to represent complain about the general conditions or the treatment they receive in nursing homes?

Mr Morrell—The short answer is that we have had one such complaint amongst the many that come through Disability Action. The reason for that is the isolation of being in a nursing home and problems with access to information. Although our agency is well known as a disability advocacy agency around the traps and by people who take note of these things, it is not widely known. When you think about first aid, you think of the Red Cross. When you think about crime, you think of the police. But when you think of advocacy, who do you think of? That is the reality of being a small community organisation. We do not have the budget to become known in that way. There would be many people in nursing homes, just as in many other walks of life or living situations, who would not know about Disability Action or similar organisations. That, in fact, is an important reason why one of the recommendations in our submission is about the necessity of having active standards enforcement and policing going on in these places.

There needs to be an outreach involving actually getting out there and making contact with people.

Mr Beddall—I know anecdotally of at least two people who chose to end their lives or have assistance in ending their lives rather than live in nursing homes. We hear those sorts of stories all the time, although I do not think they have actually formally come to the agency with an advocacy issue.

Mr Morrell—No. The one complaint that we did have, which came out of an issue that we formally acted on, came from a woman who wanted at all costs to avoid going into a nursing home. She did not make the threat that Phillip has mentioned, but she was quite desperate and distraught at the prospect of having to go into a nursing home. She basically prayed that someone could make it not happen for her.

CHAIR—Thank you for your submission and your presentation today. I think they are very valuable and will assist the committee in its deliberations.

Committee adjourned at 3.15 p.m.