COMMONWEALTH OF AUSTRALIA

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SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

Reference: Aged Care

FRIDAY, 11 FEBRUARY 2005

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SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

Friday, 11 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, Barnett, Bishop, George Campbell, Carr, Chapman, Colbeck, Coonan, Crossin, Denman, Eggleston, Chris Evans, Faulkner, Ferguson, Ferris, Forshaw, Greig, Harradine, Harris, Lees, Lightfoot, Ludwig, Mackay, Mason, McGauran, McLucas, Murray, Nettle, O'Brien, Payne, Tierney, Watson and Webber

Senators in attendance: Senators Allison, Forshaw, Humphries, Knowles, Marshall, McLucas and 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.

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Committee met at 9.04 a.m.

HATFIELD DODDS, Ms Lin, National Director, UnitingCare Australia

HUCKERBY, Mr Fred, Director, Blue Care (Qld), UnitingCare Australia

YOUNG, Mr Rod, Chief Executive Officer, Australian Nursing Homes and Extended Care Association Ltd

DEERAIN, Ms Margaret Louise, Manager, Policy and Research, Catholic Health Australia

GRAY, Mr Richard Nelson Worsley, Director, Aged Care Services, Catholic Health Australia

SULLIVAN, Mr Francis John, Chief Executive Officer, Catholic Health Australia

CHAIR—The Community Affairs References Committee is continuing its inquiry into aged care. I welcome representatives from UnitingCare Australia, Australian Nursing Homes and Extended Care Association and Catholic Health Australia.

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 giving false or misleading evidence to the committee may constitute a contempt of the Senate. The committee has before it your submissions and I now invite you to make an opening statement to be followed by questions from the committee.

Ms Hatfield Dodds—Thank you for the opportunity to speak with you this morning. The establishment of this committee, its work and ultimately the presentation of its report present the Australian government with a significant opportunity. The issues addressed in this inquiry are important for the future provision of quality care to the structurally ageing Australian population. The challenge will be to take the problems besetting aged care seriously and to provide leadership to ensure that Australia has a well-resourced aged care system that meets the needs of all those who need to access it.

As our population ages, aged care spending will increase, as will the number of pension recipients, while the income tax revenue from our ageing cohort will be lost. Revenue to meet the particular demands on government due to structural ageing must be raised in a fair and sustainable way. Diversity of available care will be vital as government and other providers of aged care seek to enable older people to experience quality of life and exercise their right to participate in decisions about their own care.

Baby boomers moving into aged care will expect and demand a well-resourced and easily navigable continuum of care. People with disabilities are living longer than ever before. Ageing people with disabilities and their ageing parents are an emerging and growing group of Australians that require particular forms of care and more flexibility than the current system allows. The population of younger people with disabilities living in inappropriate accommodation within residential aged care facilities is another small but significant population

group that requires innovative policy responses to have their quality-of-life needs adequately met.

There are a range of significant work force issues in the aged care sector. Serious staff shortages, especially of qualified nurses and allied health professionals, are widespread. We experience continuous difficulty in recruiting qualified staff because of shortages and the necessity to compete with the acute sector that has a capacity to remunerate at much higher levels. Too much paperwork leads to staff burnout as dedicated staff struggle to maintain levels of care while dealing with burdensome documentation requirements. There is no real measure of the actual staff requirements for residential care.

We believe that the establishment of benchmarks for staffing in residential care that meet duty-of-care standards and optimise quality-of-life outcomes would be a significant step forward. We would like to see the Hogan report's recommendations on work force training benchmarks fully realised. The development of accurate indexation is essential. While the Aged Care Standards Agency has improved its processes over the past few years, greater consistency in audits is still required. Around 80 per cent of community care is provided by family or other carers. We believe that there is a large unmet need.

Community care requires an injection of funds to ensure that the health and quality-of-life needs of ageing Australians are met, and to provide respite for carers. The UnitingCare network is one of the largest providers of community services in Australia, including approximately 12 per cent of the aged care places that are directly funded by the Australian government. It is our hope that this inquiry will lead to better partnerships between networks like our own and government to address the immediate and pressing needs facing the aged care sector.

CHAIR—Do we have any other presentations?

Mr Young—The Australian Nursing Home and Extended Care Association represents 800 aged care providers across Australia, from the public and the private sector—or voluntary and for-profit sector—and community services. Our vision is to strive for, and is committed to, excellence in residential care within a financially viable environment. We have responded to the committee's terms of reference in our submission, emphasising some of the issues that we feel are important to achieve the sorts of outcomes that we believe we need to aim for in providing quality residential aged care. Some of those issues obviously surround our ability to attract and retain the adequate mix of staff with adequate and appropriate skills to deliver the service regime that the government, the community and us as providers feel that we should provide and that our elderly residents deserve.

In the context of providing that sort of level and quality of care, there are some real barriers to us achieving the ongoing retention and recruitment of that necessary staffing, mainly in the area of being able to pay appropriate wages. That touches on the issues of subsidy and indexation. In the broader context, however, of raising the profile and standing of residential aged care as a career path of choice for the future, as an environment which is attractive and interesting and which is recognised by the medical and broader nursing profession as an area of choice and a career path of choice for the future, there is a lot of work for us to do in achieving those objectives.

We believe it is attainable. We believe that the government's 1997 reforms were, in part, a driver down a path that will assist in that process, but there are some impediments in the current framework. The 2004-05 budget and Hogan report and the response to Hogan has addressed some of those issues but does not go anywhere near far enough. One of the ongoing issues that really impact on our staff and make it very difficult for us to retain and attract staff is the amount of red tape and documentation that still exists in the system.

ANHECA has assessed that the lost hours or wasted hours of registered nurse time is about four million hours per year and the cost of that to the system in both departmental hours and industry and sector hours is about $90 million per annum. We believe that we need to move very rapidly to overcome that, because one of the biggest reasons that staff give us for either not joining the sector or not staying in the sector is this excessive red tape.

In the area of quality improvement, we as a sector have been highly supportive of the 1997 reforms. However, we have had some real concerns about the current construct and are highly supportive of the ongoing provision of quality and the enhancement of service provision through quality, but believe that there is a real need to separate out the framework of quality and the compliance component that sits within the current structure of the aged care agency.

Mr Sullivan—I have an introductory presentation which I might table rather than go through, but could I just make some points?

CHAIR—Sure.

Mr Sullivan—Firstly, thanks very much for lettings us appear once again to provide further evidence to your inquiry. CHA, along with other aged care organisations, supported the $2.2 billion five-year aged care package released at the last budget. We welcomed the release of the *Review of pricing arrangements in residential aged care,* conducted by Professor Warren Hogan. We were a significant contributor to that review and have been supportive of a number of the reforms that have been flowing from the Hogan review. It has been clear to everyone involved in aged care that the sector needed to have further reforms and investment if Australia was going to be prepared for our ageing population, with appropriate infrastructure and services available according to need.

The federal budget of 2004 was a defining moment for the aged care sector. However, much more must be done and further guarantees need to be given that people accessing aged care services will not be disadvantaged by changes and reforms to aged care.

The aged care program has increasingly relied on resident fees to get by. Residents already pay up to 30 per cent of the costs of the service—despite the fact that residential aged care is now more accurately understood as a health care service, not a supported accommodation program.

The Australian Institute of Health and Welfare figures reveal a stark reality. These days, the average age of admission to a home is 86. Over 63 per cent of people are admitted to the high-care end of the service. Well over 80 per cent of these people are pensioners. They are the frailest and sickest in the program. They also have not had a long history of personal superannuation and accumulated wealth. Close to 83 per cent of the residents die in the homes. Of those, 31 per cent

die within the first nine months since admission. In many instances, these people are receiving terminal care, yet the current policy setting is to rely on consumer and resident fees.

CHA is particularly concerned that areas of disadvantage are diminished. In a program where equity is questionable and is determined more by geography, housing prices and family support, it is incumbent for government to keep subsidies at market rates to ensure the less well-off do not fall behind and, in some cases, out of the program. In many respects it is difficult to comment on how some groups will be affected by the aged care reforms and changes to funding arrangements, because in many cases final decisions have not yet been made about the future policy directions, such as the conditions to be included to receive the conditional adjustment payment, prudential arrangements for accommodation bonds and the revised resident classification scale and related funding.

I would like to comment, however, on one group in our society that may be adversely affected by changes to aged care and for which CHA believes every measure needs to be taken to ensure their needs are examined and addressed. The group I am referring to is the elderly homeless. The Hogan review identified homeless older people as one of the most difficult groups to place in residential aged care. They experience discrimination because of their unique care and support needs, and also because aged care providers can be financially disadvantaged when taking in homeless people, both in terms of care funding and in capital funding.

The current resident classification scale, even when maximised, does not reflect the level of specific care resources required. The intensive level of care and one-on-one support required by such care recipients is provided only with great difficulty under the current funding regime. Currently, all providers who cater for this special needs group are religious and/or charitable organisations. It is unlikely under the proposed parameters that the new aged care funding instrument to be introduced on 1 July 2006 will correct this situation; in fact, under current modelling future care funding could be considerably less.

At a time when many in the community are feeling economically comfortable and secure, it is becoming easy to overlook those who are doing it tough. The homeless elderly are certainly living in our community and they are doing it very tough. They deserve respect and they deserve to be treated with dignity. This is a critical time to ensure policy and funding decisions ensure homeless older people are not forgotten and indeed they, and those who care for them, should receive the assistance they need to ensure the highest quality of life. I will leave other aspects, except for two.

Underpinning our submission is a call by CHA for a quality care compact based on an agreed level of care which binds government, providers and staff to achieve specific care results for the frail and sick. A key component would be the establishment of an aged care benefit schedule to modernise government care subsidies and to deliver appropriate support to frail elderly Australians, regardless of where they live. The quality care compact is needed not only to bring certainty to the frail elderly but to inject new confidence in the aged care work force. An investment in aged care services is based on maximising care, not profits.

In our view, a compact would include a commitment to introducing a benchmark of care which is fully funded by government and provides clearly defined levels of service. It is linked to the benchmark. There needs to be a commitment of funding to ensure appropriate staffing

levels are in place for facilities, depending on their size, and the resident profile. The benchmark of care needs to take into account all aspects of a person's needs: physical, emotional, social and spiritual.

The establishment of the aged care benefit schedule to modernise government care subsidies and deliver real support to frail elderly Australians, regardless of where they live, is essential. There needs to be recognition of pastoral care. We need to ensure the commitment to paying nurses and care workers attractive salaries, a commitment to ongoing training and development of staff, appropriate accountability for public funding, and the accreditation agency or any future equivalent should be fully supported to focus not only on compliance monitoring but on increasing its role in supporting and working with facilities to ensure best practice and continuous improvement.

The final issue for us is that presently the dysfunction between hospital and community care disadvantages frail and sick elderly people. CHA has long been on the public record calling for the Commonwealth to take full responsibility for the elderly, particularly the over-75s. This would work in a similar fashion to what the Commonwealth now does for veterans. We would encourage the committee to consider creative solutions to this issue in the interests of the elderly and in a spirit of collaboration and cooperation between levels of government.

CHAIR—Are there any other presentations? If not, we will move into questions. Mr Young, could I just get you to clarify a point you made in your submission. You identified the amount of wasted hours on what you consider to be red tape. Were you saying that that is unnecessary red tape or is that the total amount of paperwork that is actually required in the industry?

Mr Young—I am saying it is unnecessary red tape. If it was red tape that was required for direct care services then we would not be raising it as an issue. It is really to do with the existing validation regime. The department of health send staff into a facility to confirm that the facility's claim for funding under the residential classification scale, the subsidy level that is paid in respect to a resident, has been accurately assessed and claimed by the facility. What happens is that when the validators come into a facility, they tend to look only at the documentation and look at it in a very focused, minute context. It drives staff then to excessively record; rather than saying, 'Mrs Jones needs to be toileted,' to record every day or every time every day that Mrs Jones is taken to the toilet. Record keeping in this detail is not a requirement anywhere else in the health system. Unfortunately, it is an ongoing part of the aged care system. If you are in the acute sector, such incidents which are not necessary to record, such as that type of service, would be on an exception basis: 'Mrs Jones needs to be toileted' and it is assumed that she is taken to the toilet, as required, on a daily basis. The current system drives so much needless documentation, needless recording of these various steps and servicing arrangements, and that's where the unnecessary component arises.

Senator KNOWLES—I want to carry on with that because, as you know, there are a number of facilities that do not meet accreditation. I would be interested to know how ANHECA would suggest that the red tape be reduced, given that it is a very important area and it is dealing with a group of people who are potentially very vulnerable to short cuts and poor practice, and I would be fascinated to know how you would suggest that we as a government and as a sector can be fully accountable to the community by reducing the red tape. I am a great one for reducing red tape. If there is a way to do something more simply and more efficiently, I am for it, but in this

area I would be very interested to know, because it is an area where we will all cop a lot of flak if something is not right, because the people themselves are not really capable of standing up for themselves in most cases.

Mr Young—There are various components of the existing system which I think go a long way to really protecting the interests of residents. There is the Complaints Resolution Scheme run by the department of health that is responsible for compliance—or supposedly responsible for compliance, because one of our difficulties is, there is a huge grey area between that role of the department, which we totally support, and the compliance role that the agency also adopts.

We believe that the agency's role is to do quality improvement. In other words, it should be systems focused, not detailed process focused. When the agency goes into a facility, which is what you would do in ISO or any of the quality improvement regimes that operate very effectively in all sorts of other industry sectors, it would look at those systems. It would support facilities where they are deficient. The department has the responsibility—it is legislated and we accept that—to run the Complaints Resolution Scheme. It runs that in two parts: (1) actually reviewing complaints and (2) anybody can make a complaint about us. They can make an anonymous complaint about us. A staff member, a visitor, a relative, a GP, anybody coming to a facility is entitled to make a complaint. We accept that. The number of complaints has been dropping.

Senator KNOWLES—The number of complaints has been dropping also concurrently with the tighter reporting standards, hasn't it?

Mr Young—No. The reporting standards or the compliance component and supervision of complaints—which we say should be a quality improvement process; it should not be, as it currently is, 'We hit you over the head every time there's a complaint about you, whether or not it's proved'—is one process. The accreditation systems quality improvement is another. What I was talking about with red tape is quite separate to all that. Every facility must do good quality documentation. No dispute. They must do good quality care plans. No dispute. Any reputable health care service, whether it is an aged care facility or a hospital or whatever, should do quality care planning, assessment and ongoing assessment of residents.

What drives this system, in the unnecessary red tape component, is that necessity to document minutiae, detailed activities every day which can be seen—if you have a care plan for a resident and that care plan says, 'Mrs Jones must be toileted, showered, fed,' whatever the circumstances of the care regime are, you do not have to document that that has happened every day. If the aged care agency comes into the facility and looks at the systems, if that care plan is not being implemented—because bear in mind that they talk to at least 10 per cent of staff, they talk to at least 10 per cent of relatives and the residents every time they do a review audit—then those sorts of things become quite apparent very quickly.

They would be highly critical of us if we were not preparing a proper care plan based on an effective in-depth assessment of the resident and then actually recording the outcomes of that care plan and adjusting it on a very regular basis, but that is not the part of the documentation we are talking about. It is the additional component of that that is unnecessary, driven by the validation process.

Senator KNOWLES—Presumably you have raised this repeatedly before. What response have you had?

Mr Young—At the moment part of the government's 2004-05 budget outcomes is to move towards a new funding instrument for 1 July 2006. The intention is, hopefully, that at the introduction of a new funding instrument, which would at this stage involve the initial assessment, the aged care assessment team would do the gatekeeper role for approval for entry into residential care or community aged care packages and then there would be a further assessment of what is the level of funding that would sit behind that person's entry into care.

If that external assessor structure is eventually adopted—and there should be a major trial of those ideas later this year—then there is an external assessor who is not a provider who takes away some of the accountability provisions that currently sit within the framework that drives that validation process and the excessive documentation.

Senator KNOWLES—Ms Hatfield Dodds, I want to come to you. You were talking about staff shortages due to the incapacity to remunerate by comparison to other sectors. What is your opinion of the Aged Care Career Pathways Program?

Ms Hatfield Dodds—I am going to hand that to Fred, who is actually working the system.

Mr Huckerby—I am not aware of the pathways you are referring to. Could you explain a little bit more?

Senator KNOWLES—The government has put in $150 million since 2002 to try and encourage more people to go into the aged care sector and there have been those programs—

Mr Huckerby—I have it. What I would say about that is that it is very welcome. There is no doubt it is a magnificent step in the right direction. What I would say is that in the Hogan review, Hogan recommended a certain level of extra places for registered nurses, enrolled nurses, new certificate III certificates and certificate IV certificates. What the government provided in the budget in response to that review was approximately half the level of training and places requested in the Hogan review. Whilst I think that it is great that the government is moving towards a better career path, better training, more places for the nursing industry and the enrolled nurses and carers generally, there needs to be more. I think Hogan probably got it fairly right.

Senator KNOWLES—How do you propose that one snaps the finger and does that overnight instead of in an incremental way?

Mr Huckerby—I am not proposing that it be done overnight. I would propose, in the same way the government has responded through the 2004 budget, that each level that I have referred to here would be incrementally increased till it finally got to the Hogan review limits or possibly even more in the three out-turn years of the forward estimates.

Senator KNOWLES—Can I ask how much UnitingCare got post last budget with the $3,000 per resident?

Ms Hatfield Dodds—In total across the network? I do not have that aggregated figure. I can get it for you, Senator Knowles.

Senator KNOWLES—Have you, as a consequence of that injection of funds, increased your remuneration to your staff?

Ms Hatfield Dodds—In some instances we have; in some instances we have not. Frontier Services, our agency that works across rural and remote rural Australia, I know has used the funding for that purpose. They experience continual difficulty attracting and maintaining staff and that is around a dispersed continent and just having difficulty finding adequately trained staff in Tennant Creek, Alice and Darwin.

Senator KNOWLES—The government does not set wages. Let us just get that on the record: the government does not set wages, it is the facilities that set their wages and it is the facilities that negotiate their wages. The facilities have been saying, 'We need more money. We need vastly more money to be able to remunerate our staff'—I am a bit concerned now to hear that you say capital city facilities have not had wage increases for the staff.

Mr Huckerby—Can I interject there? We have had wage increases. In Queensland I actually run 20 aged care facilities. In Queensland the average increase in wages through our enterprise bargaining agreements over the past three years for the total of Blue Care's 90 residential facilities in Queensland has been running at about six per cent a year. What Lin is referring to is that the government indexation to offset those pay increases has been running at 2.01 per cent—about two per cent. I will acknowledge the additional conditional payment of 1.7 per cent last year which brought it up to 3.76 per cent. There is no doubt that was a magnificent benefit to the industry.

However, even with that it has not nearly kept pace with the pay increases. You will see in our submission I refer not only to Queensland but also to South Australia. We talk about salary increases of between 14 per cent and 18 per cent over three years and indexation to compensate for that of six per cent plus the 1.75 per cent conditional payment which carries on for the next three years also.

Senator KNOWLES—The Australian Government is increasing total funding to aged care over the next four years by over $2,000 per resident per year in addition to indexation. It is up to also some of the institutions to be able to make their own savings and their own investment decisions and everything else to be able to come to that and not just say, 'Governments, you are responsible for increasing our funding so we can then provide the money to our staff.' I do not quite get why, with the massive increase in funding that has gone in, we are still saying the staff are so far behind the acute care sector. Mr Sullivan, you got a cheque for a nice $59 million, I think.

Mr Sullivan—How much, Senator?

Senator KNOWLES—$59 million, was it?

Mr Sullivan—Not even close!

Senator KNOWLES—Or was it $60 million?

Mr Sullivan—I did not get the cheque. If I got the cheque, we would not be in our humble surrounds in Canberra. You will know, obviously, that each of the facilities gets the cheque.

Senator KNOWLES—You would be cruising on the QEII now, wouldn't you? I think it is in Sydney at the moment.

Mr Sullivan—It would be a preferable place! You know that each of the facilities, or its overarching legal structure, gets the payment and, as you probably recorded at the time, we were very supportive and complimentary of the budget. The questions you are asking, I think, are complex rather than simple. In our analysis—and this is what we put in the budget submission—we thought the shortfall on the indexation was closer to two per cent. That is why we welcomed the 1.75 per cent, because it is close. In reality, the retention of staff is determined heavily by wages—also conditions, but mainly wages.

Under the present arrangements, our modelling of the 1.75 per cent would mean that there would still be a shortfall of around $170 a week for a nurse working in an aged care facility as compared to a hospital. Why is the gap still there? I can understand the frustration. It is like anybody. When you pay something, you think you are getting close. Is that going to close the gap? Then it widens. That is the nature of any sort of industrial relations market. But in hospital care there is a greater capacity, it seems, on both the state government side and on the private health insurance side to keep pace with wages.

I think the hard reality, and what most people would tell you across the table, is that because the aged care program is so heavily reliant on government subsidy around the care funding, which goes to wages, and because the overall operating budget is so significantly determined by wages, the gap unfortunately is exacerbated. That has been our experience. The first point, though, is that the money you mentioned—the $3,000 or something a bed—was particularly targeted at capital-specific works, not wages.

Senator KNOWLES—Which takes the pressure off other money.

Mr Sullivan—With respect, we have been asked since 1996 to not mix the money.

Senator KNOWLES—Yes, exactly, but that is not what I am saying.

Mr Sullivan—I think you were. You were taking the pressure off the money. You cannot take pressure off money if you are not allowed to mix it. The reality is that the capital components, the bond payments and the regular payments people make for accommodation in capital—if you are running a decent, efficient business—go to capital. The money on funding goes to providing the funding. The disaster people ran into post-1996 through to 1999 was that some were trying to chop and change, and we got heavy counsel from previous aged care ministers about running an efficient program, so we are running an efficient program, and it is not fair to say that once you get $3,000 for capital it is taking the pressure off funding. In reality, it is a nonsense.

Senator KNOWLES—I am sorry, and when I apologise like that I am not saying I agree with you. I am simply saying to you that, if one is trying to raise the funds for capital and you get an

injection of $3,000 a bed, the pressure is substantially taken off the fundraising that you are doing for the capital on the other side.

Mr Sullivan—People going into the homes have a requirement on capital and a requirement on care. They pay twice. They pay their capital component and they pay towards care. If the government is giving people $3,000 for what they have done on capital, or prospectively will do on capital, the money goes to capital. It does not ease the burden on the care funding.

Mr Gray—Senator, wage parity is just one aspect of work force issues. Clearly, Professor Hogan in his report identified a number of training places that the government should provide. Of course, as has already been stated, the budget put in place half of what Professor Hogan recommended. Professor Hogan made that recommendation based on a particular statistic that he mentioned in the summary report on page 24, where he said that over the decade the aged care work force growth need is 35 per cent against an eight per cent increase in the entire Australian work force. I think the fundamental challenge facing aged care in the future is the growth factor of the work force needed in aged care against how the entire work force is going to grow. That is why we need the training places urgently.

Senator McLUCAS—Mr Gray, I think Professor Hogan is talking about broader work force issues, not purely nursing. Do you—or anyone, in fact—have any comments about the staffing mixes, whether or not they are right and how they are applied in various settings?

Mr Gray—We have always said to Catholic Health Australia that there is a need for a benchmark of care that will identify a skills mix and level of staffing needed to provide the care for residents under particular dependency benchmarks. Unfortunately, one of the problems with the Hogan report was that it really did not provide us with any real statistics about any correlation of actual work force numbers against dependency levels, nor did the census report identify staffing in residential aged care. We certainly would support an appropriate level of staffing and skills mix to meet the dependency care needs of residents.

Mr Young—We have a slightly different view, and that is that we believe that the current work force structure is not going to service adequately whatever we do—if we maintain the current classifications, if we maintain the current connection by way of parity to the acute hospital sector—and we believe that we really need to start to break open the shell, as it currently stands, and to look again at an aged career path, an aged career structure and an aged care work force structure which perhaps might be very different. Our belief is that, if we continue along the same path we are on at the moment, in 10 years time we will simply not get sufficient qualified staff. It will not matter what skills mix we say we should have. If we are going to be constantly competing with the acute hospital sector for the same staff, we believe that we are going to have an almost impossible task.

Therefore, we think we have to basically start over again, put a fresh sheet on the table and look at what we are going to need in 10 years time. We really are enthusiastic about getting nurse practitioners in residential care working as an adjunct to medical staff. We have medical staffing problems anyway. Let us look at ways that we can have an enhanced nurse role that creates a better clinical career path. Let us look at ways that we can enhance the role of our management teams. Do we have to take all of our clinical directors of nursing into management? Can we have

general managers to relieve much of that load? Can we continue to enhance the enrolled nurse's existing role but create something quite different and enhance carers?

We also have a belief that in the not-too-distant future some of the information technology that is going to be available to the sector will help us to support lesser skilled staff to do much of the work today that we consider is purely the registered nurse's—and no-one else's—role.

Senator McLUCAS—Do any of the other groups want to comment on what Mr Young said? I think you are talking about a brand-new day, where we do not look at a hospital based model of care, which I want to come back to with Mr Sullivan in a minute. It is a completely different model, and we start again.

Mr Young—I think if we are going to raise the status and standing of nurses—and nursing and aged care as a profession of choice and a career path of choice—then we have to do something that is quite different from today.

Senator McLUCAS—Are there any barriers to a greater use of nurse practitioners, for example?

Mr Huckerby—Only the requirement for nurses to be available 24 hours for high care. At UnitingCare, we would support a combination of both the approaches that have been mentioned to date. I think that there has been some incredible forward movement in regard to training of carers and I believe carers, enrolled nurses and assistants in nursing can play a bigger role in the aged care industry, supporting to some degree the approach Rod has already outlined.

Ms Deerain—I draw attention to a recommendation we made in our submission that in the aged care sector it is community care, geriatric care and acute care. A lot of the work has been focused on residential care and the attention that it needs but we would argue that you have to look at across-the-board needs and it is community care, which is obviously growing, and the acute care sector.

Senator McLUCAS—I am glad you made that point because we do tend to focus very much on the work force issues around residential aged care. Do you have comments about work force in community care that you want to put on the record? Are they the same issues?

Ms Deerain—They are similar issues but working in a home and working in a residential care facility are quite different. There are lots of similarities but you would have to look at it across the board. You cannot top up one part of the aged care sector while the other one might suffer.

Senator ALLISON—I wonder if we can explore the benchmark of care concept in your compact, which is a really good idea. Can you give the committee some examples of the levels of service which would rise under the benchmark of care that you would like to see. What, for instance, is not being done within residential aged care now that might be done under such a benchmark?

Mr Gray—Under the benchmark of care approach, what we would be saying is that there are certain dependency levels and clinical groupings of care need for residents. When you have a

group of residents that are in a similar care cohort or case mix, then you really need a mix of staff to meet that care need for that particular case mix of residents.

Senator ALLISON—By definition that is not happening now? You have someone with very high care needs and you cannot afford to meet those needs. Is that the simple conclusion we draw?

Mr Gray—Not necessarily. It depends, because we have identified that if you have one group of residents—the homeless alcoholics, for example—where you are not able to mainstream those types of residents, you have to put them in a facility that is dedicated to their care needs. The current funding system does not allow sufficient funding to meet the particular care needs of that group of residents. The same could be said for other particular groups of residents, particularly those who have behavioural issues or very complex nursing and care needs.

Senator ALLISON—The homeless remain homeless, rather than being in care. With the next group you are about to tell us about, can you say what they are not getting that they ought to get?

Mr Gray—The funding level is not adequate to meet their need. Therefore, what is happening generally is the organisations that are particularly catering for those groups are having to use other resources of their own to continue providing the care for those people.

Senator ALLISON—You are not saying they are not getting it; you are saying there needs to be a recognition of the level of care, which is what this benchmark would do. It would not deliver extra care; it would just pay for what is being delivered.

Mr Gray—Yes, you are right. The principle of an aged care benefits schedule is that it identifies every element of care that needs to be provided to an individual and sets a level of funding to meet the cost of that care. Like an MBS schedule, you would add up the items of care which would then total a given amount of funding, which then could be transportable. Wherever that resident needed to have the care provided, that funding would flow with that person.

Ms Hatfield Dodds—It is person focused rather than system focused. I do not think everybody living with mental illness or every ageing person with a disability has their needs met in aged care, whether it is community or residential. That is our experience across the country.

Senator ALLISON—They are two groups that you would identify.

Ms Hatfield Dodds—Absolutely.

Senator ALLISON—Mr Young, you made remarks about the Aged Care Standards and Accreditation Agency, and the fact that there is evidence coming through about $90 million worth of red tape, which you regard as largely unnecessary. You complain about the agency not coming back with any useful analysis of this data. Is that correct? Do you get no feedback from the data that is collected? Do we know, as a result of what you record, how many times people go to the toilet, for instance?

Mr Young—No. There is no data of that nature and that is not really the agency's role. We do get some limited data from the agency but it really surrounds the responses to their questionnaire

when they exit a facility, which they administer themselves. It surrounds the number of visits that they make to facilities throughout a given time period—usually three months, six months and 12 months of a current year; whether they have done so many spot checks, so many support visits, so many review audits; the number of facilities that have been accredited in full; the period of time they have been accredited and the number of facilities that may have been non-compliant against one of the 44 standards. That is about the extent of the statistics that we, as an industry, get from the agency.

What I was referring to in our submission was that it would make the agency's work far more substantial and give a stronger focus and security to the sector if we could get some interrelated reliability outcome for teams in geographic areas. What are their outcomes? Are they consistent? What are the outcomes for teams in states in geographic areas as to where noncompliance occurs? Is there some consistency of noncompliance occurring in a state? That is because the agency is arranged on a state by state basis. Is there consistency in those outcomes across the country? We simply do not know that. I am not aware that the agency has the capacity or the plan to create that sort of statistical data. If it were available and you were able to get much better confidence in the outcomes being consistent across the country, there would be more confidence in the agency's work itself.

Senator ALLISON—On the question of outcomes, it is often said we should be counting bedsores instead of how many times people go to the toilet; in other words, we should identify the things that go wrong and find ways of solving them. Is that your view?

Mr Young—Yes.

Senator ALLISON—What about the budget changes for Medicare which should have encouraged GPs to flock to aged care centres? Your submission said July. Has that happened?

Mr Young—I do not have the latest statistics and I am not sure if any other member of the panel has them. There has certainly been a very welcome acceptance by the sector that it enhances the financial returns and the involvement of GPs. The last statistic I saw mentioned 1,200 CMAs that had been done in the sector. That was at the end of September. The projection was for around 45,000 to 50,000, once the system has been introduced, everybody is aware of it and it is taken up fully by GPs. At the moment it is probably too early to tell, but the sector is very enthusiastic about it, think it is a great idea and welcomes it, as well as the Allied Health Initiative. We heard some statistics about that yesterday. There are some indications that the industry has been taking up that initiative also.

Senator ALLISON—Chair, if those statistics might be available in time for us to report, it would be useful for us to have them.

CHAIR—Is that possible?

Mr Young—Yes.

Mr Huckerby—It has not been successful in every circumstance on the ground. In some areas we are having great difficulty, still, attracting GPs to residential care facilities, regardless

of the annual benefit, which I think is $8,000. In some areas it has been successful but I still find, practically, there are great difficulties in attracting GPs.

Senator KNOWLES—Is that because of the availability of GPs?

Mr Huckerby—Because of the nonavailability of GPs for residential care. There is a reluctance on the part of GPs in many areas to come to residential care facilities.

Senator HUMPHRIES—The department of health estimates that the increase in money available to the aged care sector for dealing with cost increases it has had to sustain in recent years through the conditional adjustment payment is in the order of a seven per cent increase over the next four years in real terms, after inflation. I am interested in whether you accept that that is actually the level of the increase.

I get the impression from some things that I have heard today that you do not see that increase coming through. I also draw your attention, if you have not looked at it, to the submissions the nurses have put forward to this committee. They say, in effect, that they do not believe the sector can be trusted to pass on those increases to nurses and kindred occupation groups in nursing homes to lift the level of care. Can you be trusted? Will you pass that money on? Do you accept that you have that extra money? Given that some of those increases that are already coming through have not been spent on wage increases, what is the satisfaction we can enjoy? That you are going to use this money to generate better conditions for nurses and other employees?

Mr Young—I will try to answer your questions in two components. I had not heard the department's assessment of seven per cent in real terms over the next four years being the increase. When we analyse what is the increase this year, we are looking at a two per cent indexation and a 1.75 per cent CAP, so we are looking at 3.75 per cent this year. Next year the 1.75 rises to 3.5 and on current indications it looks like the indexation component that we would get would probably be about the 2.3 to 2.4 per cent level, so we are looking closer to seven per cent but we are still considerably short of it.

The following year the conditional adjustment payment rises to 5.25 per cent and whatever indexation that year is. Let us assume it is two per cent; then you are looking at something like seven per cent in approximately real terms. The year after that the CAP rises to seven per cent plus whatever indexation is, so again let us assume it is two per cent, and in a four-year time frame you would expect a nine per cent increase would be something close to seven per cent in real terms. It is difficult to know whether that is all the department is including or whether they are including a provision for an escalation in the acuity level of the resident mix in that time frame as well, because the funding system does recognise that the residents are growing older and frailer and therefore pays additional money in reflecting that, based upon their assessment within the system.

I cannot give you a black-and-white answer without knowing the assessment, assumptions and basis the department has used, but it is difficult to see how that would translate into a flat seven per cent each year across the next four years, until you get to year 3 and 4 of the conditional adjustment payment. It is certainly something less than that.

Senator HUMPHRIES—What about the answer to the question about passing on whatever it is—six, seven or eight per cent? When you have more money to put into what you say is a critical problem of not having the capacity to pay nurses what they are worth and keep them in that sector as opposed to the acute sector, are you going to use that money for that purpose?

Mr Young—When you come to that question, we have a single subsidy that goes across Australia. There are already significant pay rate variabilities from state to state but each of those states lives within its own industrial jurisdiction. When you look at New South Wales, for instance, the New South Wales Industrial Commission had an interim order passed down last August for six per cent and, the August before that, five per cent. A hearing of some many days standing occurred last year and the final decision of the commissioner will probably be handed down very soon.

When you are looking at using it as a sample state, that is 11 per cent over the current two years and it will almost certainly be an additional five or six per cent flowing from probably 1 January this year or whenever the commissioner makes his decision, so in a cumulative sense we are already at 11 per cent. We are probably going to rise to 15 per cent within a two-year time frame. How do you compare that to Victoria, which is in the process of negotiating an additional enterprise bargaining agreement at the moment; or other states that have negotiated enterprise agreements on a whole-of-state or partial-state basis; or Queensland which will be spoken about in a moment?

It is an entirely different structure but most states do live within some industrial framework. That means they pay either whenever the commission decides or whatever the negotiations are with the respective unions in those states, with some organisations negotiating a new enterprise agreements, but they are reflective usually of the existing market base for the wage levels for staff in those categories. It is not possible for us to say in every instance that every facility is going to pay every part of that money, or at least 70 per cent, which is what our average wage bill is, in salaries and wages at a point in time. But given the industrial structure and given that there is a large industrial coverage through the various unions within each of the state jurisdictions, then every one of those is moving at a different pace but nonetheless those negotiations are going on and the wages are increasing and being spent for that purpose.

Mr Gray—Clearly, the wages movements are, percentagewise, in excess of the increases in funding and of course, obviously, these increases in funding through indexation and the conditional adjustment payment are principally going to increases in wages through the award rates being set through the industrial commissions and also the negotiations through the enterprise bargaining agreements. There are two parties to those agreements and therefore there are two parties involved in negotiating those rates of pay under those agreements. Certainly, as around 70 to 75 per cent of the costs of residential aged care are wages—in that order; up or down, depending on the level of dependency of the facility and the staffing levels involved—that is where, clearly, the overwhelming increases in funding from the Commonwealth go.

Mr Sullivan—Could I make one point about the trust. When we were all assembled on budget night, the minister, along with the head of the department and the deputy secretary, briefed us all about the budget package and this issue was raised by nurse representatives on the floor, once the 1.75 per cent had been announced. I thought both the minister and the deputy secretary

responsible for the program, quite pointedly, did not say unequivocally that all the money would have to go into increased nurse wages.

Senator HUMPHRIES—I accept that they believe that you made that decision. They are not dictating to you how you spend the money. But you are telling the committee that you see the low wages that have been paid to nurses relative to the acute sector as a serious problem. I am saying, to the extent that you have some discretion outside the industrial system, that you will actually spend the money on that purpose. You will spend it on improving the conditions of nurses.

Mr Sullivan—Of course. That is my answer to Senator Knowles. There are two buckets of money and, when you conduct the program, one bucket of money deals with capital and one deals with the running.

Senator HUMPHRIES—The conditional adjustment payment is a payment for recurrent expenditure, isn't it? It is not for capital.

Mr Sullivan—That is right.

Senator HUMPHRIES—So you have got more. You have got, according to the department, seven per cent more over the next four years, possibly more, depending on how you calculate it, in the bucket of money for wages. Are you going to use that money to increase nurses' salaries?

Mr Sullivan—We are going to use the money, as we were asked to, to increase the quality of the care. In the previous answers it has been very clear that we need to increase quality of care. Obviously, staffing mix and the appropriate staffing and the appropriate training of the staff and the retention of that staff is crucial to that. It is a complex answer. It is too simple to say, yes, you will increase wages. Increasing wages is our strategy to deliver the outcome, but we are all committed to increasing the quality of the care. That is what we are asked to do under the accreditation system and that, I am sure, is the goal of the government.

Mr Huckerby—I am sure if you were able to go in and count it, you would find that virtually all that money would be going to wages.

Senator HUMPHRIES—Although in your case it has not all gone to wages so far, has it? As Ms Hatfield Dodd said, there were some states under your control which had not had their wage increase so far. They are using the money that has already flowed through.

Ms Hatfield Dodds—Using the money that has already flowed through. Some of our agencies have held it to use for other purposes. Most of that money is going to go to wages over the next few years but in UnitingCare—and I think it would be true across most networks—we are focused on quality of care and quality of life. It is trying to look at what is in the best interests and needs of the residents of our aged care facilities and the people we are providing community care to. What do they need? We are trying to build a work force around the needs of Australians who are ageing rather than primarily around the needs of the work force. Clearly we want to relate with our work force in just, equitable and fair ways, but certainly UnitingCare would say our primary focus, in being in the aged care industry, is about increasing quality-of-life outcomes for Australians who are ageing.

Senator McLUCAS—I want to go to the issue of future planning and the changing dynamic of those people requiring community care and residential aged care and what your views of government planning structures are and how they could be improved. I am also interested, Mr Sullivan, in your comments. I think you are putting an alternative view about the nature of residential aged care. You used the term 'terminal care' and that is almost like a medicalisation, and moving away from the philosophy underlying residential aged care, which was about ageing, not medication. Can you talk further about that in that planning context.

Mr Sullivan—Certainly. In the context of the current scheme, which really commenced in the mid-eighties, there now seems to be very little foundation in an assumption that 100 beds, however that 100 is constructed, per 1,000 residents over 70 years of age is necessarily the right answer. We certainly believe that the government needs to review that and there is no evidence that Hogan undertook that piece of work, because we have now raised that 100 to 108, consisting of 20 community aged care package places, 48 low care and 40 high care in that 108 mix.

Of our current resident population, 65 per cent of all places consist of people who are classified as high care. Our average age of entry into the system now for residential care is 80 years. Our average age of residents is 83 years. If you go back to the 1980s, those ages were roughly eight years less, so the whole sociodemographic ageing population issue in 20 years has changed quite dynamically, whereas our planning ratios, other than changing the mix of community, has really not changed dramatically at all, and, if we are actually providing the number of residential places, then it should be something like 60 high care and probably 20 low care to reflect the current population of residents within the system. When you are looking at the future, all indications are that the number of low-care residents are going to continue to decline, as opposed to high care, and given our population, age and mix, that is no great assumption to make.

I think there is a real need for us to relook at the current planning ratios, and one of our real concerns is that since 1992 there have been no community aged care places funded out of this program at all. We now have 30,000 places, rising over the next couple of years to about 37,000 places. Based on 153,000 operational places today, that means 20 per cent of all places are now community. There is no problem with that; everybody who wants to stays at home and is looked after for as long as possible and remains independent. But we do need to ensure that, in making that fairly dramatic policy change and providing that service, we are not undermining the residential framework, because government is continuing to provide additional residential places at the same rate in the same planning framework.

If we are going to continue to have a growing proportion of places in the future provided in the community, do we need to reconfigure our current assumptions about future demand for physical places in residential care facilities? I do not know the answer to that but I am certainly desperate for the work to be undertaken, because the worst thing we could possibly do, if we continue within this current framework of a capped income stream facility—a facility of capped supply and capped demand—is actually put an excessive number of residential beds out there that are then not used in the future.

Ms Hatfield Dodds—We would certainly agree with that. Our projections are looking at a similar thing: that there will be an absolute increase in demand for residential aged care, that that will move further up the high end, and that increases in technology and expectations and

demands of the ageing cohort of Australians will mean that we will need proportionally many more community places. I think we are going to need to think much more innovatively about how to support people in communities. Certainly there is a large evidence base to show that, if we can keep ageing people in their own homes and in their own networks, they function much better and experience a far less dramatic loss of function as they continue to age. The evidence I have seen indicates that even moving people half a kilometre or a kilometre out of where they have been residing breaks all those fairly fragile networks of relationship and sense of belonging that keeps people going.

Ms Deerain—And if we are going to have a person-centred approach to aged care, which we have referred to under 'Other issues', some of those rigid planning requirements do not really fit, because there is ageing in place, there is a policy, a preference to stay at home for community care, and the reality that people are going to be in residential, and if it is person centred, to set a rigid 108 places just does not quite fit. Therefore, I would agree with the view that it is time to look at where the dependency need is, and that might be different for each locality, but the fact is there are policies to look at the person, and the rigid planning ratios do not quite fit that model.

Ms Hatfield Dodds—And to some extent there are those population groups that we have all mentioned this morning that I think do need particular policy considerations: people ageing; people living with mental illness; people living with alcohol or drug issues; people who are homeless; and ageing people with disabilities, with their ageing parents. I just think that is a kind of bulge coming through, that we are not really thinking very strategically, nationally, about how to engage those population groups.

Mr Huckerby—The demographics show that, really, community care will be a major focus for the future. I believe that most of the baby boomers will wish to stay in the community or very close to it, and I believe therefore that HACC and other community programs are going to have to be looked at very carefully in regard to funding, right now, so that we do not get lost five years down the track.

Mr Sullivan—In answer to your second question, but leading on: obviously, from the statistics, people are going into high care, and it has been appropriate that they go into high care sometimes directly from the community because of the other programs the government has put in place, the investment in community aged care packages and the like. In this budget the government recognised the issue of palliative care for the first time, which only goes to further our argument that people are in the end stage, often, when they are in high care.

I know that back in 1996, for example, when we changed the terminology from 'nursing home' and 'hostel' to 'aged care home', it was done with the view of trying to give people the impression they were moving to another home. I do not think people in the community actually believe that. I think people in the community feel they are moving into an aged care home because they are in the end stage, and in some cases it is plainly obvious, and in many cases families cannot look after them. In a lot of cases people are coming from hospital, and if they cannot leave hospital they are actually receiving the same service that we expect them to get when they go to the aged care home. I think we do need to cop it, that it is a health service. I would not say 'medicalising' the service, but I think we want to see it as a health care service and extension thereof.

That takes us to the other point about the dysfunction between the sectors and earlier comments even about community care, the HACC program, the supported accommodation programs and the like, and takes us to our recommendation No. 19, which I know is topical, but we do believe that the Commonwealth should take full responsibility for the elderly, from hospital through to the home.

CHAIR—Yes, Senator Forshaw.

Senator FORSHAW—I apologise for being late this morning but I have been tied up with another parliamentary committee. There is another aspect to this which interests me, and I think it is within the terms of reference, but because you are here today I want to ask you about it. That is the provision of housing or accommodation for the ageing community in retirement villages, in developments where you have the two or three stages. I know that the organisations, particularly some of the church based organisations, are involved in that, but I am interested to know whether you see that as a trend that should be promoted and how that interacts with the ability of your organisations to maybe take a whole-of-ageing approach, and fund and provide the nursing home accommodation on the basis that you have. Do you understand the point I am getting at?

Mr Sullivan—I do.

Senator FORSHAW—I am seeing it increasingly: developments going up in Sydney, where I live, and people wanting that type of retirement village accommodation as a move away from the big home. It seems to me there is a shortage of that. How do we promote that?

Mr Sullivan—In a sense, your question goes to Senator Knowles' question of me. The trend over the period, let us say the last eight years, has been that aged care organisations have become more sophisticated in how they will set up services along the continuum from retirement through to the nursing home. Not only is that consistent with trying to provide people with a whole package of care post retirement but it was also a very prudent way of structuring your business such that you could cross-subsidise the capital needs that were a shortfall at the nursing home end.

Professor Hogan hints at this in his assumptions of his review: that the future will be about a consolidation of the aged care industry, stand-alone type facilities will struggle, particularly if they are small. It does not mean they will completely fall over but it will be harder because they are more limited in their range of funding. We have found in our sector—I am sure it is across the board—that a lot of our more sophisticated providers are moving into the range of services; it has to be said it is not with great gusto but it is increasing. Some of our providers are even into the extra service place.

Senator FORSHAW—I am not suggesting that we need an explosion of this necessarily, because there clearly is a big case for people being able to remain at home for as long as they can, but I get issues brought to my attention where it becomes a big struggle for the partner who is trying to look after the other partner. But, from what I have seen, it also assists with the delivery of other services like HACC services, because there is a greater understanding within a complex like that of the interaction between each of these sorts of services.

Ms Hatfield Dodds—It is a people centred way of providing the continuum of care. If you have a co-location of different levels of care and accommodation in care option, people can enter—I have seen in York in the UK, with the Rowntree Foundation, they have a village where people can enter at 56. You come in, you are choosing where you are going to live and you are being quite proactive about it; then you can move right through to palliative care. Some of our larger agencies that have the capacity are exploring that. Blue Care in Queensland is looking at that, where you can move through from retirement to residential aged care.

Essentially, you come in and you become part of the community. You can develop a sense of belonging and a sense of place so it is not so dislocating that you feel you have to hang on to your suburban home until you are 80 or 86 and then you head off to die or you head off to be abandoned. 'Hands up who wants to go into a nursing home, Australia?' No-one wants that, but this is an option where you can be a lot more proactive when you are younger and choose where you live and choose your community.

Mr Huckerby—Our futuristic villages will actually co-locate with our domiciliary services too so that the whole continuum of care is provided. It would probably be extreme that someone then moved on; well, not extreme but there would be a lesser movement towards residential care even for palliative care.

Mr Young—Our organisation has, as a primary policy, the support of members to—if they do not own and operate a continuum of the accommodation types—look at going into a network with others that are providing those. They can then, as part of future delivery of care, be able to cover the continuum. What we believe is, as the baby boomers a little further down the track look at entering the system—but even for their own parents—they are looking for a one-stop-shop. If I am going to walk out of my home, or my mother is going to walk out of her home, and if I am going to enter a different sort of environment I want to know that I can deal with that organisation all the way through and not have to be moving from one place to another in the future.

Senator FORSHAW—Thank you.

CHAIR—We are going to have to leave it there. Thank you all for your submissions and your contribution today. The committee will take a short break.

Proceedings suspended from 10.20 a.m. to 10.35 a.m.

HAIKERWAL, Dr Mukesh Chandra, Vice President and Chair of Committee on Care of Older People, Australian Medical Association

SHAW, Mr Bruce Victor, Senior Policy Adviser, Aged Care and Therapeutics, Australian Medical Association

CHAIR—I welcome representatives from the Australian Medical Association. The committee prefers that evidence 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.

Dr Haikerwal—Mr Chairman and members of the committee, thank you for the opportunity to give evidence to you further to our written submission. Older Australians' access to quality aged care services, wherever they live—in residential aged care homes or within the community—is increasingly restricted by shortages of qualified health care and aged care staff and social professions.

The February 2004 National Aged Care Summit hosted by the AMA Melbourne, in partnership with our fellows from the National Aged Care Alliance, agreed that aged care is fundamentally a health issue. There are serious barriers to delivery of appropriate care for the aged, due to inflexibility in health funding programs, separation of responsibilities, lack of transitional care, inadequate integration of services and a shortage of both nursing home beds and community care. We need to think outside the current boundaries and work together to develop a model for seamless care.

One of the major issues confronting aged care is work force. There are substantial disincentives and barriers that currently make it difficult for GPs, geriatricians, nurses, other health professionals and carers to operate in the aged care sector. The disincentives include an inequitable fee structure for doctors and inequitable wages for nurses and other aged care staff. For instance, aged care nurses are paid about 25 per cent less than acute care nurses in hospitals. In an ever-diminishing pool, and with high demand for nurses, it is not surprising that the sector is not attractive.

The AMA was disappointed that neither the government's recent National Aged Care Workforce Strategy, nor National Aged Care Workforce Census, consider medical practitioners to be part of the aged care work force. General practitioners are the backbone of the health service in this country, yet GP participation in residential aged care facilities has declined. Health Insurance Commission Medicare data reveals that only 16 per cent of GPs are visiting nursing homes on more than 50 occasions a year—that is, once a week.

Issues which make it difficult for health professionals to participate effectively in the care of older Australians include environmental factors, as well as money, a deficient rebate structure for

doctors, the absence of appropriate Medicare Benefits Schedule items for geriatricians, the large number of non face to face administrative tasks and red tape expected of GPs and staff of the facilities, the lack of integration of medical services in the aged care system and the absence in many facilities of consultation rooms with adequate treatment facilities and computer facilities which would otherwise facilitate access to patient records for all professionals and would save on duplication.

Consultant physicians in geriatric medicine have specialist training in geriatric medicine, perform comprehensive assessment of older people, work in multidisciplinary teams and actively coordinate care. They are best placed to provide specialist aged care advice and education across the whole of continuum of care. However, government health programs such as the existing Medical Benefits Schedule structure and the MedicarePlus initiatives economically marginalise the geriatric medical work force and restrict the provision of private hospital, community and religious specialist aged care.

There are only 300 or so consultant physicians in geriatric medicine working in all of Australia, with the overwhelming majority being in the public hospital system. What this means is that, despite the clear health needs and the increasing numbers of older people in our community, those other than in public hospitals have limited access to the type of specialist aged care expertise that geriatricians and consultant physicians specialising in aged care can provide. We have a big gap in the availability of physicians in geriatric medicine to do this work.

We need to think of ways to train and attract more consultant physicians to geriatric medicine, to make the most of their time and to involve the GP and other health professionals in more integrated team approaches. A key to this development is the MBS items, which encourage GPs to work in aged care settings and for geriatricians to provide core geriatric medical services.

Purpose-built consulting rooms within medical facilities, with adequate examination facilities, modern clinical equipment, access to electronic prescribing, records and billing services and a new Medicare aged care attendance allowance item for comprehensive on-site aged care consultations are needed if aged care residents are to get the health care they deserve.

IT has become an important aid in medical practice. Access to information technology within an aged care facility would improve the manner in which medical services can be delivered. It would also help to overcome the problem that information needs to be replicated, sometimes on four different occasions. This is a major disincentive to work in the aged care environment.

The AMA welcomes the government's commitment to make dementia a national health care priority area and will be seeking to ensure that the initiative is developed in ways that will positively address the dementia epidemic that is before us.

There are many challenges to Australia continuing to provide quality health and aged care services. We are convinced that these are policy issues, which can and must be met. For our part, as a peak body representing medical practitioners in Australia, the AMA is committed to work constructively with government and other stakeholders to meet these challenges. Thank you.

CHAIR—Mr Shaw, do you want to add anything?

Mr Shaw—I will not add to the opening statement, thank you.

Senator HUMPHRIES—Thank you for your submission, gentlemen. The committee has been looking this morning at how to fund some of the work force issues which have been raised in submissions, and there has been discussion about the conditional adjustment payment that the federal government is making available to nursing home operators to increase the money for operational or recurrent aspects of their operations. Obviously, we could all speculate about whether that is enough and whether there needs to be more but, given the range of issues you have raised in your submission, what would you say was the most important thing for nursing home operations in Australia to be doing with that extra money—some say seven per cent in real terms over the next four years.

Dr Haikerwal—I think one of the key problems for facilities is to attract staff and retain them. The reason for that is that there are other attractive propositions for them outside the aged care arena, and we need to be able to make that arena—even with the people that are very keen to do aged care—something they want to maintain. That obviously means that not just the terms and conditions of service are improved—in other words, the wages are improved—but also the way in which they engage with people within facilities, the people who visit facilities and the residents.

It means making sure that the environment in which they are working is much more collaborative. It also means the environment is more educative, so they actually feel they are getting something out of it. They are giving some to the facility and learning from the facility, and that whole environment is one they are comfortable to work in and they are part of that whole-of-life learning experience. It is not simply money, but also the way in which that money is apportioned to make it a more exciting educative environment.

Senator HUMPHRIES—You seemed to be touching there on what you refer to in your submission as environmental factors, in the way that nursing homes or aged care facilities operate. What is the problem there? Is that a longstanding culture which has been hard to change or is it the structure of those who provide facilities in these sorts of centres?

Dr Haikerwal—Fundamentally it is a caring profession, and I think the providers of aged care facilities are trying to do the best that they can. What has happened in time is that the size of many of the facilities has increased, so they have become fairly unwieldy. The difficulty in attracting staff is there, so that the staff who are there are fairly pressurised and—even where the work force is well maintained—have an awful lot of work to do that is not around direct clinical care. A lot of time is spent in administrative duties and in crossing t's and dotting i's, which is important but need not necessarily be done by clinical staff.

That takes away from their enjoyment of what caring is all about: looking after individuals and the opportunity to then relate with other professionals working in their environment. It is not fundamentally a flawed set of people or a flawed set of principles; it is just that people are pressured with what they are doing in those places that are not core. The core things tend to then lag behind.

Mr Shaw—There are also some aspects of the design of residential aged care. We refer in our submission to the lack of consultation rooms. There are now some that have been planned and

some that are actually being built that have consultation rooms for visiting health professionals, including doctors. I am told that there are a very few in the country but I have been in a lot of nursing homes and cannot remember being in one that has a consulting room. I do not think I have ever been in one that does not have a hairdressing salon—an interesting comment on the priorities, I suppose. It would make life so much easier in terms of being able to access patient records on the IT within a consultation room facility. The lighting would be better, so if someone has a cut it is much easier to treat than on their bed in their room where you get the normal lighting within a room. They are some of the structural issues that would make the environment more amenable to attracting staff into those sorts of areas.

Senator HUMPHRIES—You would be aware of, and perhaps even involved as an organisation in, the trial which the Australian government is engineering in Tasmania on the use of electronic records. I assume that is the kind of thing you are talking about here in making it easier for doctors to work in that setting.

Dr Haikerwal—The health initiatives in Tasmania and South Australia obviously are welcome. They also need to be rolled out in a way that is going to be useful. That is a bigger picture. What we are picturing here is more on the facility level. You could have access to your practice or have the program you are using for your medical database to have data at the premises. You can then do things like not have to go back to a practice and print out prescriptions and then take them back or send them back. It is a very clunky process. You could get it down to seeing the patient, writing a prescription, printing it out and giving it to them. You could look through a patient's record, see what has been done and it is all electronically available. It is very much on site. The bigger picture is still very important—the National Electronic Health Transition Authority and so on. They are all very significant and important changes to the health scenario.

Senator HUMPHRIES—You make reference in your submission, and others have spoken today, about the duplication of inspectorial regimes in nursing homes. I assume that that catches doctors as well; they end up being involved in that. While we have not so far had any specific illustrations of that—and presumably it is paper based—is the AMA able to produce and table for us examples of forms or documentation that you would regard as necessary—or parts that you would regard as unnecessary—that doctors, for example, are asked to complete in nursing homes?

Dr Haikerwal—We could certainly get our members to produce the forms that have given them some grief from outside, and have those sent in. For instance, in each facility there are different regimes for writing prescriptions. There are different forms. Some innovative areas are allowing the form you write the prescription on to be the prescription that goes to the pharmacy and is then dispensed. Others expect a prescription to be written separately for each one of those items.

When people are admitted to aged care facilities there is an excellent set of documents that has to be filled in with the facility nurses doing admission procedures. If that could be done at a similar time or simultaneously with the GP doing the admission, and indeed the pharmacist doing some other work, the duplication and triplication of the same sorts of questions could be reduced to one set of admission protocols. That is why there needs to be collaboration at that level. That seems to be something that people find difficult to deal with: why should there be

collaboration? I strongly put a pitch for the need for that collaboration between people to work as a team at that level.

Senator HUMPHRIES—Presumably the e-health initiative would be something that would address that over time because you would only have one database to address, rather than several forms.

Dr Haikerwal—Exactly right. It is very important for the IT to be provided for and implemented. Obviously it is a cost that needs to be thought through.

Mr Shaw—It could, Senator. It also raises the possibility of adding to it. They might think, 'Oh, this is great. We can have more forms to fill in.'

Senator HUMPHRIES—It is possible, yes. You never know with technology, do you?

Senator McLUCAS—Where does ACAT fit in that process? Where can we streamline all the information that a GP has collected, everything that happens on admission and ACAT? Do you have a comment about that?

Dr Haikerwal—It is obviously very significant. People getting transferred to aged care facilities, often from the hospital, will not necessarily have even a summary of their medical history from when they were in the community. The hospital information may be the only information that is there. If you had an electronic health record, that would be a very useful way of charting somebody's progress and not missing out on important drug interactions or reactions and allergies.

The ACAT role is obviously to ensure that somebody is at the right level to be admitted to residential aged care. With the changes that the government has put into place, that has been streamlined to some degree. Also, if somebody's level of need changes, that can be done from within the facility without reference to an ACAT. We see the team that does the assessment as being very important in not just assessing for admission but in the ongoing care. People who are going into aged care are older and frailer, with many different problems that interact. Their level and complexity of need is much greater. Anybody working in the aged care sector needs more support from geriatricians because people are now much more aged and much more complex.

Mr Shaw—We have referred in our submission and in our opening statement to the problem of a shortage of geriatricians and the difficulty in accessing geriatricians. The ACAT teams play a very important role and basically do a very good job but that is one key area where the shortage of geriatricians is quite critical to the performance of the ACAT teams.

Senator HUMPHRIES—You might not have read the submission we received today by aged care advocates who talk about a culture of retribution, intimidation and payback in some aged care facilities; talking about people who complain being targeted by staff, and things of that kind. Do your members report many incidents of that kind of inappropriate behaviour in nursing homes or aged care facilities?

Dr Haikerwal—The concerns that have been reported are around difficulties in having care instructions or advice followed through because of the lack of staffing. The difficulties arise as to

how you could complain about a particular system and whether the complaints authority is effective enough; whether the accreditation authority is too strong to complain to. Sometimes it is hard to know which is the best way. Because of the complexity of management and administration and overseeing of the sector, it is difficult to know which is the best way to report those problems.

Senator HUMPHRIES—My question is not so much how we deal with it and whether the complaints resolution service is the best way, or what; it really is whether your members are actually hearing those sorts of complaints. Do relatives or the aged people themselves often report to your members that there are cases of intimidation and maltreatment because they have complained?

Dr Haikerwal—I have not had any reports. I do not know if anything has come through to the office. They would probably go directly to these other authorities if they felt there was a problem, or they would be advised of the way to go. The culture is very much one of trying to resolve things, from a doctor's point of view. Because there is such a paucity of places and very limited choice, once people are in a facility they are glad to be there because they are somewhere where they can be looked after. They would probably try not to rock the boat. If that was the case and if that was the culture, it would obviously be very serious and difficult to deal with because there is very little they can do.

Mr Shaw—Senator, which advocacy group made that reference?

Senator HUMPHRIES—This is ADACAS, which is an ACT based advocacy and support group.

Senator MOORE—We have had statements from a lot of advocacy groups across the whole country, so whilst that was the one in the submission, it is not unusual to hear from families and from groups that this happens.

Mr Shaw—Dr Haikerwal referred before to the pressure because of lack of staff in facilities. It is not always easy to get the prompt service that you want or need or might imagine that you need, and that leads to pressure among residents as well, so it is a difficult situation. We would not downplay it, but the whole environment, certainly in residential aged care, is one of constant pressure.

Dr Haikerwal—I do not think that is an excuse, though, if people are being targeted, if people are being scapegoated or neglected because they actually had the guts and the gumption to make a statement that they were not happy. That is not acceptable and certainly we would favour the approach of the aged care commissioner, complaints commission and so on to make sure those things are dealt with properly.

Senator McLUCAS—I want to go to the question of the panels of GPs and your comments in your submission, particularly your second dot point where you talk about the legal advice to the department about professional indemnity risk. Would you like to expand on that for the committee, please.

Dr Haikerwal—One of the key improvements we felt, through the MedicarePlus recommended Medicare package, was a recognition that aged care was an area that was struggling. We were very pleased that, for instance, the comprehensive medical assessment actually came to pass. It is something we have been pushing for for quite some time as at least one way of recognising the complexities of people going into aged care facilities needing some specific time to be properly assessed. The panels' proposal—for want of a better word—was really a good start. It had a lot to do, though. The ask was really quite huge and, unfortunately, the level of funding did not really follow the expectation of those panels.

Certainly the time scales meant that things were going through at a rapid pace and therefore some of the things like indemnity were probably not considered. At the time this was happening, indemnity was quite high in our level of awareness and we were concerned about somebody acting on the panel, chairing a group of aged care facilities they were supposedly looking after on behalf of their division, and whether there was some individual liability for them and who would take up that liability if somebody was unhappy with a solution that they proposed or, indeed, something went wrong in an aged care facility.

So if Dr A is looking after a patient in facility A but Dr B is the person that is looking after this panel that is supposedly giving advice, what is the liability of Dr B, who is giving this advice? Today the way it stands is that Dr A has the individual responsibility. I think that was a bit of a grey area. Our advice was really, 'Beware.'

Mr Shaw—The particular reference in the dot point, Senator, and the point of your question is that we became aware that the Department of Health and Ageing had obtained legal advice on this issue. We were not able to obtain a copy of that legal advice but we did manage to have a discussion with them about it and they confirmed that they did have legal advice. I might be putting words in their mouth, but my memory is that they confirmed that it was an unresolved issue they hoped would not happen. From our perspective, in our unfortunately increasingly litigious society, it is a potential issue.

Senator McLUCAS—We might follow that up further with the department. My personal experience in talking with divisions about the effectiveness of the panels is that, in one particular case, the assessment was that there were no new GPs going into residential aged care, that the incentive was not enough to attract new GPs into the sector. That was in a regional area. Do you have any comments about whether or not that is across the board?

Dr Haikerwal—There is going to be a continuing problem. Yesterday we met with our partners, National Aged Care Alliance. A wide variety of people come to that group. The main comment from the nursing groups and the provider groups is that we have a group of very dedicated doctors that do this work and they see the vast majority of our patients, and they are coming towards retirement age and there is nobody coming behind them, so what is going to happen when these guys eventually decide to stop working? Another tragic example is somebody who was unable to work any further after a car accident and all of a sudden they had difficulty getting doctors in.

I think it is a first step in the right direction to actually recognise the fact that there is a problem. We have our work cut out for us—and we will do that work—to lobby very hard to ensure that the current rebate structure that exists for patients when they get a consultation does

not diminish when they are the second, third, four, fifth, sixth or seventh patient to be seen by that doctor in the facility. That is crazy. We also want to make sure that the geriatricians are able to get access to the facilities and provide the specialist care that is required, because it is getting more complicated. People are getting older and they have got multiple problems.

We see our role as very much highlighting the need and providing solutions that can entice people back and make them feel supported when they are doing this difficult work. They may even enjoy doing the work, but they feel unsupported, and it is hard to do when they are in the facilities because of the constant pressure. A visit that should maybe take 10 to 15 minutes is taking a lot longer because you have to go, you have to get access, you have to find someone, you have to then find the patient, you have to do what you do, you have to write it up and then you have to tell someone what needs doing and then follow up.

It can be improved if you have better lines of communication, some proper advice that everybody is happy with. The classic example is of somebody who is particularly unwell: whether or not they should be resuscitated; whether they should be transferred; whether they should allow palliative care to take place. That decision sits very much more comfortably with the treating doctor, with the resident's relatives and with the nursing staff if it is made collaboratively at the outset. Those sorts of issues can certainly make that flow of information and the management question much easier and reduce a lot of the anxiety.

Senator McLUCAS—The building up of those relationships takes time and it is clear to me that the doctor does not have that time when they are attending.

Mr Shaw—Could I add two points to that and then make a suggestion that Mukesh might like to add to as well. Firstly, we have referred in both our submission and our opening statement to a figure of 16 per cent, which is an analysis that the HRC did for us over a year ago now, of GP consultations in residential aged care. I had a conversation yesterday with someone who has had more recent HRC analysis which indicates that the figures are, in fact, less than that.

This was broken down. We did not do it when we had it done, we just had a national figure, but the information that I was told about yesterday was broken down into rural and metropolitan areas. The figure for metropolitan areas is apparently down to 16 per cent of GPs providing what we would regard as meaningful services in residential aged care—that is, the one a week or 50 a year consults—and 14 per cent in the rural areas. There is less option, of course, for doctors because there are usually only one or two doctors in towns, whereas in the city doctors can choose whether or not they do that.

On the other hand, there are incremental improvements. We are quite hopeful that the introduction in the second half of last year of the CMA—the comprehensive medical assessment item—and the RMMR—the residential medication management review item—will make it easier for doctors to provide services in residential aged care. The other thing that I was going to suggest you might like to elaborate on is taking that idea of consultation rooms further as a result of the conversation that we had yesterday about integrated facilities—the hospital in a nursing home type context.

Dr Haikerwal—The suggestion is one that has some merit and, in some areas, has already started to grow legs. This is where different services come together. For instance, an out-of-hours

service could be facilitated in an aged care facility where there are medical rooms, and it is on neutral land so that nobody feels there is poaching happening amongst the different doctors in a given area.

You could have people that are on aged care packages coming to the facility which facilitates those packages. You could have the community in the area coming in to use it as an after-hours service if necessary, and, obviously, the residents could be looked after by their doctors working out of those same rooms. That could be expanded to include the concept of a teaching nursing home, which really includes the teaching of the medical staff and the nursing staff, but also the ancillary staff—the cooks, the cleaning people, people who work in the area—and you can create an environment where people feel that they are part of a team and have a specific role that has some benefits.

There are many improvements that could be made with the current system, using the infrastructure that is there, and bearing in mind that many of the newer facilities are being built in greenfield sites with quite large new developments around them. Unfortunately there always seems to be a blockage between different parts of the same department, and it is difficult to get collaboration happening within the system. Even in the Department of Health and Ageing, one group does not really understand what the other group is up to. That is a real blockage and a real concern to us. One of the things I would like to be able to do is get the two together and say, 'How do we work this better?' If there is a new instrument you are using to assess people in aged care, it should not just be hived off to the aged care people to look at. There is a big implication to us as GPs that are going in from the general practice part of that portfolio to say, 'Let's have a look at the instrument and see how we can input into that and minimise the trauma of people as they are being admitted,' so you only ask them the same awful 30 or 40 questions once, not four times.

Senator FORSHAW—I would have thought that the percentage in non-metropolitan areas might be higher but I assume that it may also be more affected by the location of nursing homes, so that if there is no nursing home in that town—

Mr Shaw—This is the trouble.

Senator FORSHAW—The figures are of concern, that it is down to 14 or 16 per cent, but has any work been done on the way in which nursing homes are structured anyway? For instance, there might almost be a natural tendency for fewer doctors, and for the same doctors to see a multiple number of patients in a nursing home. To pick one example, a person goes into a nursing home in a town or a suburb that is some distance from where they lived and the relationship with the family doctor is broken. How do the nursing homes function here? They get new residents come in and they need to get a doctor. Do they automatically approach the GP who generally services the home? You have a bit of an impediment in the system. But is it desirable to have every GP in the suburb visiting every nursing home, seeing one patient each, if you know what I mean.

Dr Haikerwal—They are very good points that we have addressed in various forums. The important thing is that the locations are moving to greenfield sites away from the inner city areas in terms of development and development costs. Obviously that means that that relationship is

broken. In group practices there will be GPs who like to do the aged care work, are good at it, and they will do a lot of those consults and the other doctors will not do that.

In terms of getting a GP who is going to work in the area, the first response is: with great difficulty. The second response really is that when they do have somebody admitted, they will ask the original doctor if they are prepared to travel. If the answer is no, usually the family or the resident is given a choice of who they would like to have look after them. What it generally comes down to is asking which doctor is prepared to take on a bit of extra load, because the load is really quite large.

Senator FORSHAW—From an already defined group of doctors.

Mr Shaw—You will often find that there is a situation when an older person is admitted to an aged care facility—to a nursing home, to use the old term—that might be 20, 30 or more kilometres away from where they lived, which is where there local GP, as well as their family and friends and support base, is. Their GP will continue to service them for a time, will provide the initial advice on admission and will come the first couple of times. But the first time there is a crisis, it is difficult. The doctor will have a surgery full of people 30, 40, 50 kilometres away and cannot just drop everything to spend an hour on the road. That is where that nexus starts to get broken.

Dr Haikerwal—Just on your second point, whether every single GP should go to every single nursing home—

Senator FORSHAW—If it is desirable to do that.

Dr Haikerwal—From the legislation's point of view—and we would support that the patients have a choice in who comes to see them, assuming that is possible—there is such a paucity of people wanting to do this work that if you put any barriers up at this stage and say, 'Look, you can only have a certain number going in,' you are going to really restrict the field.

Senator FORSHAW—I am not in any way suggesting that. I am more thinking that from delivery of a professional service it could be argued—and I am just being devil's advocate—that it may not be inherently bad to have a team of doctors within a locality that specialises in this sort of work.

Mr Shaw—It is where the panel of GPs idea could be developed further.

Senator FORSHAW—The real issue is how do you replace those doctors when they leave the profession?

Dr Haikerwal—From the point of view of the facilities themselves, the RNs that are working in those facilities, I think it is important that they have an understandable consistent term of engagement with whoever is coming in. If you have 20 different people with 20 different ways of doing things, that is not really going to be very useful. That is why the GP facility adviser role, which is what we were advocating around the GP panel proposal—

Senator FORSHAW—That is how the private hospital systems work, isn't it? That is it exactly.

Senator ALLISON—You make the point that there are only 300 geriatric specialists in the country and pretty much all of them are in public hospitals. Ideally, how many should we have? What is their role in relation to the GPs? Do you see these specialists coming into nursing homes? How do we get more of them? Why do you say that they are marginalised economically and that MedicarePlus initiatives economically marginalise the geriatric medical work force?

Dr Haikerwal—How many more? The difficulty is in recruiting to the area. It is really a very important part of the scene. Because of the complexity and the increasing age at which they move out of the community, the level of complexity for people in medical facilities is much greater and therefore we do need that support. Many of the initiatives in Victoria—for instance around the HARP proposals, the Hospital Admissions Reduction Program—show that if you have some support for people in the community when they are doing the care, they are prepared to do more complex kinds of care. That is what the role of the geriatricians would be, to provide that sort of back-up.

Senator ALLISON—Consultation and advice to GPs is what you see, rather than these specialists going into nursing homes?

Dr Haikerwal—Consultation and liaison would include going into the nursing homes to give some advice if that is required, but it need not necessarily be hands on. It may just be advice about management plans or whatever.

Senator ALLISON—And there is no economic incentive to do that?

Dr Haikerwal—The current situation is that the geriatricians are treated as consultant physicians. The way in which they work, the collaborative manner in which they work, the manner in which they could work, including having liaison kinds of consultations, is not really provided for. One of our key negotiations with the geriatricians, the health department and the minister is to say specifically the way in which the geriatricians are working is different to the model which was written 20 or 30 years ago.

Senator ALLISON—Is this just a simple matter of another item number for geriatricians to be able to make themselves available for consultation to GPs?

Mr Shaw—That would go a long way to help.

Dr Haikerwal—That would be a major part of what we are trying to achieve; very similar to what we are trying to achieve in the psychiatry arena. This is the way psychiatrists are working. There are fewer psychiatrists. We need more people outside. We need to have some help for the first line to be able to do more work, to reduce the demand further down the track.

Mr Shaw—If you did provide that basis, for geriatricians to provide services, that would act as an incentive for doctors looking at doing a speciality to go into geriatric medicine. You would then need to obviously think about providing the training resources to do that.

Senator ALLISON—Yes. If you just look at the MBS, presumably a consultant can go into a nursing home and treat a patient. What you are saying is they cannot work in a collaborative way with GPs—integrated, giving advice and so forth. There needs to be something in the schedule for that purpose.

Dr Haikerwal—There is also the other role and this is about the continuum of care. People who are leaving the community to go to hospital when they are not well are treated in a hospital in an acute facility, which is their right.

Because they are old does not mean they cannot get access. Everybody has the right to be treated properly when they are sick. Once they recover, the recovery phase is longer and therefore they need a step-down kind of facility. That sort of work is also only done in the public sector. Very little of that is done in the private sector because it takes so long. The bed days run out and then they do not know how to get transferred. That sort of structural reform, that New-Age treatment, was not recognised in the past as being important. It is now very important because of the demographics and needs to be reviewed.

Senator ALLISON—How many doctors have taken up training in geriatrics? I presume the divisions of GPs offer courses for GPs in geriatrics.

Dr Haikerwal—There are some diploma courses that are available. There are some people who have an interest in geriatrics and will do various courses. At the moment there is one in South Australia and there is one mooted at Monash in Melbourne but at this stage it is not particularly well formalised.

Senator ALLISON—Should there be a specific program funded in the same way as the better mental health outcomes, or whatever it was called? Should there be a similar program for geriatrics through the divisions of GPs?

Mr Shaw—Either the RACGP or the divisions or both. Something like that would be very useful. It would need to be done in fairly broad consultation with the various stakeholders so that it was done properly.

Dr Haikerwal—It has to be around finding people who have an interest in this and supporting them in doing that work they want to do, and giving them the educational background so they can do that with the support of the geriatricians. In terms of whether that recognition should have some different item number, we have great difficulty with having different levels of recognition and different levels of item numbers and so on. The concept of specialised training and upskilling sounds very important but having separate descriptors may be a problem in general practice. What we are seeing here is the care of people with chronic and complex care needs, whether they are older, whether they have psychiatric problems or whether they have other problems that are not currently recognised. We would like to see all that chronic and complex care reflected in one kind of descriptor for chronic and complex care. If you are then looking after somebody with a psychiatric need and you have an interest in that, we would encourage increased education and support in that area, or geriatric increased support in that area.

Mr Shaw—The idea that Dr Haikerwal referred to before of the teaching nursing home, that would be an ideal environment to do that in collaboration with an appropriate university or institution.

Senator ALLISON—Would you agree that GPs are by and large undertrained in the area of geriatrics? That is the position that is put by geriatricians. Do you agree with that?

Dr Haikerwal—If you talk to any specialist group, they would all say, 'We should have at least six months in our speciality,' so as a general practitioner you would spend all your life training. There is a basic core skill that my college, the College of General Practitioners, and indeed ACRRM, require, which means I can do any kind of activity at a general practice level. I need to know the limits to which I can work, and then get support in if I need extra support. If I get extra teaching and training I can do a bit more and I am prepared to do more as long as I know I am supported. I have a problem with the concept that every time something new comes up you need to have another six months training program.

My college tells me that I have the credentials to do my work. Beyond that, for the extra I need to do, sure, I am happy to get extra skills but I do not need to go off and do a diploma every time some specialist college decides that I need to. I am not scared to say that to them at the AMA House just now; I will go back and tell them.

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

[11.21 a.m.]

COWIN, Ms Gerardine, Assistant Federal Secretary, Australian Nursing Federation

ILIFFE, Ms Jill, Federal Secretary, Australian Nursing Federation

FOLEY, Mrs Elizabeth Ruth, Director, Policy, Royal College of Nursing, Australia

HOGAN, Ms Kaye, Member and Adviser on Specific Professional Issues, Royal College of Nursing, Australia

CHAIR—I welcome representatives from the Australian Nursing Federation and the Royal College of Nursing, Australia. 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 submissions and I now invite you to make an opening statement to be followed by questions from the committee.

Ms Iliffe—We want to structure our presentation so that I make a short opening statement on behalf of the Australian Nursing Federation. Elizabeth will do likewise from the Royal College of Nursing, Australia. We would like to leave the rest of the time for questions on our submission.

You have to look at aged care in the context of the nursing work force generally. As I am sure you are aware, the nursing work force in Australia has reduced over time and is steadily decreasing. This is at the same time as increased dependency in acute care and in aged care and certainly in much faster throughput of more acutely ill people in acute care. More nurses are working part time. Whether this is because of a work/family balance or whether it is because of the stress of work remains to be seen. There has been research that has pointed to both of those factors being important.

A factor that is also important is that the nursing work force is getting older so we have an average age of 42, and in aged care an average of over 47 for registered nurses, and not much better for enrolled nurses. It is a very worrying statistic because it means that almost 40 per cent of the nursing work force will be contemplating retirement within the next 10 to 15 years. They will be the nurses with the specialist qualifications and our most experienced nurses. It takes a while to replace them. We are not educating enough nurses, either enrolled or registered, at the moment through our system to replace those nurses.

Particular issues in aged care: staffing levels, being able to recruit enough nurses to work in aged care and then to retain them in the aged care sector. Because of the staffing levels we have an inadequate skills mix which impacts on nurses' capacity to provide quality care. Our nurses are leaving aged care because they cannot provide quality care and that distresses them. If they cannot provide quality care they do not want to work there. That is quite apart from the fact that they are worried that if they do not provide quality care their registration will be in jeopardy.

Documentation in aged care has been an issue. The current moves by the federal government to introduce the new aged care funding instrument, to have questions reduced and to have the assessment done externally should have a positive impact on documentation in aged care. It is a while before we will see any results of that. Unfortunately it is going to be another 12 months at least but there is some light at the end of the tunnel which we think, having been involved in that, should make a positive impact.

Another big issue, when you are trying to recruit from a tight employment market, is the remuneration for nurses in aged care compared with what they can obtain in other sectors. Nationally it is $170 a week less, which is a significant amount. Despite two injections of funding—$211 million and then a further $877.8 million in the last budget over a four-year budget cycle—the wages gap has increased from $84 in two years to $170. The reason it is increasing is because that money does not get through to wages. There is no requirement—no condition—attached to the funding for that money to get through to wages, and there is no transparent mechanism to see where the money is going.

As I say to providers, 'I am quite happy to stand beside you and say, "We want more money," if you can tell me what you do with what you have. If you cannot tell me that or will not tell me that, it is a little bit hard for us to stand beside you and argue for more money.' We think the money that is allocated for wages should go to wages, and I will leave it there.

Mrs Foley—The Royal College of Nursing, Australia welcomes the opportunity to appear before the committee today to provide additional information or clarification on issues in our written submission on July 2004. As stated in our submission, RCNA's primary concern is that the committee gives due recognition to the fact that nurses are the largest single group of health and aged care workers and provide the vast majority of primary health services for older people.

Nurses are, and will continue to be, essential care givers as the population ages and care needs become more complex. Nursing work force issues therefore need to be addressed as a priority in order to ensure the future care of older people in our community. In addition, the ageing of the population means that there will be increased need for health promotion and management of chronic illness, particularly for those living in the community. Nurses are the ideal group to provide this type of care, which is another reason for addressing nursing work force issues as a matter of priority.

RCNA reiterates that the current situation in aged care in terms of skill mix and staffing numbers for level of care to be provided is completely unacceptable for a wealthy nation such as Australia and gives a strong indication that our society does not value our older people. The federal budget initiatives of 2004-05 of increased funding for aged care work force education, including the increased undergraduate tertiary places in aged care nursing and enrolled nurse medication management, are welcome and will go some way to rectifying current problems in aged care.

However, there are two areas of concern to us. Firstly, in relation to specialised education, aged care is a specialty area of nursing, whatever the context in which it is practised, and much more attention needs to be given by the government to funding for specialty gerontologic education programs. Secondly, in relation to skill mix, there are enormous demands on registered nurses to provide comprehensive assessment and care of older people in an environment of

supervising an increasing number of unlicensed workers, particularly in residential facilities. Addressing numbers of qualified staff is a priority in aged care, in order not to compromise the standard of care for frail older people.

RCNA, as a professional organisation for nurses, has a primary interest in ensuring that nurses have access to affordable, specialised education at varying levels, in ensuring an appropriately skilled work force and in ensuring adequate numbers of staff to provide safe, competent and quality care for all older people in our community. Thank you.

Senator McLUCAS—I would like to go to the issue of wage disparity. In 1996 we had CAM and SAM, and that ensured that the capital money was kept separate from operational money. I do not think you are going quite so far as to say, 'We want to return to CAM and SAM'—but maybe you are—but you want a more transparent method of tracking the funds. Is it CAM and SAM or is it—

Ms Iliffe—I think there were three difficulties with CAM and SAM. One was working out what fitted into CAM and what fitted into SAM, and there were arguments about what went where; the second was that you had to use the money or give it back, and some providers were not that skilled at matching their CAM money over a period of time, so you would have all this money right at the end that they were using up if they did not want to give it back; and the other was the acquittal process.

I do not know why humans do it, but we always go from one extreme to the other. If we do not like something, we chuck it out completely and we do not learn anything from what we have had. We start with something different and then that is a problem, so we chuck that out and get something else.

I think there needs to be some accountability. It amazes me that there is no requirement for providers to report on how they spend this enormous amount of money. We get grants from the government for all sorts of things. We have two projects that we are running at the moment for the government—one is nurses' use of IT and the other one is developing competency standards in nursing in general practice—and we have to audit that; we have to acquit it; we have to explain how we spend every dollar. But there is no requirement for that in aged care, and that really astonishes me.

I think there should be an accounting mechanism whereby at least the money that is spent on care is identified. At least have two buckets identified, so that you have some way of knowing exactly how much has been spent on care and how much has gone to wages. There is a level of reporting that the government should require, with the amounts of money that they are allocating to the aged care sector, particularly as they are constantly being asked to allocate more.

Senator KNOWLES—With the conditional adjustment payments and so forth, the government has said that, to be eligible for additional funding, aged care providers are required to encourage staff to undertake training, publish audited financial statements and participate in periodic work force surveys.

Ms Iliffe—There is a real difficulty with the audited statements, in that some entities are parts of larger entities. Their audited statements are part of that larger entity, which means it is

impossible to differentiate. I am not a member of the particular working group, but there is a working group at the moment trying to develop a format for what that reporting means and what will actually be reported. The providers do not want to have to do any more financial work, which is quite reasonable, and we certainly do not want them to have to do that either. The criteria that they are working on have not yet been publicly released; when they are, perhaps they will be sufficient. I am hoping that they will be but at the moment we do not have—and have not had since 1997—any way of telling how much providers are spending on particular things, and the audited accounts do not give that detail at all. Particularly if the facility is part of a larger facility, you just cannot get that detail.

Senator McLUCAS—I may be wrong here but I understand that the audited financial statements are not public.

Ms Iliffe—No, they are not required to be public.

Senator McLUCAS—They will be provided to residents and prospective residents. It is my understanding—and I may be wrong—that they were not to be published.

Senator KNOWLES—My understanding of 'publish' is to publish, and that is a requirement.

Senator McLUCAS—We might clarify that with the department.

Ms Iliffe—As I said, it depends on the structure of the audited accounts and what they show you. I think the government is trying to get that information and they are trying to get it from providers so it is not going to be too onerous for them. We have been asking for this for eight years now, because we have seen the deterioration of remuneration. The ANF has a table, which I am happy to provide to you, that we provide periodically to the government—and the last time I met with Julie Bishop I provided her with a copy—where we put down what the public sector amount is, what the amount is in the private sector, what the difference is and then we multiply that out by the EFTs annually and then by the budget cycle and the amount is around about $655 million.

The amounts that the government allocates are sufficient to achieve parity. Both in the $877.8 million and previously in the $211 million, the amounts were sufficient. It is just that they do not get to wages because there is no mechanism or no requirement that they do so. I am happy for you to have a copy of those tables.

Senator FORSHAW—Where do you think it goes?

Ms Iliffe—I do not know. There is no reporting, so I have no idea where it goes. It could go to a range of places. Providers might be quite genuine when they say they do not get enough money and that the indexation formula is not sufficient. They may be quite right. I am not making a comment on that, one way or another, because we do not know how they spend it. It puzzles me, because Professor Hogan had the same difficulty—not so much from the not-for-profits but certainly for the for-profits—in getting that information. If it were me, I would be putting my books on the table and saying, 'Look, I don't have enough. This is how I spend it and I don't have enough.' The fact that they do not do that bothers me a little.

Senator McLUCAS—You have been describing the gap between acute care remuneration and aged care remuneration. I want to go to the community care question a bit later because we always tend to focus on residential aged care. Is part of that story the fact that in a number of states there has been significant growth in the pay for workers in acute care? Is that part of the reason you have gone from an $80 to a $170 difference between the sectors in a very short period of time?

Ms Iliffe—The real difference has been since the separation of CAM-SAM into global funding. You can see the tracking. It has happened since then. On average nationally there is about a 4.5 per cent wages growth in the public sector over probably the last three years. I think that is an indication of ability to negotiate better outcomes because of shortages; it always happens like that.

There are two issues. There is a timing factor in that the public sector normally sets the benchmark and then you go to the private acute sector, and then you go to aged care and try to flow those on. One of the reasons you flow them on is so that there is a level playing field for the public sector, the private sector and the aged care sector, so you do not have a Cinderella down here not being able to get quality staff. We try to have a level playing field so that nurses can move in and out of sectors quite easily and sectors such as aged care can attract quality staff.

When you argue in the commission in the public sector, you are negotiating with state governments. When you are arguing in the aged care sector, mostly we are working on—we are in the public sector, too, and the private sector—enterprise agreements, so we are arguing at a facility level. Their argument is that they do not have enough money. It is constant: 'The government doesn't give us enough money. We can't pay the wages because the government doesn't give us enough money.' That is the argument all the time and it is very rarely any different.

In one of the cases we ran in the Northern Territory, the decision was that that is irrelevant, that that is not a relevant argument; if the person deserves the wages then they deserve the wages. Where you get the money from is another issue. Of course, the issue for us is that if the provider is not spending the government money on wages, or if they are not getting enough money from the government, then they cut staff. They cut registered nursing staff so that they can pay additional wages. It is a pretty awful cycle that you get into.

Senator ALLISON—Just picking up on that point, I do not know whether you have seen UnitingCare network's submission. They outline the wage increases between 2002 and 2004 and then contrast that with the indexation which has been applied. There are very significant differences. I do not recall a submission to this inquiry but I do think that in the past we have had some of those residential aged care providers open their books and provide us with balance sheets; I might be wrong.

Ms Iliffe—There were some made available to the Hogan inquiry and there has been quite a bit of work done by the National Aged Care Alliance—and their documents are up on their web site—that talks about the indexation formula. There are reports that were done by La Trobe University and there was a series of them looking at the inadequacy of the indexation formula for keeping pace with wage movements. Rather than using the formula that is currently used, they recommended a different formula and they recommended it for particular reasons which

they outlined in the paper. Those papers are available on the National Aged Care Alliance web site, if you want to have a look at them, or I am happy to email you the paper so that you can have a look at it.

Senator ALLISON—You are not suggesting that the indexation is okay as it is, necessarily?

Ms Iliffe—No.

Senator ALLISON—I just wanted to clarify that.

Ms Iliffe—I am persuaded by the arguments that were put up in the La Trobe paper that the indexation formula, for the reasons that they give in the paper, probably needs to be looked at again.

Senator ALLISON—Specifically since wages are such a high component of the cost, very closely linked to increases in wages. You would say that?

Ms Iliffe—Yes.

Senator ALLISON—Thank you. Ms Foley, you, like every other submission to this inquiry, say that it is inappropriate to keep young people in nursing homes or residential aged care. I wonder if you could just spell out for the committee what expertise you think there ought to be, in the nursing sense, in caring for young people with disabilities as opposed to the frail aged.

Ms Hogan—I do not think it is very different. There should be some ongoing education programs to attract and retain people in the area that they like to work in and where there is obviously a need, with the increasing number of younger people who seem to end up in residential facilities.

Mrs Foley—Both our submission and the ANF submission talked about the fact that aged care nursing is a specialised area of nursing. That is the important thing to realise. Younger people with disabilities will clearly have quite different needs from the older population. Because nursing of older people is a specialised area, nurses who work in aged care—particularly in residential facilities but across the whole community and other settings too—will have those specialised skills for looking after older people. Therefore, it is putting an extra demand on them to also have specialised knowledge of younger people with disabilities which could require quite different care from looking after older people. The environment for younger people is of concern as well. They probably need to be in an environment with people of similar age. Things that will give them motivation during the day will obviously be quite different to activities that might be available for people in an aged care facility.

Senator ALLISON—What qualifications or courses or training would you recommend for nurses in facilities where there are young people with high support needs? Is there a disability accreditation system?

Ms Iliffe—There is.

Mrs Foley—Yes, there are disability programs, and also in terms of rehabilitation, which you might think is an odd term to use for older people, but again that probably highlights a difference between them. There are specific rehabilitation programs for nurses that would be appropriate for young people with disabilities but those skills may not necessarily be the skills that gerontic nurses might have.

Ms Iliffe—There certainly are courses available for the disability area.

Senator ALLISON—You have drawn attention to people with mental illness and suggested they should not be mainstreamed. Obviously, people with dementia are mainstreamed because they make up a big proportion of the population. What is happening right now with people with mental illness in aged care? Are they mainstreamed? Are there separate units for them? I think you are suggesting there should be. How realistic is that? What proportion of the frail aged is affected by mental illness?

Mrs Foley—I do not know those statistics, but they would be available and we could find them for you. There are facilities that we know members talk about, facilities that they work in, where there are specifically designed dementia units, but it is certainly not a common practice across the country, and because dementia is an increasing issue in aged care, much more attention should be paid to it.

Senator ALLISON—Yes. I think that has been established by almost every submission we have ever had on this issue, but I am interested specifically in mental health—mental health which is not dementia.

Ms Hogan—I think there is increasing evidence of an increasing number of aged people with depression, and we have heard about the increasing age of people being admitted to residential facilities, but there are also elderly people in acute settings with depression too. It is extremely important that we continue to provide education in the aged care sector for all those contingencies and that we do not focus too much on just dementia. We need to focus on dementia but we need to keep a balance in there with the other mental health conditions.

Ms Iliffe—Yes, I think that is the key. I am not sure that it is feasible to establish particular units for everybody who has a specific problem. People like to be cared for where they are close to their relatives and their homes so that their family can visit and support them, and I think the key is providing the education to staff who work in the acute sector and in the residential sector and the community sector so that they can adequately care for people with mental illness. It has been neglected a little because of the focus on dementia because of the large numbers that we are going to be looking at of people with dementia. It is a real problem. Mental illness generally is a little bit overlooked. As much as it is in the general community, it is overlooked in aged care as well, but I think the key is education for nurses and doctors and other staff working in aged care.

Mrs Foley—I think there is another aspect to depression in older people. Sometimes it is not so much a clinical depression as maybe just a sadness about being put into an environment that maybe they had no choice in going into. Perhaps they were not appropriately oriented which is not a very good clinical term, but they were not appropriately nurtured into the environment in which they now find themselves. There have been examples of people who were diagnosed as clinically depressed and who were on medication, but when somebody found a particular interest

of theirs, their whole personality changed, so I think that is a really important aspect in aged care.

Senator ALLISON—Like bringing a cat into the centre.

Mrs Foley—Yes. One incident I heard of was a gentleman who had loved to race cars, so they brought in a motorised wheelchair for him. It might have been a dangerous experiment, but he was able to scoot about the place and his whole persona changed.

Senator ALLISON—Thank you for giving us some suggestions on how to overcome the burdensome nature of paperwork. It is very difficult, I think, for this committee to grasp what the real issue is here, so that is useful. Ms Foley, have you put forward these suggestions that you make on page 5 in an official capacity? Have you put this to the accreditation agency and, if so, what was the response?

Mrs Foley—No, we have not at this stage.

Senator ALLISON—You would like us to do that?

Mrs Foley—The first port of call was to bring it to this committee and once the deliberations of this committee are more public then we could take it a step further.

Senator KNOWLES—How has the nursing fraternity in general approached the issue of enterprise bargaining arrangements?

Ms Iliffe—We have embraced it. Except for in New South Wales and a small number in the private sector in Queensland, we enterprise bargain all the time—aged care, public sector, private sector. You have to work with what you have to work with, and enterprise bargaining is what we have to work with. There is only one thing I would say about it. Nurses work in a sector where you want to use as many of your resources as possible on achieving positive outcome for the people that you are looking after, and enterprise bargaining, which means that you will negotiate generally at a facility level rather than at a global level, is quite expensive. It is expensive for the facility. It is very time-consuming. We try to make it as least burdensome as possible. We operate, in most instances, from a fairly collegiate relationship with employers because you get better outcomes if you do, but it is expensive. In Victoria, for instance, it is 350-odd times, instead of once if you have got an award. It is added expense to the system. Awards make sense in that they are less resource intensive for the sector, but we are not in that environment and so we enterprise bargain, and that is what we do.

Senator KNOWLES—Can I move on to the issue of accommodation for younger people. This is clearly an area of responsibility for the states. What have you done thus far in getting the states to really grasp this? We find it a bit disturbing when we have examples of state ministers who have responsibility for this area approaching the Commonwealth to house younger people with disabilities.

Ms Iliffe—It has been on our agenda and I know it has been on the college's agenda for a long time. As long as I have been in nursing it has been inappropriate to have young people in nursing homes. There are facilities available. We have made approaches to state governments and to the

federal government to address the issue. For nurses, we are on the ground looking after people, and we would really like an environment where, instead of people arguing about whose responsibility it is, they just get together and do something about it in a cooperative fashion. So often what we see is government saying, 'Well, it's not our responsibility.' Governments of both persuasions—I am not being particularly critical of anybody here—both at a federal and a state and territory government level, say, 'It's not our responsibility. It's somebody else's responsibility.' I do not care whose responsibility it is. Why can't we get together and do something to fix it?

There is a bucket of money that is paid by taxes and somebody has to decide how that money is going to be allocated. There are a lot of programs where the federal government says, 'This is what this money has to be spent on.' I don't know what the solution is, but I would like to see something done about it, rather than arguing about who is responsible for doing it.

Senator KNOWLES—I agree with you. In an ideal world that is what would happen. But we are dealing with structures where the state does not want to give up the responsibility and they say to the Commonwealth, 'Get away.' I agree we are talking about all political persuasions here; we are not talking about just the current arrangement. The states say, 'No, we want to retain that responsibility,' but then they shirk the responsibility. So we have got the CSTDA that is the vehicle by which this happens. The Commonwealth throws in the money. The states then say, 'Well, we have a whole lot of reasons why we're not doing it.' There has to be that collaborative approach. People like your good selves are a very integral part of that approach, to be able to say, 'Come on, you have to now fulfil your responsibility.'

The Commonwealth, for example, in recent times, has said to the states and territories, 'We want a collaborative approach on this and the way in which we will assist the younger people with disabilities and we want to set up some trials or consultations.' One state thus far has agreed to do that, and that is Victoria. Do you see a way in which we could move that forward?

Ms Iliffe—As part of our submission on the Australian health care agreements we recommended that it be one of the areas that the Commonwealth, states and territories commit to working on together, and the Healthcare Reform Alliance also says this, so those recommendations have been put to state governments and put to the federal government in those forums.

One of our suggestions was that it be taken up as part of the Australian health care agreements because it seems to me that when something gets on at that level, something is done about it. Also, we have raised it with AHMAC, but it is really hard to get things on their agenda. We have raised a couple of things with AHMAC and they sort of get lost in the process. I suppose other people have that same experience. It is something on which somebody has to take leadership. While the states might say, 'Go away,' and while they might say, 'You don't give us enough money to do it,' at some stage, if we are going to resolve the problem, the Commonwealth and the states and territories have to get together.

Senator KNOWLES—I am not disagreeing with that. What I am saying is that the Commonwealth at the moment has offered the states some pilot projects.

Ms Iliffe—That is really disappointing.

Senator KNOWLES—The pilot projects are there for the offer and the states have slapped the hand of the Commonwealth and said, 'So what?'

Senator McLUCAS—That is a political statement on an issue that—

Senator KNOWLES—No, it is not a political statement.

Senator McLUCAS—I have to say that the nurses may have a view, but really this is—

Senator KNOWLES—I am sorry, it is not a political statement. If it is perceived as a political statement, I am sorry. It is not meant to be perceived as a political statement.

Senator McLUCAS—Let us ask the states why.

Senator KNOWLES—I have actually been here long enough to deal with states of all political colours. I have to say none of them have been too flash in this area.

Ms Iliffe—I am quite happy to take it up. If that is the case and only Victoria has taken it up, I will find out the information, what is on offer and we will take it up. We will ask the branch secretaries from the ANF certainly to take it up with their state and territory health ministers. I am quite happy to do that. We have got an executive meeting next Thursday and I will put it on the table and ask them to lobby their state and territory ministers. Hopefully, that might start the ball rolling.

Senator KNOWLES—Thank you.

Mrs Foley—I guess the senator is giving us approval to continue to lobby the state governments.

Senator KNOWLES—Exactly, because it does have to be the collaborative approach. When we say, 'Let's get all these pilot programs going where we might actually see some resolution to this very important program,' to have only one state say, 'Yes, we agree,' is disappointing.

Senator McLUCAS—With the Commonwealth State Territory Disability Agreement and the Commonwealth-State Housing Agreement being underfunded by the Commonwealth, you can understand some reticence from the states.

Senator KNOWLES—Now, that is political.

Ms Iliffe—It should be us fighting.

Senator McLUCAS—I know. I have to equal the balance.

CHAIR—Order! Senator McLucas.

Senator McLUCAS—Sorry, Ms Iliffe. I alluded to wage disparity in community nursing and we did not get to that. Can you talk to us about that?

Ms Iliffe—Nursing in the community is funded in three ways, broadly. I am speaking broadly here. You have nurses who work attached to aged care facilities who are involved in community aged care packages—actually, four ways—and the Extended Aged Care at Home packages. They are under the same awards and agreements as nurses who work in residential care, so they suffer from the same difficulties with inadequate remuneration. We have nurses who are employed by state governments who are attached to either community health centres or hospitals and they are in a much better position because they are under the public sector agreements, so their wages are the trendsetter in nursing.

We have nurses who are employed by DVA. They actually do very well also. One of the things that has really disappointed me is that DVA have some excellent standards for nursing, for community nursing, but they are not shared—I raise this all the time hoping that someone will do something about it—by other sectors of government, particularly the Home and Community Care program. DVA have done, probably because they have more money, some really good work in community nursing standards, which they should be commended for, but it does not generate to other areas of government, unfortunately. I will put in a plug also. If we had a chief nurse, then it might happen.

The last one is the Home and Community Care program. The programs are so scattered and there are so many of them. I know a lot of work is being done at the moment in the Home and Community Care program and that there may be some changes in some common assessment in accreditation, so that is one area that may be corrected; but we cannot keep track of the nurses who are working in Home and Community Care programs at all. A couple of years ago we sat down and listed all the Home and Community Care programs that employed nurses and gave them to our state and territory branches. There were hundreds of them. The next year when we did them, at least 30 per cent of them had changed, so it is just impossible to track them. So what awards and agreements they are working under we only find out if it comes to our attention.

There are other areas: nurses working in general medical practice; nurses working in Aboriginal medical centres. We negotiate with them on a national level as much as possible, but it varies considerably in the community. It is very fragmented.

Senator McLUCAS—The data you have given us here is essentially residential aged care?

Ms Iliffe—Yes, it is.

Senator McLUCAS—That is what I presumed.

Ms Iliffe—Yes, it is residential aged care. In the community, nurses will fit into those broad groups or other key organisations like the Flying Doctor Service, for example. For nurses in Aboriginal medical centres we have a national award, because it is easier for the facilities. It is cheaper for them to negotiate at a national level rather than individually.

Senator HUMPHRIES—Going back to that question of increased wages for nurses, I put the question to representatives of the aged care providers as to why they were not using the moneys that were being provided to them by the federal government to pay nurses more. There were a variety of answers. You would be interested to go back and read about them. ANHECA I think suggested, in respect of New South Wales where there is an industrial commission process, that

there was a 15 per cent increase for aged care nurses coming down the pipeline. That was going to, I think they were saying, substantially fix that problem in New South Wales. Is that how you see that?

Ms Iliffe—I think it is 15 per cent over 3.5 years, which works out to be the national average. I do not know whether that will eventuate in New South Wales or not. There used to be parity in New South Wales because in New South Wales it is an award system rather than an enterprise bargaining system and it was easier to maintain parity. That has not been the case over, I think, the last three years; they have fallen behind.

One of the difficulties we have in aged care in negotiating aged care outcomes is that there is a time lag. You do your public sector cases and then you do your private sector acute cases, then you get down to your aged care bargaining, so there is often an 18-month time lag between outcomes in the public sector and outcomes in the aged care sector.

It is easier in some respects for New South Wales to maintain parity because of the award system, because they are just bargaining at that level. New South Wales has up until recently, as I said, been able to maintain parity, which is really curious. When you look across the country, they are all being funded by the same federal government. We have some providers who are able to pay competitive wages. In fact, in the Northern Territory we had an aged care provider who was paying above the public sector rate, and in Tasmania as well; so it is really curious how some can but others cannot.

That is why it is really hard—and I am a sympathetic person; I am a nurse—to be sympathetic sometimes. If some people can do it, why can't everybody do it? I think the providers—and I have said this to them; we have a good relationship even though it is a combative relationship most of the time—are quite deliberately depressing wages because it is a good reason to put pressure on the government to give them more money. I have to say that the government has been responsive to us on two occasions and allocated the amount of money that we have asked for.

In the budget papers 2002-03 and 2004-05, the only reason for that money being allocated is to close the wages gap in 2002-03 and pay competitive wages in 2004-05; but the wage gap keeps growing because we do not have a mechanism to see that that money gets through to wages. I think the providers know that we will keep pushing for more money for wages to close the wages gap, while there is a wages gap, and so it suits them to actually have a wages gap, whether that is conscious or unconscious. I think it is quite conscious, but they would say it is not.

Senator HUMPHRIES—That is a very interesting comment you make there. The college suggests that we overcome that problem by putting some sort of condition in the grants that are going under the CAPs. There is an attraction to that, but, given the complexity of circumstances surrounding nurses' wage increases at the moment, with some awards, some enterprise bargains and so on, and the variety of conditions across Australia, is it really practical to mandate that in some way, do you think?

Ms Iliffe—I have actually put a suggestion to Minister Bishop. We are really reasonable. What I have suggested is that one of the conditions is that over the four-year budget cycle they

can demonstrate that they are moving towards closing the wages gap, recognising that in different states and territories there will be different gaps and that the gaps will be different at different times. If they can demonstrate that they are closing the wages gap, then that would satisfy us.

You are quite right, Senator, there is a gap, and in different states and territories there are different cost factors and cost pressures and bargaining capacities, and we do not anticipate that there would be ever anything closer than a five per cent difference. We will probably never achieve across the country complete parity because of that gap, but if the providers could show that, yes, my gap is 15 per cent but next year before I get my conditional payment it is 13 per cent, and next year before I get my conditional payment it is 10 per cent, we would be happy with that, and that is not difficult to do. That would satisfy us, because we know that they are consciously working to do that and they are using some of that money that has been allocated for that purpose, for the purpose it was intended for.

Senator HUMPHRIES—Could I just change to a different subject. We have had at least one submission which has spoken about intimidation and retribution, as it is called by staff in nursing homes, for people who use complaint mechanisms—relatives of aged people, or aged people themselves. We are going to examine one of those submitters later today, but do your members hear much about that? I suppose it is possible they could be accusing some of your members of those sorts of things. Are you conscious of that being a problem in establishments across Australia?

Ms Iliffe—It is not something that we would ever condone at all and it has come up from time to time. Sometimes it is more a fear than something that actually happens. It is a fear that it might happen, if something is raised, and I think that applies to anyone who is making a complaint. I mean, I am terrified of making a complaint to Telstra in case they cut off the phone! So you do have that fear, and probably without any justification whatsoever. I think some of it is the fear. If it happens, then it needs to be dealt with, and I think that the facility must have in place supportive processes so that complaints can be received. The other thing that you need to look at is the pressures that staff might be under at that particular time, and the skill level of staff in dealing with complaints and things.

Without looking at a particular individual case, broadly speaking, it is certainly not consistent with nursing standards that that happens, and if it were one of our members we would be wanting them to be counselled, but we would also be looking at the circumstances and what pressures they were under and what staff they were working with and what support mechanisms are there by the facility. But all of that should be investigated. If something comes up, there is no doubt about it; it should be investigated. People are vulnerable enough when they are older and in residential homes. They do not need anything else to upset them.

Ms Hogan—I think there is a perception in the community that that could be the case, that there could be some retribution, because, if you like, they have been lucky to get the place for their relative, but I do not know that it is totally true that that happens.

Ms Cowin—It certainly did not play a large part of our phone-in survey.

Ms Iliffe—No.

Ms Cowin—We had residents calling in.

Ms Iliffe—We had two aged care phone-ins over the last four years, I suppose, where residents and families and staff could call in. We had a day set aside. Mind you, they were attached to a federal election. That was one of the main reasons we held them, but at the same time it meant that people could ring in and tell us what their views were, what their issues were in aged care. We have also done surveys in our journal which were not attached to an election, and that was not something that was raised, that I can recall at all, in any of the responses.

Senator McLUCAS—Earlier today Mr Young from ANHECA suggested that we have to think differently about how the staffing mix has to be developed and he seemed to be suggesting that greater use of nurse practitioners would be useful. I dare say that both organisations would support that, but are there any current barriers to employing nurse practitioners in residential aged care at the moment?

Ms Iliffe—Yes, the biggest one is not the doctors; the geriatricians are actually supportive of the employment of nurse practitioners. The biggest barrier is funding nurse practitioner activities. The difference between a clinical nurse consultant who is working in advanced practice and a nurse practitioner is that a nurse practitioner is able to initiate medicines, prescriptions for medicines, diagnostic investigations and direct referrals, but they need to be funded, particularly as aged care is a federal government program. The biggest barrier is having a bucket of money that will fund those activities, because they are not covered by PBS and MBS. That does not mean to say that you would want to attach them necessarily to PBS or MBS, but that is one option, or making another bucket of money available.

I am really pleased that the federal government is running some nurse practitioner pilots in aged care. We have one that is running at the moment which is a really high-quality one, I think, in Canberra, and I am fortunate to be on the tender selection committee for that, and there are another three that were put up just recently. Mind you, none of them made the cut, but they all had potential with a little bit more work on them. But that is the biggest thing. You can have a clinical nurse consultant in aged care who does the same clinical work as a nurse practitioner but does not have the autonomy to do that independent function, and that has got to be funded and that is the biggest barrier.

Senator McLUCAS—And the clinical nurse is funded out of the operational funds of the residential aged care facility?

Ms Iliffe—Yes. Mind you, facilities can do that. They can. They can even put in for project funding to meet that cost, or they could meet it out of their existing funds, just so long as it does not take more away from wages.

Mrs Foley—We do certainly support the establishment of nurse practitioner roles and, like Jill, would hope that the pilot projects will highlight things like what might be barriers to expanding the program across Australia, because that would certainly be our hope.

Ms Iliffe—The other thing that we have been pushing is a better use or a greater use of enrolled nurses in aged care. We think that they are a very underutilised resource.

Senator McLUCAS—Because of the growth in personal carers?

Ms Iliffe—No. I think that the growth in personal carers has been because they have been filling a gap that was left by there not being enough enrolled nurses. The education of enrolled nurses has been a responsibility of state and territory governments, and at one stage we only had New South Wales that was educating enrolled nurses. The rest of the country opted out. Fortunately, now we have more traineeships for enrolled nurses, which means that you can access federal government money and it means we are able to educate more enrolled nurses. That is going to take time, of course, and they have an expanded scope of practice now. That took a while also to get accepted and move through the nurse registering authorities, who are very cautious people, and there had to be a lot of work done with the profession to accept an expanded role for enrolled nurses, and we would have to take some responsibility for holding them back a little bit, but that now has changed. We would like to see a greater utilisation of enrolled nurses in aged care. We think they are a very useful resource.

CHAIR—Thank you for your submissions and your presentations today.

Proceedings suspended from 12.16 p.m. to 1.06 p.m.

BAKER, Dr Kenneth Robert, Chief Executive, Australian Council for Rehabilitation of Disabled

AUSTIN, Ms Julie, Senior Policy Adviser, Carers Australia

CHAIR—I welcome representatives from ACROD, Australian Council for Rehabilitation of Disabled, and Carers Australia. 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. You 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 submissions, and I now invite you to make an opening statement, to be followed by questions from the committee.

Dr Baker—Thank you for the opportunity to appear before the committee. ACROD is the national industry association for disability services, and its membership includes 550 non-profit, non-government organisations which provide the full range of disability services to people around Australia. Over recent years there has been growing interest in the rather complex issues surrounding the intersection of ageing, aged care services and disability services. We have established a national policy committee on ageing and disability to focus on this constellation of issues. That includes representatives not just from the disability sector but also from national aged care bodies and, indeed, Carers Australia.

Last year for the first time we held a national ageing and disability conference and intend to hold that conference again this year, reflecting the level of interest it attracted. This area is of growing interest and concern within the disability sector. As I have said in ACROD's submission, our interest is in the linkages between aged care services—or the lack of linkages in disability services—in most of the terms of reference for the inquiry. The interest in this sort of area is not surprising. It grows out of the ageing of Australia's population and with that, as we know, comes an increase in the incidence of disability, so that although one in 25 Australians under 65 years has a severe or profound disability or core activity restriction—that is, a significant limitation on their mobility, communication or capacity to care for themselves—this ratio rises to one in four for people over 65. As the population ages, the incidence of disability will increase.

At the same time, people with disabilities—people with life-long disabilities—are also ageing as a population. Historically, it was rare for someone born with a disability or someone who acquired a disability very early in life to live to be old. This is becoming increasingly common, and that poses a challenge for both aged care services and disability services, and for governments that set the policies and funding models for those services. There is the added complication that people with certain types of disability age prematurely—that is, they demonstrate health conditions and impairments that are normally associated with a much older age group. People with down syndrome are an example of this.

Our view is that the response from governments to this development, this growing interface between ageing and disability, has been inadequate. Much of the policy effort at government level, it seems to me, in these human service areas where demand exceeds supply of services,

goes into restricting entry, erecting barriers—setting restrictive eligibility criteria—rather than focusing on improving pathways and improving linkages between sectors. The result is an ineffective and inefficient interface between the two service systems. An example is people who may have been long-term residents in state funded group homes—they may be people with an intellectual disability—and that is their home and has been their home for many years. When they age, because they are in a state administered and state funded group home, they are denied access to services that other people have access to; services such as community nursing, palliative care, dementia support and so on. This effectively denies them the right to age in place, which is a right that is increasingly expected by the general community.

The incidence of young people inappropriately housed in nursing homes also is an example of the suspicion about cost shifting which so inhibits development of sensible policies in these areas. There are some good statements of intention within cross-government agreements. The Commonwealth State Territory Disability Agreement includes some statements of intention around improving the linkages across government, and there are some commitments to improve the interface between aged care and disability services, but in the formation of that agreement the federal Department of Health and Ageing is hardly involved and has no sense of ownership over the outcomes of that agreement.

The Department of Health and Ageing's community care strategy, called The Way Forward, pays only lip service to ongoing discussions between the federal Department of Health and Ageing and the Department of Family and Community Services which at federal government level is the key link between ageing and disability. There are some interesting and good pilots under way. The Department of Health and Ageing, through its innovative pool, has funded 10 pilots around the country which are using federal aged care funding to top up state aged care funding for people who are developing additional needs as a consequence of ageing. That is very good and I know that those pilots are subject to evaluation this year. I would hope that, subject to that evaluation, they not only continue but that the principle of combined funding and joint funding that is established by those pilots can be more broadly applied.

There are also some interesting pilots being funded at state level; some in New South Wales, trying to manage the issues for people who are seeking to retire from what are now called business services—organisations that employ people with disabilities. I also suggest that there needs to be a review of age eligibility barriers to services to take into account the premature ageing of some people with disabilities.

To conclude, in general, human services at a philosophical level has moved increasingly to embrace the idea of person centred planning, of building services, customising services, to suit individual needs. If that philosophy were applied to the group of people who are ageing with a disability, applied in terms of government policy, funding models and service designs, we could find some innovative and successful solutions to these problems.

CHAIR—Thank you, Dr Baker.

Ms Austin—We are here in the interests of Australia's 2.6 million carers. They are providing the bulk of the care in the community, particularly the primary carers, and they are all doing it in an unpaid capacity. The Australian Institute of Health and Welfare has estimated that this care is in the order of 1.192 million hours per year, which is equivalent to about 653,000 paid full-time

equivalents, which far exceeds the paid work force. That is what I mean by the unpaid carers carrying the burden of care. They are certainly doing the major part of it.

Despite this, too often we find, particularly among the service providers, that the carers' needs are ignored or disregarded. Because the focus is on the person needing the care, the carer becomes invisible and their willingness and capacity to care becomes overlooked in the situation. It is just assumed that they will carry on.

Carers quite often do not identify themselves as carers. They look on it as part of the family role and the relationship that they have with the person needing care. Hence, they often do not assert themselves in terms of what their rights are for information and support for themselves and support for the person needing care. It is only when we reach a crisis situation, and the carer seeks some support to manager the crisis, that intervention occurs and someone tries to help this person.

We all know that the population is ageing. As well as the population ageing, the carers are ageing but also the ratio of primary carers to people ageing is going to decline. Carers Australia commissioned a large piece of work from NATSEM last year which highlights that, and I will table that for the committee.

In this scenario in the next couple of decades, with fewer primary carers and more people needing care, obviously it is going to put a much greater demand and reliance on formal community services to fill the gap. There is already a large number of people in the community who do not have a primary carer to rely on, so they are already relying on the formal services. Then it becomes a matter of managing the resources that are available and where the priorities are given.

In some ways, from the carers' perspective, in recent years the situation has improved. There seems to be greater recognition of carers in terms of political leadership at the moment, both at the federal level and some of our state governments, in policy directions and legislation particularly addressing carer needs. That is a start, and it is a good start. We still have an awfully long way to go in terms of translating this to services on the ground and assisting people on an everyday basis in a way that is going to make a real difference to their lives. We have addressed some of those issues in our submissions, so I would be happy to take questions on that.

Senator KNOWLES—Dr Baker, could you tell the committee what is the incidence of disability now for younger people? I ask that in the context that babies with down syndrome are detected and pregnancies quite often terminated. The caring in that ongoing situation could be into their 30s, 40s, 50s or whatever. Is it mainly head injuries? Is it birth abnormalities? What is it, do you know?

Dr Baker—I would have trouble giving you an accurate breakdown of types of disability in that way. According to the latest ABS household survey, 5.9 per cent of Australians have a severe or profound disability. Among younger people with a disability, the significant area of growth is around autism and within that spectrum of conditions, which includes ADHD. It is also true—and this is clearly relevant for planning purposes—that, because of medical interventions and improved nutrition, children that may have died in an earlier period are now living, but they are children quite often with very complex medical needs and very high support needs.

Senator KNOWLES—Do you have numbers of people that we are talking about—say, in their teens, 20s, 30s, 40s? The only numbers that I have seen are those under 50, and they are all sort of grouped together. I would find it helpful if there was some data that we could refer to that showed that breakdown in the under-50s group.

Dr Baker—You are talking about Australians generally, not Australians in nursing homes?

Senator KNOWLES—Those requiring assistance or even those considered to have a disability sufficient to require ongoing assistance.

Dr Baker—That data may be available. If it is, the Institute of Health and Welfare would be the best source.

Senator KNOWLES—How about the pilot project that has been offered to the states to look at ways in which they can generate more accommodation for younger people in need? To my knowledge, only one state has accepted that offer to date. Have you had any communication with the state governments about that?

Dr Baker—Was this the offer announced in the last budget that was around the provision of respite care?

Senator KNOWLES—No, respite care is a separate thing again, but go on.

Dr Baker—As I understand it, the states have been quite slow to take up that offer, which was an offer by the Commonwealth which had to be matched in funding by the states. I do not know why they have been slow to take it up.

Senator KNOWLES—Have you spoken to the state ministers or governments about this?

Dr Baker—I have raised it with one or two departmental heads.

Senator KNOWLES—What response have you had?

Dr Baker—The response has been inconclusive, from my point of view. I do not know why the offer has been slow to take up. I imagine the requirement for matching funding is an issue.

Ms Austin—I understand, as of yesterday, that South Australia announced that they would come to the party with matching funding. They have negotiated something. It is still under negotiation with a couple of states. The others are holding out. It is a pretty mixed picture at the moment.

Senator KNOWLES—Previously, I was referring to the minister's offer to the states and the territories to look at the pilot projects for the Aged Care Innovative Pool. That is another issue.

Dr Baker—Those pilots which I mentioned are under way. Some only began in the last three months or so. Others have been going much longer. It is a very promising development, because it involves cooperation between Commonwealth and state and sensibly involves shared funding. The clientele that are being provided with the service in those pilots have mixed needs

and some of those needs derive from life-long disability and others derive from the fact that they are growing old. It makes sense, from a policy point of view, for both levels of government to be involved.

Senator KNOWLES—Are you familiar with the pilot project of the Multiple Sclerosis Society of Victoria and what they have proposed?

Dr Baker—Is that involved with moving young people out of nursing homes?

Senator KNOWLES—Yes, it is, but the specifics of it—

Dr Baker—I am not aware of the specifics of it, other than that is the intention of it.

Senator KNOWLES—How best do you see that we could actually get things up and running to get more young people out of nursing homes—and I will qualify it—given that their disabilities are not all the same? Whether they have multiple sclerosis or whether they have brain injury or down syndrome, their needs are invariably different.

Dr Baker—Yes, I understand that, and that some of the needs are quite high. These are not people, in some cases, who could easily be moved into the community, but I do think that in general it requires a commitment by both Commonwealth and state to move them into the community with sufficient levels of support. One solution might be for the Commonwealth to allow the aged care funding that it provides for that place within the nursing home to follow the person into the community, be properly indexed so it would be increased in line with the cost of living over the years and for states then to provide the difference between that amount of money and the amount that it requires for them to live in the community.

For a young person to be in a nursing home where the average age is decades above their age is a very potentially demoralising experience and deprives them of a range of experiences that the rest of us in the community expect as a matter of course.

Senator KNOWLES—At times it can be equally challenging for the old people, too.

Dr Baker—Indeed, that is right.

Senator McLUCAS—Dr Baker, in your submission you talk about the community care system as being fragmented and unduly complex, then list very clearly why, with the myriad of government agencies and then service points. The point you make about the difficulty of navigating that system for a consumer has been reflected in many submissions. Do you have a view about what should happen at a governmental level in terms of the funding of community care services and also from the community based organisation level? What can we do to make it easier for people to access community care services?

Dr Baker—Some of the proposals in The Way Forward, which the government has issued, are good and sensible. Clearly one of the objectives of that inquiry and the strategy that has been announced is to simplify the system and reduce the 17 Commonwealth community care programs into fewer funding streams, fewer sets of guidelines, fewer sets of eligibility criteria and also to work more with the states to get a better interface there.

I am particularly concerned that that inquiry, good though it was—and, as I say, there are some good things in the strategy that has been announced—almost completely ignored the intersection or the overlap with disability services, which is absolutely crucial for that group. That simply reflected government silos, departmental silos, bureaucratic silos and nothing else. It is very disappointing that the inquiry and the strategy that was released did not go beyond the boundaries of the Department of Health and Ageing.

Senator McLUCAS—The other point you made in your earlier commentary is the point that as we age healthier, the issue will be not that we are old but that we have a disability. Are you suggesting that more and more it will be disability packages that are required for people to gain assistance, rather than aged care services?

Dr Baker—Yes. Ideally there would be a mixture of models but the idea of a package is a good one, in that it is something constructed to suit the particular needs and preferences of the individual. To that extent it begins from the right end. It does not begin with existing systems or boundaries and try to fit a person into one of the available boxes, but it begins with the person and then tries to reshape the boxes so that person gets service which is most appropriate to them.

Senator McLUCAS—But then a person gets reviewed by an ACAT team and they move out of the disability umbrella into the ageing umbrella. I do not know how successful that transition is.

Dr Baker—There is a problem and it is not just a government problem. It is an industry problem as well. I suppose the solution to it is that people who are working in the disability area and in the aged care area need to have some common core set of skills and competencies and knowledge, so that they know something about each other's areas. The ACAT teams make assessments where they are largely unaware of the raft of supports and services offered by the disability sector.

Senator McLUCAS—Just some clarification: you said that a group home resident would not have access to federally funded aged care services, and I think you mean the CACPs. Then you said palliative care. I am not quite clear why. Are you saying that a person who continues to live in a group home, someone with perhaps an intellectual disability, cannot receive a CACP because they are living in a state funded group home?

Dr Baker—Yes, that is my understanding.

Senator McLUCAS—Do we have the specifics of that? I do not want to go to the person or individual.

Dr Baker—I could get specifics.

Senator McLUCAS—We will have to ask the department as to why that CACP should not be delivered in a state run group home.

Dr Baker—I think it is seen by governments as an issue of cost shifting: that because the person is in a state funded group home, then the state ought to be paying for all their care needs.

Senator McLUCAS—Even if they have been assessed by ACAT as a person who needs a community care package?

Dr Baker—Yes.

Senator McLUCAS—Are you aware that that is across the states, Dr Baker?

Dr Baker—I am not fully aware of that. I have had a number of reports from different states but I have also had reports that, for example, ACAT teams in some states apply guidelines in an inconsistent way.

Senator McLUCAS—We have had that evidence from others as well. The other evidence we have had is that ACAT assessments often result in an analysis that links that individual with whatever is currently available, which is a bit concerning.

Dr Baker—Yes.

Senator HUMPHRIES—We have had some information provided to us by the department of health about support that the federal government provides to carers. For example, there is reference to the National Respite for Carers Program, which has risen in funding from about $15 million a year in 1995-96. It would be over $100 million now. Are those sorts of programs, in your opinion, Ms Austin, actually useful in helping delay the point where older people need to move into aged accommodation; for example, when it applies to people with dementia?

Ms Austin—I do not think there has been any specific research done on whether it is effective in delaying it. Having said that, for people who want to age at home and have the carer capacity to do that, there has certainly been a very strong uptake of such programs and the figures indicate the uptake of respite has been markedly increased just in recent times. There is a lot more flexibility about respite now than there used be. It is not so much 'one size fits all'. That is not to say there are not all sorts of problems as well: in some states you have to book 12 months in advance to have a two-week block of respite so you can go on holidays; or the person coming to the home does not quite understand the situation and wants to do it a particular way. There are problems at individual level but the overall figures are indicating that there is a much greater uptake of it.

Senator HUMPHRIES—I suppose you would argue that the more dollars we invest in helping people remain in their homes with carers extends the period or delays the period before which they have to move into more community costly forms of accommodation, like aged facilities.

Ms Austin—The more support that is in the home, whether it be respite or other services coming into the home, takes the load off the carer, particularly where it involves people with continence problems, dementia problems, really high care sorts of issues. You would hope that it would delay the move to residential care. That is the aim of it.

Senator HUMPHRIES—Dr Baker, you said fears about cost shifting led to governments being reluctant to share responsibilities for particular categories of persons. I note the point you make and it is a reasonable point, but unfortunately it is very hard to avoid confronting that issue

about cost shifting in dealing with the way in which services are structured. Your suggestion that it might be possible to take young disabled people and let them retain their Commonwealth aged care funding when they go out into the community effectively means that a responsibility, which at the moment is entirely in the hands of state governments—that is, for looking after and accommodating, young disabled people—is being substantially or wholly transferred to the Commonwealth. In a practical sense, how do you overcome that problem?

Dr Baker—Under the Commonwealth State Territory Disability Agreement, funding responsibility for those services is joint. Administrative responsibility for community accommodation lies with the states but funding is a joint responsibility. It seems to me that it is a very narrow view from governments around this. That is why I was impressed by the innovative pool program. It seems to break through that narrowness and recognise that there are, in a sense, cost savings for both levels of government if they share the cost.

Senator HUMPHRIES—Just one last question: you talk about a national equipment strategy. What sort of equipment are you talking about and how would it work?

Dr Baker—There is a full range of aids and equipment and there are many schemes, but the Continence Aids Assistance Scheme is one; also provision of wheelchairs and communication assistance devices. There is a very wide body of aids and equipment that assists either people with a disability or the frail aged to live more independently. At present those schemes are fragmented. Responsibilities are divided across government departments; they are divided between Commonwealth and state. For example, with the Continence Aids Assistance Scheme, the federal Department of Health and Ageing provides that for people in a rationed way; provides that for people who are under 65 or over 65 if they continue to work for eight hours a week or more, but when a person turns 65 and they have continence issues, those issues do not disappear overnight. They then become ineligible for that scheme and they have to then find an equivalent scheme funded by their state government.

That creates uncertainty and anxiety for them and I think is an inefficient and ineffective way of doing it. There has been enough research now that shows that, as a whole, the current schemes leave significant gaps, are inefficient and are fragmented. The states, Commonwealth and relevant non-government organisations could come together and develop a coordinated or centralised system which could ensure that there was equitable and available aids and equipment for people which, in the long term, would allow people to remain independent and so reduce the pressure on more formal services.

Senator MOORE—I have a bit of a passion about that equipment program because, no matter when I go to visit people, it seems to come up, both through your organisation, Ms Austin, and also through your organisation, Mr Baker. I have one particular question. You are both well established and have done your own research: how are your voices heard in the process of developing policy and the policy recommendations you put forward? What is the communication link between your groups, government policy, the pressure on COAG, all that kind of thing? I would like to hear from both of you about how you think it works and how it could work better.

Ms Austin—We are a federation of organisations made up of the state carer associations, so with that we have the mandate as the peak organisation to speak for carers at the national level.

What that translates to is the regular meetings with relevant ministers, bureaucrats in the department, the regular round of submissions to inquiries like this, to the budget process, I suppose all those quite usual lobbying avenues that any other lobby group would use; taking opportunities wherever they arise, such as this inquiry, so we are getting our message out to as many people and through as many avenues as we can, in order to try and influence policy. Over the last couple of years we have had some success in that with recent initiatives that have been announced. It is an organisation that has been going for 10 years and it has reached a state of maturity but there is still a long way to go. It is quite resource consuming and, because we largely get our funding from government, that in many ways limits our capacity as well.

Dr Baker—We try to employ many avenues as well, particularly on this issue which crosses different government departments and different levels of government, and it is because of that that I think this issue is a particularly difficult one for us. The common experience is to visit one minister or one government department and one bureaucrat and be told, 'Yes, you've identified a genuine problem but it's not our problem.' It is the problem of the other department or the other level of government, so it is very difficult to get ownership over this problem, even within the framework that surrounds the Commonwealth State Territory Disability Agreement, which does bring together the Commonwealth and the states at ministerial level. The relevant ministers for ageing are not part of that dialogue; they do not feel ownership over the solutions that are developed. For that reason, it is difficult; it is frustrating. I was part of a forum that was conducted by the National Disability Advisory Council on this issue of disability and ageing, and that council has said that it is one of the priority issues for it in the year ahead. At least the federal Department of Health and Ageing was a representative at that meeting, but it is not an easy problem to deal with.

Senator MOORE—Both your organisations offer recommendations to levels of government regularly, based on research that you have done and the change in the community. When your ideas are not implemented for a range of reasons, are you advised as to the reasons why not, and engaged in that post-consultation process? Everywhere in the process it is said that peak bodies are consulted all the way through. I am just wondering whether the process is also after something that is not able to be achieved. Are you involved in that post-decision process?

Dr Baker—It is hard to give a single answer to that because it does differ according to the policy that is being discussed and the level at which the consultation has taken place. For example, on our federal budget submission we do not get feedback, but when we put a submission into the Department of Family and Community Services, putting specific recommendations around employment assistance for people with disabilities, we usually do get feedback.

Ms Austin—There is no formal process for the feedback but by keeping the dialogue open with the relevant people, you are constantly reiterating the point; and if it is not taken up at that point in time, then hopefully it will be later on.

Senator KNOWLES—Ms Austin, the issue of carers for an ageing society is genuinely a very serious problem. In that context I ask whether you are familiar with the village life concept, whereby accommodation is being provided for lower income people, where they do not have to pay bonds or anything else. It is designed to attract the person who wants to live at home but really needs that little bit extra; whether it be care in a social interaction, whether it be three

meals a day, whether it be having a level ground on which to walk and not having to worry about the maintenance of the house and having their heavy washing done. It is not deemed to be a hostel but they can go there and have safe, secure 24-hour press button assistance if need be. Are you familiar with that at all?

Ms Austin—Is it a program in Australia or is it happening overseas?

Senator KNOWLES—It is in Australia. I meant to bring up with me the list of places around Australia, because I thought there were some here in the ACT, but as of December 2004 there were 3,500 residents across Australia in this type of concept. I raise that because it would potentially ease the burden on the carer side of things for those people, who are in many cases only borderline but nonetheless can suffer failing health because they do not want to cook or they cannot cook or their husband or wife might have died.

Ms Austin—Assistance with low-level care such as transport, communications, those sorts of things, rather than more self care type things.

Senator KNOWLES—They go into a place themselves. They leave their home, they go into a place, but they do not have to pay a bond.

Ms Austin—As you describe it, it sounds like a very attractive option as a transition means.

Senator KNOWLES—That is right. At the moment they are looking at a five-year transition in the 70s but hoping to push it out to a 10-year transition with extra care. Maybe Carers Australia would like to look at that process of village life where it is, as they call it, the ultimate ageing in place solution, and they really target people more in their mid to late 70s.

Ms Austin—The question that comes to my mind is how is it paid for? Is it the person moving out of their home, purchasing another place to live?

Senator KNOWLES—No-one has to purchase anything. That is why it is designed for low-income people. They go in there and they are effectively paying rent in the place. They do not have a fixed term. If they need to go on to another place, they can go on to higher care facilities. It is designed primarily for lower income and pensioners, where they are paying rent instead of having to try and maintain their house.

Ms Austin—It sounds good as you describe it. In talking about carers I have talked about them generically, but there are all sorts of situations: married couples, where the ageing one is okay but the other one needs care—would it suit that sort of situation?—lifelong carers, carers for people with lifelong disabilities that Ken has focused on? Is there a place for them?

Senator KNOWLES—It is not really designed for those people. It is designed for people who need help primarily with food, three meals a day, to get their nutrition; heavy laundry, transport and press button assistance if they need it. We in Australia now have to look—

Ms Austin—It is an innovative alternative.

Senator KNOWLES—forward to trying to ease that burden on carers, where those people who might be the only old person in the street or the suburb do not have anyone around.

Ms Austin—It overcomes the isolation around them.

Senator KNOWLES—It is the psychological wellbeing as well, where a lot of people need the care purely and simply because they are lonely. As we heard in evidence today, a lot of the depression is not necessarily depression as such; it is sadness.

Ms Austin—Carers of people in those situations are likely to be trying to juggle their own employment and other family as well, so it might be quite a good solution.

Senator KNOWLES—Maybe we just need to talk more about you, in your professional capacity, having a look at this as a way where it might ease the burden on carers in the short, medium and long term.

Ms Austin—I would be interested in it.

Senator KNOWLES—Thank you.

CHAIR—Thank you for your submissions and your presentation today. The committee will take a short break.

Proceedings suspended from 1.52 pm to 2.00 pm

GREGORY, Mr Gordon, Executive Director, National Rural Health Alliance

WOODHEAD, Mr Michael William, Acting Manager, ACT Disability, Aged and Carer Advocacy Service

CHAIR—I welcome representatives from the ACT Disability, Aged and Carer Advocacy Service and the National Rural Health Alliance. 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. You 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 submissions and I now invite you to make an opening statement, to be followed by questions from the committee.

Mr Woodhead—Thank you for the opportunity. ADACAS has been providing advocacy for people living in residential aged care homes in the ACT for about 15 years. In a calendar year, advocates make approximately 126 regular visits to the 23 homes in the ACT and in excess of 250 visits to individual residents. In this role, ADACAS has built a substantial profile within homes, and advocates have developed excellent rapport and trust with many residents and their families, as well as good working relationships with many managers and staff. The resourcing of advocacy by the Commonwealth has enabled ADACAS to have this high profile.

The two issues about which ADACAS has made submissions are younger people in nursing homes under terms of reference (c), and retribution, intimidation and payback in aged care homes under terms of reference (b)(i) and (b)(ii). ADACAS believes that the issues prevent the aged care standards and accreditation agencies from getting a complete and accurate picture of individual homes.

On the issue of younger people, few people would disagree that younger people, 65 and under, do not belong in aged care homes and most would agree that younger people would like to live ordinary lives in their own homes as part of the community. ADACAS's submission is quite comprehensive and discusses a set of high-level principles that it believes will lead to this aim. Other than to state that we believe that they should have the right, as in places like the United States, to take the government subsidy that is given to aged care and to take that home with them to help care for them at home, and to change the legislation and enable homes to pick up that funding in the next round of beds, I would like to put that submission aside and talk about the second submission, which is on retribution, intimation and payback in aged care homes.

ADACAS developed a discussion paper some time ago to raise awareness of the issue, and that is the basis of the submission you have in front of you. Fear of retribution has been reported in all 23 aged care homes in the ACT. Residents, family carers living in 10 of the aged care homes in the ACT, as well as staff, have reported actual retribution against residents and/or family carers. In addition, staff have regularly reported a fear of raising issues and, on occasions, staff have reported being punished for raising issues within homes. In certain homes, staff have reported senior managers holding meetings to 'find out who has rung ADACAS or the department'. ADACAS is not funded to provide advocacy to staff, and they are referred to the CRS.

Interestingly, since this issue became public in the ACT last Friday, ADACAS has received information about acts of retribution against residents and family carers in an 11th home within the ACT. Whilst ADACAS is limited to providing advocacy only in the ACT, advocacy agencies in other states have reported this fear of, and/or experience of, retribution. The issue has been highlighted by the Commonwealth Commissioner for Complaints in his annual report 2002-03, section 7.1 on page 29:

> Many discussions with relatives and friends of care recipients reveal an obvious and pervasive attitude, one where there is expressed anxiety not to make a fuss, not to complain, not to inquire too often and not to be noticed, for fear that it would reflect badly on their relative and lead to some kind of retribution.

A word search of the database for the period 1999 to 2003 indicates that there are 4,365 records that use the word or words 'fear', 'intimidation and retribution', 'reprisal', 'harassment' and 'victimisation'. It further says:

> It appears, however, that while the information is being recorded, it is not captured as a complaint issue and is therefore not being dealt with explicitly.

In addition to that, the 2003-04 annual report of the Queensland Office of the Public Advocate, a statutory agency, states in section 9.1 on pages 26 and 27:

> Clients, family members and staff who regularly approach the office with complaints express fear that they will be punished if their identity becomes known. In fact there is a long history across the disability, aged care and mental health sectors of labelling questioning or outspoken clients, family members or staff as troublemakers.

They then quote the Commissioner for Complaints. They then go on to say:

> Examples of retribution are rife. For service users, they include being openly chided, ignored, having personal possessions removed, deliberate provocation and threats of withdrawing services. Staff who complain may suffer gossip, ostracism, be allocated unpleasant tasks, lose casual rostering opportunities and be overlooked for promotion and higher duties.

ADACAS has also received support on this issue since last Friday by the council subsidised older persons advocacy group from the Eurobodalla Shire of New South Wales.

As stated earlier, ADACAS believes that fear of and experienced retribution hampers the accreditation agency from getting an accurate picture within aged care homes. An example is a home twice given full accreditation for three years that was later found to be in breach of a significant number of standards. Residents and relatives who were afraid to raise significant issues because of fear, and some with examples of actual retribution in that home, were assisted by ADACAS to raise them with the CRS. Poor practices have now been identified by the accreditation agency and that they have been in place for years and during previous accreditation periods.

ADACAS is not trying to sensationalise this issue. What is needed is a national strategy for the elimination of retribution and fear of retribution in aged care. This will need to be a multifaceted strategy, including all stakeholders in the process. However, given the fear of retribution, it is impossible to know exactly what the actual occurrence of retribution is. If the

experience of the ACT is projected nationally, then it may exist in almost half of all homes in Australia. Therefore, in order to gain acceptance of a need for a national strategy to combat retribution, an investigation is required to identify the actual level of retribution in aged care homes nationally. Once empirical studies have identified the existence and degree of retribution and fear of retribution, the national strategy should then identify and trial ways of eliminating the fear and identify and implement ways to eliminate the actual retribution.

Studies have been taken and action plans implemented in other areas of life—for example, the Institute of Criminology, and bullying in school, Family and Community Services and the National Abuse Hotline—which may have applicability here. In addition, the Commonwealth government, the Complaints Resolution Scheme and the accreditation agency need to make unequivocal statements that retribution is not acceptable in aged care homes.

The community standard with respect to harassment must also be introduced into aged care. The quality assurance and accreditation process must seek evidence that fear of retribution is taken seriously and responded to by aged care homes. The Complaints Resolution Scheme and the accreditation agency legislation must be amended to incorporate whistleblower protection, as for health complaints, the ICAC royal commissions et cetera. Other recommendations are in the paper. In closing, I am heartened by the response of the industry locally in the ACT in supporting our cause for a national strategy. Thank you.

CHAIR—Thank you, Mr Woodhead. Mr Gregory.

Mr Gregory—I have a copy of my opening statement. Thank you for inviting the National Rural Health Alliance to appear before the committee. This process is an important part of the ability of special interest groups to be heard at the highest level and in policy formulation. It is to be hoped that the Senate will always continue its strong role as the house of review so that the voices of people in more remote circumstances will continue to be heard in the work of parliament.

I would like to acknowledge our colleagues in Aged and Community Services Australia, ACSA, with whom the alliance collaborated in the production of our discussion paper, *Older People and Aged Care in Rural, Regional and Remote Australia*.

For the purposes of today's hearing I will focus on the first term of reference relating to the adequacy of the aged care work force. It is well known that Australia suffers from a shortage of health professionals relative to demand. In the situation where there is a global undersupply of health professionals, the alliance is most concerned that Australia is relying to a large extent on overseas trained health professionals as a means of overcoming our local shortage. This is a most inappropriate position for a small developed nation to be in. The alliance maintains that it is Australia's responsibility to make a net contribution to the international health work force. This requires us to train still greater numbers of health professionals across the board.

It is well known also that where overall professional shortages exist the worst deficits are in rural, regional and remote areas. The undersupply of doctors in Australia is well known and the alliance supports measures in place to ameliorate this. The alliance also supports a greater range of measures than currently exist to increase our national supply of nurses, allied health professionals, dentists, pharmacists and health service managers. It is a problem in itself that the

undersupply of nurses, the mainstay of health services in terms of their number, is much less well known than the shortage of doctors.

In the context where the shortages of health professionals are most keenly felt in rural and remote areas, the aged care sector suffers even more than the acute care. There is a very serious undersupply of nurses and other caregivers willing to serve in the aged care sector in more remote areas. In some considerable part, this is due to the wage differential that exists between the aged care and acute sectors, about which the committee will have already heard today. Anecdotal evidence suggests that inability of residential aged care facilities to find staff to work 24 hours a day, seven days a week, is a major constraint to service provision in country areas, in many cases even greater than the capital and recurrent financial difficulties experienced by those facilities.

This situation is further compounded by unmet demand for aged care in rural, regional and remote areas. The ageing of the rural population is more dramatic than in the major cities, due largely to the outmigration of young adults and families seeking work, education and/or a greater range of services. The aged care sector in more remote areas is also affected by the greater proportion of Indigenous people in such areas, and the fact that they experience ageing prematurely.

The shortage of GPs, nurses and allied health professionals also affects community care for the elderly. Aged care facilities and services already face significant financial problems in rural areas, so that the cost of additional incentives to attract workers would further threaten their viability. The NRHA and ACSA have received a number of messages from country areas in response to our discussion paper. It is clear that nurses and carers are burning out at a significant rate in country areas. I have four quotes to illustrate: carers have few holidays with no-one to replace them. Staff sometimes have to work a double shift, with few options for holidays. Registered nurses are almost unprocurable in some areas, and there are major recruitment and retention costs for registered nurses, and we need to consider providing accommodation and vehicles for them.

The alliance has welcomed initiatives targeted specifically at some of these challenges, such as multipurpose services and the Regional Health Service Program. However, it is clear from a state like Western Australia, where nearly every shire in the settled rural areas has access to an MPS, some on a shared basis, that these good programs are not yet sufficient to meet the challenge of staff shortages for aged care. The challenge is to provide aged care for all Australians within a reasonable distance of their home.

The alliance continues to support the range of special programs for rural GPs and medical undergraduates. We also support strongly the modest starts that have been made regarding scholarships in certain circumstances for rural nursing and in a small way for practising allied health professionals from rural areas. We have recently presented the government with a major new proposal that would substantially improve the rate of recruitment and retention of nurses and allied health professionals to rural and remote areas.

Members of the committee will have noted that in the joint NRHA-ACSA submission there are six recommendations relating to staffing, training and support. They are numbered 11 to 16 on page 22. The essence of these is that the particular circumstances of rural areas and the

greater deficits that currently exist justify particular policies in support of nurses, other health professionals and committees of management of aged care facilities and services in rural areas. Thank you.

CHAIR—Thank you, Mr Gregory. Mr Woodhead, I just want to be clear about what you are saying. You are saying instances of retribution and noncompliance are not isolated instances—that it is, in fact, part of an entrenched management culture across the aged care industry. Is that what you are saying to us?

Mr Woodhead—No. What I am saying is that we have had reported to us instances of actual retribution within 11 homes of the 23 in the ACT. In six of those, management is involved, so I would see that as a systemic issue within those particular homes. The others may be isolated. Certainly we have raised issues of actual retribution, where appropriate, within certain homes. Certainly in five or six homes we have raised that with the managers involved. I think as a result of that, a number of managers have had different experiences from the result of some of the complaints we have raised with the Complaints Resolution Scheme. Some of the managers we have raised issues about are still there. Others have left. In two cases they were actually promoted. One person was forced out of the industry; one was re-employed at another home. There was another case where an RN was sacked from one home after slapping residents and is now employed at another home.

Senator McLUCAS—I will move to the rural questions. Mr Gregory, you talk about the funding system in your submission and you have identified a whole range of different contributors to the costs, the higher costs of service delivery for both residential and community care. Has anyone done the work to quantify the cost differential between residential care or community care service delivery—and it would be across the five rungs, I dare say—because even from a regional centre compared to a very remote centre, the costs would be incredibly different, I imagine. Can you point the committee anywhere to get some sort of understanding of those costs?

Mr Gregory—There was at least one submission I know of to the inquiry 12 months ago, made by Catholic Health Australia, about the relative costs of rural versus city facilities and services, so that is something you might need to dig out.

Senator McLUCAS—Was that their submission to Medicare?

Mr Gregory—No. Remind me of the name of the inquiry that reported nine months ago.

Senator McLUCAS—A Senate inquiry?

Mr Gregory—No, a government inquiry into—

Senator McLUCAS—The one that came up with The Way Forward?

Mr Gregory—Yes, that is right. What was the matter name, though? Let us get the name right.

CHAIR—I do not think we are going to if none of us knows.

Mr Gregory—Hogan. Thank you very much. There were submissions to the Hogan review.

Senator McLUCAS—That identified those cost differentials; that is helpful. You talked about multipurpose services, and my experience also is that they are extremely welcome by communities once the community actually understands what the service is going to be. I recall on two occasions communities not being thrilled at the idea of having residential aged care attached to their hospital but, by and large, it is pretty well embraced now. Is that your experience?

Mr Gregory—You are right to say 'now', because initially when the MPSs were introduced, as you have implied in your question, some local communities were very anxious about what they perceived as being a takeover of the aged care facilities that they had put in place through their local committee through sweat equity and all that sort of stuff, and then someone comes in. It is true to say that the way it was handled through the governments involved was critical, but I think you are right to say that now, even in those states where it was not handled initially so well, the MPSs are going well.

Senator McLUCAS—My experience is different. My experience is where state-run hospitals have had extensions added to them that are Commonwealth funded, but you are saying these are community owned and controlled residential aged care hostels, I imagine, that have worked back the other way.

Mr Gregory—I am not an expert on the MPSs, but we have a lot of people in our network who are and who work with them and for them and it is fair to say that in some states when they were initially introduced—so this is going back six years—it was not done particularly tenderly and it got offside local aged care communities who, as I say, had had a long history of involvement in the local facility. Once we are over that hump, I think the MPS and its successor, which of course is a little different—the Regional Health Service programs on the ground are well received.

Senator McLUCAS—And those regional health services—

Mr Gregory—It entails some of the same principles, where the funds are pooled and the money is very flexibly used under local control. It is Commonwealth money for the Regional Health Service, as distinct from the MPS, where there was money from both Commonwealth and states. So you have a local model of service which meets local needs and gets over the incessant cost shifting and blame shifting over nursing home type patients, for instance, in a small community.

Senator McLUCAS—It has been put to me privately that one particular organisation was bemused that nursing scholarships are not bonded, unlike the bonded places for medical students that came out of the most recent changes to Medicare. Does the Rural Health Alliance have a view on whether or not they should have been bonded?

Mr Gregory—The first thing to say is that, of course, not all medical undergraduate scholarships are bonded.

Senator McLUCAS—No, this new set.

Mr Gregory—The new set were, yes. The alliance does have a view on bonding in general, and that is that if it is done in such a way as to provide money in return, as distinct from the additional university places which are bonded to rural practice, where there is no money involved, and if a student has full information about what is required in the bond, and that does not vary through the time of his or her studentship, then we support it. We did not support the bonding which came without money. As to your question as to whether it might be extended to nursing, unlike you apparently, I have heard no-one suggest that nursing scholarships should be bonded.

Let us bear in mind that there are relatively small numbers of rural nursing scholarships. There are three or four different types—one for re-entry and so on—but I have never heard any suggestion that they be bonded. Once people come to recognise the situation with the nursing work force in Australia, my view—and theirs often—is that we have to do whatever needs to be done very quickly, because we have a very serious shortage. Again, I have not heard the proposal that nursing scholarships be bonded.

Senator McLUCAS—I think it was more a recognition of the different treatment. The other model that seems to be working very well in terms of recruiting doctors who will work in rural areas is to recruit from rural areas and to place training in rural areas. There seems to be a similar model being applied to rural nursing scholarships. Can we apply that sort of thinking to aged care where we recruit potentially out of undertrained aged care workers—maybe personal care workers—who obviously have a commitment to work in aged care. Can we extrapolate that model?

Mr Gregory—My major concern, you will understand, is the rural aspect of all of this, not the national one, although if we were to fix up the national one the rural one would be much better.

Senator McLUCAS—The flow-on effect.

Mr Gregory—All other things being equal, as we all know, it is more likely that someone who comes from a rural area will return to a rural area. If we are concerned with the shortage of staff across the board in the aged care sector in rural areas, yes, it would help and we could use the model—which, as you say, has been trialled in general practice—of getting greater numbers of people from rural areas, whether they be nurses, ENs or care assistants or whatever, because they are more likely to go back. We know that.

Senator MOORE—Mr Gregory, in terms of access to specialised geriatric services, we have heard there is a national shortage and we have heard evidence from someone from the college about that. I would expect that that difficulty is exacerbated in regional and remote Australia, and I would like to have your comments on that for the record.

Mr Gregory—It is true—and I blush slightly to say this—that the alliance often forgets about specialists. In fact, I think I forgot them in the list that I iterated here this afternoon. We are short of specialists of all sorts in rural and remote areas, just as with all other health professionals. The department of health, I know, has worked with the states and the territories to do some work on outreach models for specialists. The work was done about a year ago, and I do not know what has become of that.

There was in the budget, as you know, a rejigged MSOAP, Medical Specialist Outreach Assistance Program. It was rejigged because in its first iteration it was not popular with the few regional specialists that existed. It has now gone down much better. So there is a government program in place, but it is true to say that we are still short of specialists. I will refer to two groups in particular. We all know there is a serious problem with birthing in the bush, and if we had more midwives and obstetricians—I will be shot for saying midwives, because they are not technically medical specialists—in rural areas, that would be wonderful.

Also, we really need to invest more at the front end of life, in healthy pregnancies and a healthy first three years of life. So much after that would be easy if we got all that right. We clearly need access to paediatricians and other people who specialise in healthy pregnancies and healthy babies, and in rural areas that would make a wonderful difference.

Senator MOORE—Mr Gregory, following up, I know in your opening statement you referred to Indigenous services and the fact that in some of your constituent areas that is a higher number, but are you aware of any particular services in regional Australia that are focusing on the issue of Indigenous ageing?

Mr Gregory—I am not, which suggests that I am ignorant rather than that there are not any.

Senator MOORE—I am not sure. You are not aware of that in the research you have done?

Mr Gregory—No.

CHAIR—Mr Gregory, the committee has finished their questioning of you. If you would like to leave the table, you are invited to do so.

Mr Gregory—I will leave the table, thank you.

Senator HUMPHRIES—Obviously, as an ACT senator, I am concerned about the matters which are in the ADACAS submission. You mentioned that there were 11 homes in the ACT where you had recorded, through advocates, examples of this intimidation or retribution. Over what period of time are we talking about?

Mr Woodhead—About the last three years.

Senator HUMPHRIES—How many incidents altogether in that three-year period?

Mr Woodhead—I have not got that figure in front of me, but it is a substantial number of actual retribution experience.

Senator KNOWLES—Are you talking 10, 20, 30?

Mr Woodhead—Probably closer to 50.

Senator HUMPHRIES—Do they tend to involve the same people in each of the 11 homes or are they across a variety of complaints in each case?

Mr Woodhead—There are certainly some residents and relatives who have reported numerous instances of retribution but there have been quite a number of people who have experienced it, and certainly according to some staff who have rung us, who we have referred to the Complaints Resolution Scheme, in a number of homes it appears to be systemic against anyone who complains.

Senator HUMPHRIES—You said that 60 per cent of the complaints that were made or the cases that came to your attention were ones where retribution was perpetrated by management.

Mr Woodhead—That is correct.

Senator HUMPHRIES—What do you mean by 'management' in that sense?

Mr Woodhead—We are talking people who would go under a number of titles; director of care, manager, director of nursing, CEO.

Senator HUMPHRIES—So the top two or three people in any given home or facility?

Mr Woodhead—That is correct, yes.

Senator HUMPHRIES—And did you have a sense from the complaints that these were sort of renegades; these management people were acting outside their authority to deal with some localised problem or were they representative of a policy at work within these facilities?

Mr Woodhead—I doubt it is a policy. I believe it is a culture, where they have a defensive way of dealing with any sort of complaint, and that reflects often in the staff that they hire or who stay. Good staff tend to leave. Certainly what we have seen is that they do not have a transparent or robust or timely complaints mechanism. In at least one case where the agency was involved, they had one complaint in their complaints book, and we found that complaints were actually listed as behavioural issues within someone's personal file, but overwhelmingly it is a matter of bullying, I think. They are just bullies, and they use this to respond to anything.

They often state, 'Well, if you don't like it here, you can leave.' That, to you and me, might not be a threat but for someone who is frail and 100 per cent relying upon the staff, it can be frightening, particularly in the climate of supply being less than demand and where people are told by managers and by staff, 'If you complain, they'll close us down,' which is a common complaint to us. We have had that in quite a number of homes, where people have actually stated that, and that goes right down to assistants in nursing saying that.

Senator HUMPHRIES—Does ADACAS belong to a peak organisation across Australia?

Mr Woodhead—Yes, a national advocacy network; a sort of loose information-sharing network across the country. We are all funded under the National Aged Care Advocacy Program.

Senator HUMPHRIES—And have you canvassed with those other constituent organisations whether they have similar records of these sorts of acts of retribution and intimidation?

Mr Woodhead—Certainly I think most of them have reported. We have worked together on this in the past. Most of them have reported instances, and I think the difference is that they may not have the level that we have experienced, because the nature of the ACT is that we have basically a little over a full-time advocate in the ACT for just 23 homes and so we are able to visit and have a high profile in those 23 homes. In places like New South Wales and Victoria, where there are roughly 900 homes in each state and they have five or six advocates, there will be homes there that have no profile at all. In fact, they rely very heavily on people who can phone. We find that the people who suffer retribution the most are people in high care and in those states, or in any state, they are the ones who are much less likely to have access to a telephone and who are much more vulnerable because of their frail nature, and often very much less empowered or totally disempowered. It is the nature of our work which enables us and puts us in a good position to identify the level here in the ACT.

CHAIR—Just before we continue, Mr Woodhead, we have had a request from the press to take some photographs during this public hearing, and I just want to see if there is any objection from any members of the committee or any objections from you.

Mr Woodhead—I have no objection.

CHAIR—If there is no objection, then that is okay. Senator Humphreys.

Senator HUMPHRIES—Of those who are not management, who are identified as the source or the object of these complaints, are they mainly nurses or a variety of other workers within the system?

Mr Woodhead—It is a variety. To me it comes down to their personality. If they are defensive, if they are bullying, then that is where it is likely to come from. We have had instances told to us of people who have been complained against and they have shown behaviours that are no doubt retribution, and they tend to be anyone from assistants in nursing to enrolled nurses to registered nurses.

The type of behaviour, and sometimes I think it is the most damaging and vicious type, is where it is not very tangible to anyone but the care recipient, and that is with things like rough handling. They are rougher in the way they lift them. They do not answer buzzers in a timely manner. They are left in bed until last so they miss activities, particularly favoured activities. But the most vicious one is where staff stop coming in and saying 'Good morning' and smiling and answer buzzers with, 'What do you want this time?' but in a quite rough way, and that unfortunately is quite common against people who raise issues.

Senator HUMPHRIES—And you are sure that the cases you are talking about are examples of victimisation of residents, not merely neglect or poor service resulting from pressure on staff in that particular facility?

Mr Woodhead—I have to be informed by the resident and the family carers. This is what they experience, and if that is what they state, that is their truth, and I think we need to take it very seriously. If we compare it to the community standard of sexual harassment, if a woman has a perception that she is being harassed, then it is an offence and the employer needs to deal with

that. I think we need to apply that community standard to aged care. I think because people are in institutions, they fall between gaps in justice and the law.

Senator HUMPHRIES—As far as you are concerned, the problems that exist here, this range of problems from speaking gruffly to a resident through to what amounts to really assault on them, are acts that need to be guarded against in some way. You suggest that there should be some protective mechanisms developed and the complaints mechanisms need to be made more effective, and I see you suggest there should be some sort of whistleblower protection for those who make complaints. What exactly does that involve? Are you saying, for example, that there should be some kind of authority to investigate, independently of say police or accreditation authorities, a complaint that is made in these circumstances? Should a person have a guarantee that they will not be excluded from the home or have privileges withdrawn, or something of that kind? What are you actually suggesting there?

Mr Woodhead—It is a range of things. There needs to be some sort of strategy to protect the most vulnerable person; in this case, the resident. The department has contingency plans for providing accommodation for residents of homes that are forced to close, as we saw in Melbourne, but there is no contingency plan for moving people from a home should they be seriously at risk. Certainly we have had cases where people have refused to take issues forward because there is no protection. We need to have some strategy and I do not have the answer. That is for somewhere like the Institute of Criminology to come up with answers to.

But certainly for people there needs to be something in place to prevent people from being sued for raising issues. We have had residents who are threatened with being sued for raising issues around a possible untimely death and we were threatened with being sued on one occasion for raising the issue with the coroner about that death. There certainly needs to be whistleblower protection for staff. Staff are the ones there every day, they are providing care, and very often it is staff who contact us initially. They need to be protected against being sacked or punished for raising those issues.

I teach a lot of staff issues around retribution and marginalisation through the certificate levels III and IV, through community organisations and the Institute of Technology here. They are constantly raising issues of concern and they are afraid of losing their jobs because of that. I tell them there are plenty of other places to get jobs, because there are always shortages. They need to be protected, because they are the ones who see what is going on day after day.

Senator HUMPHRIES—I do not believe we have had a submission from the national advocacy organisation that ADACAS is a member of. I wonder if it is possible for you to approach them and ask whether other constituent organisations have figures on these sorts of incidents in their own jurisdictions and whether they could pass that on to the committee.

Mr Woodhead—Yes, Senator, I am happy to do that.

Senator HUMPHRIES—You have obviously made a number of complaints to the complaint resolution service.

Mr Woodhead—Yes.

Senator HUMPHRIES—I assume other people who you have dealt with—relatives or even aged people themselves—have also used that service directly.

Mr Woodhead—Yes.

Senator HUMPHRIES—What is your assessment of their taking those complaints seriously and passing them through to somebody else to action?

Mr Woodhead—I think they are very good at dealing with normal complaints that do not deal with abuse. Abuse, as Rob Knowles pointed out in his report, is not something that is always recorded as part of the complaint. We have had cases in front of the CRS where retribution has continued through the process, and we made a number of phone calls to the CRS to say, 'This has got to be stopped.' On occasion, even the involvement of the CRS has not protected the resident. It adds a level of protection, as does the involvement of an advocate. In some cases, I visited a resident every day to maintain a presence after they raised complaints of abusive behaviour by a staff member.

Senator HUMPHRIES—Complaints come in anonymously, of course, to CRS.

Mr Woodhead—Yes.

Senator HUMPHRIES—I do not know whether the complaints that you have made, or that your organisation has made or advocates have made, have tended to be anonymous or not.

Mr Woodhead—One of the dilemmas that we have is that we have an advocacy code of practice which states that we cannot leave a client in a vulnerable position. If they express a fear of retribution, then we would say to them, 'That is a possibility.' We offer them options of what paths they can go down. They can raise it internally anonymously or they can take it outside. With our help, they can do it anonymously or confidentially, where they give their name but do not give permission to pass it on to the home. We use all those methods.

When people ring, we always say, 'If you tell me something anonymously and I pass it on to the department, it is second-hand. If you ring them, you can be anonymous, you can be confidential or you can be fully open. You can do that and that then becomes first-hand to them.' We always encourage them to go through the CRS, if that is the case. We always do it with staff, because staff could have their own agenda. There could be internal industrial issues that we are not interested in. That is always a danger. As I said before, we do not advocate for staff, so we always urge them to go to the department and raise those issues. We will also raise the issues, but it makes it much more powerful if the staff do it as well.

When a number of people raise issues within one home, if there is a pattern arising, we develop what is call a systemic complaint. We do quite a number of those to the CRS against particular homes, or we do it directly to the home if we feel they are able to deal with the issues. Most homes deal with those sorts of systemic complaints reasonably well; some of them very well. But if we believe that there is a culture within that home, or our experience is that those issues will not be dealt with, then we will go to the department. If those issues involve serious issues of abuse, retribution or whatever from higher level staff—in other words, management—

then we will go directly to the department. In fact, the department and the accreditation agency have said to do so. They want to hear it.

We have raised issues of retribution and fear of retribution in aged care on a quarterly basis for the last five years at least. We meet quarterly with the accreditation agency, the department, representatives of the industry bodies and representatives of CODA and we constantly raise the issue and ask them to take it nationally. Certainly, Rob Knowles looked at that and picked it up. We raise it with the department separately on a quarterly basis. I think they all recognise it. The frustration is that very little is being done. We need this national strategy to deal with it, we really do, because we are dealing with people who are amongst the most vulnerable in Australia. We are talking about people in their eighties and nineties. People view them anyway as not being productive members of society. That is reflected in the staffing levels and the staffing pays, and therefore they need the most protection.

There are similar strategies in place for people with disabilities and for children—they are there—but there is nothing in place for the protection of older people. When the ACT set up their abuse taskforce, they told us that they are not dealing with abuse by paid carers. Abuse is abuse and we need to call it abuse, not just because they are relatives or friends who are doing it. It is paid carers. We need to deal with it.

CHAIR—Mr Woodhead, it is a very disturbing issue that you have put before the committee.

Mr Woodhead—I have been at ADACAS for 10 years and we have been dealing with it for a long time.

CHAIR—Yes, and I am sure it is something that the committee is not going to ignore. In order for us to get a more precise picture on some of the detail, would you be prepared to provide in writing to the committee some of the details of the numbers and instances that you did not have with you today.

Mr Woodhead—We are certainly able to provide the numbers of people who we open and close for fear of retribution, we can provide numbers on the people where fear of retribution was an issue and we can provide numbers on the number of people who have reported actual retribution to us over the last few years. You have on the record two confidential statements that I sent in as part of that and some cases studies.

We have not always recorded the number of people who talk to us on our visits and who have said, 'I don't want you to raise that,' for whatever reason, because we had no way of recording that. We could not open them as a client because they did not give us permission to do so. There are substantial numbers of those. I am talking about hundreds of people over the last five years who have said. In the last financial year ADACAS had, I think, 207 or 208 clients. Most of those expressed some level of fear of what might happen if they raised issues.

CHAIR—Thank you, Mr Woodhead.

Mr Woodhead—Is there a time frame for that?

CHAIR—We have a lot of work to do in the committee, so we certainly do not need it in the next week or so. The sooner we can get it the better, of course. Thank you, Mr Woodhead, for your submission and presentation today.

[2.52 pm]

BRUEN, Mr Warwick John, Assistant Secretary, Community Care Branch, Department of Health and Ageing

CREELMAN, Ms Alice, Acting Assistant Secretary, Policy and Evaluation Branch, Department of Health and Ageing

CULLEN, Mr David John, Executive Director, Financial and Economic Modelling and Analysis Group, Department of Health and Ageing

DELLAR, Mr Stephen, Assistant Secretary, Residential Program Management Branch, Department of Health and Ageing

FINLAY, Ms Gail, Assistant Secretary, Department of Health and Ageing

MERSIADES, Mr Nicolas George, First Assistant Secretary, Ageing and Aged Care Division, Department of Health and Ageing

BARSON, Mr Roger Andrew, Assistant Secretary, Disability and Carers, Department of Family and Community Services

CHAIR—I welcome representatives from the Department of Health and Ageing and the Department of Family and Community Services. 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. You 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 submissions and I now invite you to make an opening statement to be followed by questions from the committee.

Mr Mersiades—As you indicated, we have submitted a fairly comprehensive submission. I do not propose to traverse the details of that but I thought it would be useful for the committee if I provided some context which broadly outlines some of the significant developments over the last few years to improve access to aged care services, the quality of services and the choice of services available to older Australians.

Over the years a comprehensive quality assurance framework has been established for residential care. It comprises the accreditation based quality assurance system whereby accreditation is a precondition for receiving Australian government funding. Certification is a key component of that quality assurance whereby, in partnership with the sector, there is a continuous improvement in the physical quality and safety of aged care facilities. We have the Aged Care Complaints Resolution Scheme, which is available to anyone who wishes to make a complaint about the quality of care being provided. That is supported through aged care advocacy services, which are located in each state and territory of the Commonwealth to provide

free and confidential support services to residents and their families, and a Community Visitors Scheme which improves the quality of life of residents who have limited family and social contact and may be at risk of isolation for cultural and social reasons. Underpinning that we have the Charter of Residents' Rights and Responsibilities. We are also in the process of introducing, later this year, a quality reporting system for the community care packages, EACH packages and the National Respite for Carers Program.

Over the last few years the emphasis on quality has included initiatives aimed at increasing the supply and quality of the work force in the sector. This initiative is centred around a five-part strategy which includes gaining a better understanding of the aged care work force, establishing the factors that affect the recruitment and retention of aged care workers, promoting best practice, improving training curricula, providing direct support for training and providing adequate funding for aged care providers. The details of the measures and initiatives within that strategy were outlined in the submission.

In terms of access and choice, the supply of residential aged care and community aged care places continues to increase. For the first time in many years, the previous benchmark of 100 places per 1,000 people aged 70 and over was reached in June 2004. The benchmark was increased to 108 places in the last budget in response to the Hogan review. At the same time we issued indicative releases for the out years to allow for the planning and delivery of those services. The number of places that have been allocated, and the timing of them, is sufficient to achieve a benchmark of 108 in 2007.

Because many older Australians prefer to receive services in their own homes for as long a as possible, significantly the new benchmarks have seen a doubling of the community care places from 10 to 20 to allow more people to exercise this choice. Since 1996 there has been an almost 600 per cent increase in the number of care packages to 28,562. EACH places have also grown rapidly in recent years from an initial 290 in 2001 to 3,224 expected to be available by 2006.

In rural areas the number of multipurpose services has increased significantly. In June 2003 there were 83 services providing 1,810 operational places. There has also been significant additional funding provided for services in rural and remote areas to support viability. Also, viability funding has been extended to Aboriginal and Torres Strait Islander flexible services.

With regard to community care and support for carers, the Commonwealth's contribution to the HACC program has grown significantly in recent years from about $400 million in 1995-96 to almost $800 million this financial year. In recent years there has been a real increase of six per cent per annum over a number of years, which is a very large real increase. As a result, the number of clients who are being assisted has increased from 375,000 in 1995-96 to an estimated 750,000 last financial year.

Other carer support and community care programs have also grown significantly. The National Respite for Carers Program has increased from about $90 million about seven years ago and is estimated to be $105 million in 2004-05. Other programs which have increased to support people to manage their care requirements and to remain in the community for as long as possible include the National Continence Management Strategy.

Significantly, the government released *The Way Forward* report as a result of the community care review last year. We are working with the states and territories to implement these reforms. The essential features are around achieving a common approach across all community programs in key areas such as access, eligibility, common assessment, accountability and quality assurance, all with a view to making the system easier for clients and their carers to navigate.

With regard to interface issues, in particular with the disability system and the hospitals, there have been recent initiatives to try and improve arrangements. Through our innovative pool pilots we have been working with the states and territories to develop service models around providing more appropriate services for younger people with disabilities who are in residential care, and also for the care of older people with disabilities.

With the interface with hospitals, in the last budget the transition care program was introduced, which aims to provide 2,000 places over the next three years to provide short-term transition care in a post-hospital context so that people leaving hospital can do so in as independent a way as possible and be more independent than would otherwise be the case; they can return home or, if they need to go to a residential facility, it would be at a lower level of care need than would otherwise be the case. In conclusion, that illustrates that over the last few years a good deal has been done to improve aged care services. That is not to suggest that we are not always looking for opportunities to do better with our existing resources.

Mr Barson—I am not going to enlarge very much on the submission that we provided to the committee. Our role in this is very much with our colleagues in the Department of Health and Ageing. To answer any questions members of the committee may have around the interaction between disability services that operate under the Commonwealth State Territory Disability Agreement and services for people with disabilities that operate within the Department of Health and Ageing, particularly those for frail, older people, the Commonwealth State Territory Disability Agreement, as you may know, is the agreement between governments over responsibilities for services for people with disabilities.

For the area of interest here, accommodation support, it is agreed that the state and territory governments have the responsibilities for planning, priority setting and administration of accommodation support services. Accommodation support services as a group are best thought of as residential care services and range from larger institutional services through group homes, to services provided to small groups of people with disabilities who live in rented accommodation, through to some individual attendant care. I am happy today to answer any questions the committee may have in terms of the arrangements for accommodation support services and the interaction with nursing homes and aged care services in general.

Senator McLUCAS—Mr Mersiades, could we go to the issue of planning to start off with. You outlined in your opening statement the change from 100 per 1,000 of people over 70, to 108. Firstly, where did 100 per 1,000 come from in the beginning? What was the basis for it?

Mr Mersiades—I have not gone through the files to check for myself where it came from, but I understand, through various corporate memory avenues, that the figure was established in about 1985 and it represented the provision level at that time nationally. Of course there were wide variations across states.

Senator McLUCAS—But it was worked from what we were actually doing?

Mr Mersiades—Yes. It reflected what the provisional level was at the time. Perhaps Mr Bruen, who was around then, not to mention—

Senator McLUCAS—He was a very young man then, wasn't he?

Mr Bruen—Very young. Yes, it was in the *Nursing homes and hostels review* that I think was published in 1985 or 1986. The research carried out in that review showed that the provision of residential aged care in Australia by international standards was quite high and that the emphasis really needed to be on developing community care services. The government of the day made a decision not to reduce the ratio but to preserve it at that level. It was actually about 103 but in those days it included nursing homes for younger people which were subsequently transferred under the CSTDA. It so happened that it turned out to be the round figure of 100. It was not one that was artificially derived. It was actually the provision ratio at that time, as Mr Mersiades has said.

Senator McLUCAS—And what was the driver for the move to 108 which happened at the last budget?

Mr Mersiades—It was the review undertaken by Professor Hogan. Dr Cullen will be able to give you more information, but essentially he looked at provision levels. He looked at disability projections and his projection suggested that a figure of about 108 would be sufficient to meet requirements in the medium term.

Senator McLUCAS—Then the change to reducing by two the number of low-care places and doubling the CACPs: it has been put by a number of groups that in fact the delivery of low-care places is much higher than need exist. One submission told us—and I think my figures are in the ballpark—that 60 per cent of funded low-care places are currently occupied by high-care residents. Why are we continuing to fund low-care places, albeit two fewer than we were, but still at that seemingly high number, compared to what I understand the need to be?

Mr Mersiades—I think what you are touching on is the fact that the level of frailty across the board in the places has been increasing. If you look at the frailty levels in the low care, you will find that a large proportion of those places are also occupied by people with high-care needs, and they are funded on that basis as well.

Senator McLUCAS—Yes, but why is the government continuing to fund low-care places where there is relatively less demand for those places compared to the extraordinary demand for high-care places?

Dr Cullen—The policy of ageing in place means that you enter as low care and then you become high care.

Senator McLUCAS—Dr Cullen, I do not think that is what is happening, though. From a lot of our submitters, people are saying that more and more people are using community care packages or HACC services, but when they are entering into residential aged care they are increasingly entering as high-care residents.

Dr Cullen—With respect to the people making the submissions to you, our data would indicate that people enter at low care and age in place to high care. Because there are a large number of people in low-care beds who are receiving high care, if one were to reduce the number of low-care beds, as you suggest, then there would be nowhere for those people to enter.

Senator McLUCAS—I am not suggesting you delete them, but the evidence that has been put to us is that, increasingly, people are entering residential aged care as quite elderly—85—with a very complex set of medical needs and invariably as high-care residents. Dr Cullen, you said that your data says that people are entering as low care.

Dr Cullen—And as low care.

Senator McLUCAS—What is the split currently?

Dr Cullen—We would have to take that on notice.

Senator McLUCAS—We would have that data. We would be able to capture that somehow.

Mr Dellar—If you are saying what is the proportion of people coming into care in terms of high or low, it roughly lines up with the actual provision ratios, so it is 40-48, low care being the 48. Of the people in the low-care nominated places, remembering that the pre-97 places are actually either low care or high care as declared by the provider, 25 per cent of those people, broadly, are being subsidised as high care at the present time.

Senator McLUCAS—Twenty-five per cent of pre-97 places?

Mr Dellar—No, I am sorry. That is a separate fact. Of the 48 low-care places, around 25 per cent of those are funded at high-care levels by the department. It is exactly as Dr Cullen said: that a person would enter as a low-care resident and then something happens and that person is reassessed and is then funded as a high-care resident.

Senator McLUCAS—And does the department collect data on the time frame? How long does it take for a person who enters as a resident to move to a high-care situation?

Mr Dellar—I will have to defer to Dr Cullen there. Is that information we have?

Dr Cullen—That information certainly is collected. I do not have it with me.

Mr Mersiades—We would have to extract it from the system.

Senator McLUCAS—That might be interesting to know, if you could provide that to us.

Mr Mersiades—Sure.

Senator McLUCAS—The other thing that I find intriguing is we have the 40-48-20 split but each package is not included in that calculation and I am interested to know why that is the case.

Mr Dellar—Each package is counted within the 20 but what we have not done is to establish a percentage of each package. For example, we could have had one per 1,000 or two per 1,000 or some other number per 1,000. The reason for that is that EACH is still a relatively new program. It is expanding. It is expanding about as fast as the department believes it is possible, but expanding with care. I would suggest that in a few years from now, we would be ready then to establish a ratio, but right at the moment we think it is premature to do so.

Senator McLUCAS—It is not a well-known fact, actually, that EACH are in the CAP packages when we do the ratio.

Dr Cullen—The 20 refers to community care places, not to community aged care packages.

Senator McLUCAS—Thank you.

ACTING CHAIR (Senator Knowles)—Senator, just before you proceed, the ABC has sought approval of the committee to take some wide shots.

Senator McLUCAS—I am happy with that. Other submissions have put to us that to better plan, rather than look at a national ratio that is applied across the nation, that because of differing demographics it would be more appropriate to develop regional ratios that better reflect differences that exist around our nation. Has the department had a look at those sorts of ideas?

Mr Dellar—We think about planning quite a lot and we do have that overall figure of 108. We do not have a view that it has to be 108 in any one region. When we look at our data, we basically do two things. Firstly we look at the ABS projections and we balance those against supply of places already, and we try to take into account allocated places that are not operational, so things that are in the pipe and heading on towards being operational. The ABS data does try to identify internal migration and it is certainly true that there are retirement centres of choice, and that people who retire tend to go to places other than where they perhaps retired. That is quite difficult to predict, and sometimes I would have to say there are some limits to the quality of the data in the way we interpret it.

However, in each state and territory we do have an aged care planning advisory committee. Throughout the year we get submissions and letters and reports from all sorts of people. All of that material is collected and provided to each of those committees, which are in each state and territory, and their task at the beginning of the aged care approval round process each year is to look at the data, to look at that information, to hear the views of the department, which certainly believes it has something to input, and to mix that all up and produce the best possible balance. I would not, as I said, think that we have got it perfectly correct but I would say that we do try to build the two things; the science of the numbers and the projections and the internal migrations predictions and the art of balancing that all up against the real world. For example, regions always have lines and lines are intrinsically arbitrary, which means that if you are thinking about a population on this side of a regional border, you have to take account of the population on the other side of the border. You have to think about retirement choice. To take a relevant example in the ACT, the numbers of people here probably understates the need for aged care, because there is a fairly well-trodden path of people who perhaps are about my age bringing their parents to Canberra as they become frail, and so that is the kind of thinking we have to do and that is the kind of accommodation we have to make.

Senator McLUCAS—And the industry is obviously represented on the advisory committees?

Mr Dellar—We have on the advisory committees people with expertise in ageing and aged care. We generally avoid having representatives of approved providers on those committees because of the potential of conflict of interest.

Senator McLUCAS—Sorry, I did not mean a provider from that area. Once the decision is made about the number of places, is there an opportunity for the community to discuss that with either the department or the advisory committee?

Mr Dellar—We would regard the consultative process around the ACPAC process as the opportunity throughout the year for people to tell us what their views are. We would regard that as the opportunity for people to comment. Once the ACPAC has reached its decision, that is basically approved and then issued. I have brought along a show-and-tell, which is a copy of the thing we produce each year, which is essentially the results of all that. It goes beyond simple numbers. It also attempts to say, 'In this region we think there are extra needs for dementia,' 'In that region we think there are homeless people who aren't perhaps being served over here.' There might be Indigenous people who need extra service; those sorts of things.

Senator McLUCAS—I have some specific questions that have come out of other—can I go to both?

CHAIR—Yes, certainly.

Dr Cullen—Senator, just before you do, may I return to your issue about demand for low and high care?

Senator McLUCAS—Yes.

Dr Cullen—I am just quoting here from the review of pricing arrangements, which did look at the minimum data set of ACAT assessments which, as you know, are the independent assessors of need. Of people assessed in the community, 34.2 per cent of people in the community who went to an aged care assessment team were recommended for residential care. Of those, 19.1 per cent, or more than half, were recommended for low-level care, and 15.2 per cent were recommended for high-level care, so according to the independent assessment, there is still a significant demand for low-level care.

Senator McLUCAS—We have had some commentary about ACAT assessments that you might be aware of as well, where there has been a suggestion made to us—which I do not think can be proven one way or the other—that ACAT assessments often seem to, interestingly, match what is in fact available. Anyone who has put that to us has no data to support it but it has been put to us on more than one occasion, that that is in fact what is occurring. I am sure the department has heard that sort of commentary over time. If you have any response to it, it would be interesting.

Mr Bruen—That would not altogether surprise me, because our guidelines do say to ACATs that their job is not just to be gatekeepers; their job is to match the appropriate available care to the assessed needs of the individual. It is no good an ACAT recommending a form of care for the

person when that form of care is not there, so the ACATs do have regard and are asked to have regard to what is available in recommending care options to people and their families.

Senator McLUCAS—Wouldn't it be more appropriate, though, if there is an independent assessment that it is in fact an independent assessment of the need of that person? If we are assessing someone's need and then we know there is only a CAP package there, and the person is clearly not a suitable candidate for a CAP package, we do not push them into a CAP package, do we?

Mr Bruen—No, because there are no regions in Australia where residential care is unavailable. There may be short waits but residential care is always available. The difficulty is that often people will meet the criteria for residential care but the ACAT, and usually the person themselves, if at all possible, would prefer to remain in the community, with community support, and the ACATs will, in almost all circumstances, if that community support is available, recommend that because one of the guidelines for ACATs is to try and avoid unnecessary residential care admission.

Senator McLUCAS—That is agreed and I think that is a good principle.

Mr Bruen—Yes, but the ACATs do not operate as completely detached gatekeepers. We used to have that system before we had the ACATs. The difficulty with that is, people have their assessment and then do not know where to go or what to do, whereas the assessment team is able to say to people, 'Well, here's what's available in your region.' In many cases, they will actually arrange the care, so the person is guided and helped right through to actually receive the care instead of just being given a bit of paper and left to make the telephone calls themselves.

Senator McLUCAS—There have been a couple of specific issues that have been raised with the committee today. The AMA in their submission earlier today were talking about the GP panels that were a proposal from the last Medicare changes and the indemnity question that was apparently raised for the chair of those panels. The AMA suggested that the department had legal advice that was not clear about what indemnity those chairs may or may not have. Would you like to comment about that? They are suggesting that that is an obstacle for GPs to access the panels and to participate in the program.

Mr Mersiades—That is a matter for our Primary Care Division colleagues who have responsibility amongst other things for the general practice program. It is probably best if we take that on notice.

Senator McLUCAS—Thank you, and it would be nice if we could get a copy of the legal advice if that is at all possible. When we were speaking with the nurses earlier today, they talked about the DVA standards for nursing and they were extremely complimentary of those standards. Has the department first of all investigated using those standards for nursing that the Department of Veterans' Affairs has in operation?

Mr Bruen—Are you referring to their standards for their community nursing program or residential care?

Senator McLUCAS—I think it was community nursing.

Mr Bruen—Yes, I am certainly aware of those standards. Most of the nursing that we fund is through the HACC program and the standards and quality assurance in HACC is administered by the states. Professional nursing standards is an issue that we as bureaucrats would rather leave to the profession. My understanding is that various states have adopted some or other of those kinds of standards but it is a matter for the state administrations under the HACC program.

Senator McLUCAS—But DVA have their own—

Mr Bruen—Yes, they have their own nursing program.

Senator McLUCAS—I understand DVA uses HACC services. Is that correct?

Mr Bruen—They do but they also have their own specific nursing program for their own clients which is not funded through the states. They fund it directly, so they are responsible for managing that; whereas in HACC the states are responsible for the nursing services.

Senator McLUCAS—Finally—and Mr Barson might be able to join the discussion on this one—we were told this morning that if a person is in a group home, which is a state funded service, they would have no access to a Community Aged Care Package or, the witness then said, palliative care. Is that the case? Why not?

Mr Bruen—It is certainly the case in regard to Community Aged Care Packages, yes. It is government policy that Community Aged Care Packages are not available to people in subsidised residential care. That applies both to young people with disabilities and to the frail aged.

Senator McLUCAS—How do you define subsidised residential care?

Mr Bruen—Hostels, nursing homes or group homes that receive funding through the CSTDA or a state program.

Senator McLUCAS—Even though the person is moving from a person with a disability to a person who is aged but wants to be ageing in place? The point that they were making is that a person moves from a disability environment to an aged environment and there is an inability for that to be a fairly seamless transition.

Mr Bruen—It can be if the person is living in their own home. This restriction only applies to people living in subsidised residential care.

Mr Barson—The disability residential care services or the accommodation support services are very similar in principle at least to many other residential services. We would expect that the organisations running those services will be meeting the needs of the people that they are providing services for. It is difficult for me to think through why there would be a need for, or an expectation that—say for our colleagues in the Department of Health and Ageing but in health and aged care services generally—aged care services of any kind would be provided to somebody who is already in a residential care service and presumably having their residential care needs met.

We are certainly aware, however, and we are discussing with our colleagues, that there are a growing number of issues around people with disabilities living in residential care services who are developing I guess conditions traditionally associated with ageing, such as Alzheimer's dementia, where there is again a growing recognition that those services do not necessarily have the expertise and the experience in handling those. As part of our current round of Commonwealth-state arrangements there are a couple of parts within that where we have agreed with the state governments that there are areas of expertise which are needed and that is something that we are discussing with our colleagues in Health and Ageing.

I think it is going a bit far in that environment to suggest that there is a service model which should be provided. We certainly recognise there are areas where greater expertise is needed and state governments are working increasingly with Health and Ageing officers in the states to do that, but I do not think there is a situation at this stage where it is appropriate for two models of service or two accommodation support services to be provided to a person in the one residential setting. I agree with the need but I am not convinced there is a need for services from two agencies to go to that one person.

Senator McLUCAS—The general consensus of the submissions is that we currently have two buckets of money and from time to time people move from that service type to that service type and there is, not invariably but pretty well all the time, a problem where they fall out of a service. The National Continence Management Strategy is a perfect example where, if a person has been being provided incontinence aids, at 65 they all of a sudden cannot be. Now, you actually get worse as you get older, not better. That is a problem and it needs to be fixed.

Ms Creelman—This is an issue that our two departments are aware of and have been working on, including through a small number of pilots under the Aged Care Innovative Pool, to test that issue of the increasing ageing needs being overlaid on disability needs. We have currently nine pilots under way, which are providing some additional aged care funding in the form of flexible care subsidy to disability-supported residential services in order to get a better understanding of this issue and to test whether that is something that needs to be addressed in a more systemic way. They are being evaluated at present.

Mr Barson—Certainly the issue of people with lifelong disabilities who are ageing is a growing concern to us. It is in some ways a relatively new phenomenon. We are not accustomed to having large numbers of people with disabilities live to such an age, where they would be regarded in the traditional sense as potential aged care clients.

I am reminded, although I do not have the figures in my head, of some work being done looking at people with down syndrome, where 20 years ago there were less than a handful of people with down syndrome who were of older age. Now there are over 1,000 people in Australia with down syndrome who are over what would be regarded as aged care age. With other disabilities, though, the issues tend not to be purely age related but tend to relate to the duration of the disability. With a lot of the physical disabilities, particularly spinal injury, the issues come more as a duration of disability issue. You have had that disability for 20 years, other bodily functions are starting to break down, so it is not an age related thing. That is also an area where, to come back to that down syndrome example, some 50 per cent of that older age group were found to have dementia like symptoms.

We are clearly starting to face very real issues at that older age nexus. I admit that it is not something in the disability world that a great deal of attention has been paid to in the past. Increasingly we are doing that but I would still come back to my earlier point that it is really a case of the appropriate expertise and appropriate kinds of support, rather than trying to look at how a mix of services might go into the one service. I am happy to accept that there are needs for improvement in the services.

Senator McLUCAS—It has been put to me that, as we age healthier, more and more people will have a disability rather than a need for an aged care service. There is going to be quite a big shift in the next 15 to 20 years in that respect.

Mr Barson—It is certainly true that most of the health care costs have come toward the end of life, and many of the service interventions. The concept of disability-free life expectancy and not just life expectancy itself but the period that we can expect to be alive and fully functioning without a disability is a very important part of those calculations.

Senator HUMPHRIES—How do we measure demand for aged care accommodation in Australia? The discussion about the 108 places per 1,000 head of people over 65 is sort of a measure of supply, is it not? How do we actually measure the demand that we have out there for accommodation?

Mr Dellar—It goes to the issues that my colleague Mr Mersiades mentioned a moment ago, which is about patterns of ageing, patterns of disability and the incidence of those things.

Senator HUMPHRIES—Do we assume that the level of disability or incapacity that that would suggest equates to demand?

Mr Dellar—I am saying that, and the figure of 108 for people aged 70-plus is only that. It is only an indicator. It is a way of getting your head around all of those factors and making sense of the various needs of the community.

Dr Cullen—A complex model of the aged care sector was developed, which included a model of demand for aged care. That model took into account disability prevalence at age groups; it took into account the effect of having a carer and whether having a carer would change over time. It took into account the income and assets and the changing income and assets of older people because that is known to affect their demand for care as well. It took all of those factors, projected them forward over 40 years and looked at relative demand to now. In other words, it did not try to ask the question, 'Exactly how many people are there out there who would like care?' The question that it answered was: what do you need to set the ratio at so that no more and preferably fewer people than are currently awaiting care would be awaiting care in the future? That is the basis of the 108, essentially. The supply ratio was set at a level which ensured that demand would be at least as well met as it currently is, rather than making an absolute measure of what demand is.

Senator HUMPHRIES—Is it possible to look back over the last 10 years or 20 years and say that we are better meeting demand for aged care now, we are less well meeting that demand, or is it about the same over a given period of retrospective view?

Dr Cullen—Demand is a very complex issue in aged care or in health, anyway. Economists like to say that there is an infinite pool of morbidity; that the more service you have, the more demand there will be for services. That is what makes that question very difficult to answer, but what we can say is, assuming current levels of demand, we know that 108 is a ratio which will satisfy to the same extent as that current level of demand into the future.

Senator HUMPHRIES—Can I have some clarification of some things that were raised with us this morning. I understand that to qualify for the CAP, aged facilities or providers need to provide audited accounts to the department to demonstrate that they have a level of transparency. Are those accounts provided at the moment or are they to be provided in the future on a disaggregated basis by facility, or are they lumped together so that, for example, Catholic Health Australia will provide a single set of accounts?

Mr Mersiades—We expect the minister to be making an announcement about the operation of the CAP in the not-too-distant future. I do not think we can go much further than saying that, other than what is on the public record.

Senator HUMPHRIES—I am happy with that. Thank you.

Senator McLUCAS—We were discussing who would have access to the audited financial statements. Is that also something that we should wait for the minister's comments about?

Mr Mersiades—My earlier answer applies to that question as well.

Senator McLUCAS—Thank you.

CHAIR—I guess some of you, if not all of you, were here for the previous submission from the ACT Disability, Aged and Carer Advocacy Service. Can anyone comment on what is happening in the industry in respect of those issues?

Mr Mersiades—These are the comments relating to the ACT domain about fear of retribution?

CHAIR—Yes.

Mr Mersiades—We were not here when that discussion was taking place. In general terms, the system we have in place, and the regulatory system around care, recognises that older people receiving care are perhaps amongst the most vulnerable in the community and, as a result, the care system and the quality assurance system we have in place is quite extensive in recognition of that. At the highest level, as I indicated earlier, there is accreditation against care standards, where services have to be accredited to be funded. Not too many accreditation systems are that rigorous between being accredited and receiving funding and being able to stay in business. Secondly, that is supported by a Complaints Resolution Scheme which, significantly for the immediate issue, does accept complaints anonymously and confidentially. My understanding is that in many other forms, in other sectors, such complaint schemes tend not to accept anonymous and confidential calls. There was a deliberate decision to take away that concern because it is an understandable concern that people would have; it is a natural human instinct.

On top of that, we have the advocacy services funded around the country, so they are another avenue of providing support to residents and their carers. They can do that confidentially and the information need not be passed on to us. I said earlier the Community Visitors Scheme is very important as well, because the more isolated and alone you are in a home, the more vulnerable you are; if you have a visitor, a regular visitor, that relates to you that gives you confidence in terms of your relationship with your care provider. The system recognises that we are dealing with a very frail group of the community and endeavours to go as far as possible to try and deal with that vulnerability.

We have not received a lot of complaints through the scheme about actual retribution. So while it is understandable that there would be a community perception, there is this fear and that is a natural human response. Through our Complaints Resolution Scheme and those other vehicles I mentioned to you, there has not been a high incidence of actual evidence of retribution.

CHAIR—Can you provide to the committee, on a state by state and territory basis, the number of complaints you get and the nature of those complaints?

Mr Mersiades—I will have to take that on notice. It seems like a simple question but it may not be easy to differentiate, given our data systems, about the nature of the individual complaints. Something like retribution is one of—

CHAIR—I would like to look at what you say they are, given that hopefully we will get that information from the advocacy groups, and just see how far out they are together and see if we can then gain in understanding of why that may be the case.

Mr Mersiades—We will have a look at our databases to see what we can pull together.

CHAIR—Thank you. Are there any other questions of the departments? Thank you very much for your submissions and your presentation today. The committee stands adjourned.

Committee adjourned at 3.44 p.m.