COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

Reference: Aged Care

FRIDAY, 18 MARCH 2005

BRISBANE

BY AUTHORITY OF THE SENATE

SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

Friday, 18 March 2005

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

Substitute members: Senator Allison for Senator Lees

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

Senators in attendance: Senators Knowles, Humphries, 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.

WITNESSES

Committee met at 9.01 a.m.

BOARDMAN, Mr Ian, Public Advocate, Office of the Public Advocate Queensland

FUNNELL, Ms Beverley Ann, Senior Research Officer, Office of the Public Advocate Queensland

IRONS, Mr Lindsay, Senior Research Officer, Office of the Public Advocate Queensland

CHAIR—The Community Affairs References Committee is continuing its inquiry into aged care. I welcome representatives from the Office of the Public Advocate Queensland. 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. You will not be required to answer questions on the advice you may have given in the formulation of policy or to express a personal opinion on matters of policy. The committee has before it your submission. I now invite you to make an opening statement, which will be followed by questions from the committee.

Mr Boardman—I thank the committee for giving us the opportunity to appear here today. I have asked my two research officers to come along as well because they have the expertise to speak to the issues that, with your leave, we would like to address. Our submission dealt with two main issues: younger people in aged care facilities and aspects of aged care reform. We would also like to raise the issue of lifetime planning, which is specific to the disability field. I will ask Lindsay Irons to speak briefly to the issue of younger people in aged care facilities and then Beverley can speak to the other two issues.

Mr Irons—As Ian discussed, I will talk to the issue of the presence of younger people in aged care facilities. You have our submission and, rather than speak to that, I will talk around a couple of issues that build on what is in that submission. Our concern is around what was set up originally to be a system of last resort: younger people who have acquired brain injuries or other degenerative disorders to enter nursing homes for their care. Unfortunately, in many cases it has now become the option of first resort: young people who have no other options for their accommodation and support are finding their way all too frequently into nursing homes and other aged care facilities.

Our concern around that issue is the quality of life that younger people in aged care facilities have. Nursing homes generally do not have the skills or the knowledge to care for younger people with acquired disabilities or degenerative neurological disorders. They do not have the rehabilitation focus that younger people need to recover, regain their independence and move on. Often there are not the funds for the special equipment or therapeutic services that younger people need. Staffing levels are often not sufficient to provide the level of care that people need. Most importantly, people’s social and emotional needs cannot be adequately met in aged care facilities that were set up for aged frail people. For younger people in these kinds of facilities, there is significant social isolation or loss of identity and a limited level of access to the wider community.

Some of these problems have come about, I think, because of the limitations in the aged care subsidies. Aged care subsidies are capped at around $43,000 and do not take account of the complex support needs that some of the people, particularly younger people with acquired brain injuries, might have. Being residents of Commonwealth aged residential facilities, they cannot access disability services under the Commonwealth State Territory Disability Agreement. This in turn causes upstream blockages in the acute health system with older people waiting for nursing home beds occupying acute health care beds.

I would like to draw attention to four or five key recommendations which augment the material in our submission and which our office would see as ways forward for the better meeting of the needs of young people in aged care facilities. The first would be a no-fault insurance scheme which would operate in cases when there is a catastrophic injury or where no-one could be found at fault or in the case of degenerative neurological disorders. Such a scheme would provide for significant levels of support that younger people would need after a traumatic injury.

The second recommendation would be for states and the Commonwealth to develop a different range of options for support and accommodation. Nursing homes might be one of those options in certain circumstances, but a whole range of options need to be developed in consultation with younger people and their families and, in doing so, we need to develop the capacity of the non-government sector to fulfil those needs, which is not currently there at the moment.

The third recommendation would be for a review of the Commonwealth-state disability agreement and the funding arrangements that come from that agreement to allow younger people in Commonwealth residential services to be able to access disability services to provide for their holistic life needs. Following on from that would be a specific assessment and funding mechanism targeted specially at younger people with high and complex support needs.

The fourth recommendation would be for a commitment to move a targeted number of people out of nursing homes. We know there are a number of innovative models around the country that have already done this on a small scale and we believe that, while there is some early preliminary scoping work being undertaken jointly by the Queensland government and the Commonwealth government, we need to move beyond the scoping, the data gathering, the researching and the counting to actually piloting some of these initiatives across the country to a greater extent than has been done already, as well as putting in place measures to prevent more younger people from entering nursing homes. In Queensland we have almost 1,300 people under 65 years of age in nursing homes at the moment.

The final recommendation would be for a review of the aged care system, one which links the Aged Care Act to the Disability Discrimination Act, which covers the rights of younger people in nursing homes, given that they are not adequately covered under the Aged Care Act and the various policies and standards that flow from that. This modification of the act would reflect the kind of de facto nature of nursing homes functioning as disability services and help to ensure adequate standards of care for younger people while they are residing there, whether on a temporary transitional basis or for longer periods of time. That concludes my part of the submission.

Ms Funnell—Good morning, everyone. I refer you to term of reference (c). Lindsay has spoken to the first part of that and, with your leave, I would like to make a few comments about the second part of term of reference (c), which is around the extent to which residents with special needs such as dementia, mental illness, acquired brain injury et cetera have their needs met under the current funding arrangements. These people clearly come within the scope of our office. We have a statutory mandate in respect of people with a decision-making disability or people who have an impaired capacity for a decision. I need to say at the outset that it is almost unavoidable when actually examining the shortcomings of a system that it is really at the expense of recognising the work of many dedicated people and people who often work in less than ideal conditions with minimal training. There is significant information to indicate that aged care facilities are compromised in their ability to meet the range of special needs of a whole group of people. And it is not just their special needs. In fact, aged care facilities are compromised in their ability to meet the fundamental human needs of a whole range of people. This information comes from a number of sources, including service providers, the college of psychiatrists, national disability bodies, trade unions, advocates’ families and academics.

I think it is appropriate that in your terms of reference you have sought input regarding the correlation between funding arrangements and adequacy of support and care, but I would like to briefly mention a number of other variables that exert a great deal of influence. Money is important but it does not fix everything, and I want to briefly list some other variables that do interact with the financial resources. These are overarching values and assumptions: leadership and culture of the service, quality and relevance of the service model, the degree of flexibility and the capacity to shape supports around the person, work force matters that you are well aware of, the design and structure of residential services, other environmental factors such as the kinds of activities and the level of participation that is supported, and openness and willingness to work with the family and key people—the quality of the relationships between staff and clients, management and staff, management and families, staff and families is a critical issue—and the standards of training among doctors in the detection of mental health problems and the use of psychotropic medication. These are all important issues.

In terms of funding, I think it is always important to ensure that there is adequate investment in ongoing innovation and research, because the way those different variables get configured is quite critical to successful outcomes in respect of those people. It is also a moot point as to whether we actually have any people in residential aged care at the moment who do not have special needs. Given the population using those services I think it is an important thing to consider.

I have just a couple of comments about the overall funding arrangements and then I will make some specific comments about funding at an individual level. First of all in regard to people with dementia, low funding levels have been recognised for a considerable time, including by the Department of Health and Ageing in its report in 1996 on the need for structural reform. It still remains an issue that requires addressing as part of a continuum of support and care. Community care is also a part of that continuum and needs to be addressed as part of the total response. There is still no current national plan for dementia, and this raises the question of how seriously the issue is being taken.

There are special needs associated with people with mental illness or psychiatric disability, and a body of provocative literature has emerged over the last couple of decades showing that mental illness is commonly undetected and often poorly managed in residential settings. Some actually put the figure as high as 90 per cent or more of those in nursing home care or aged care facilities fulfil criteria for one or more psychiatric disorders in an environment that often presents significant difficulties for assessment and treatment. We also have the problem of the provision of non-acute residential aged care places in Queensland for people with a psychiatric disability. It lags behind most other states, as does acute aged geriatric area spending as well as mental health spending more broadly. The lack of specific psychogeriatric services has been cited by the Royal Australian and New Zealand College of Psychiatrists by their faculty of psychiatry of old age.

Clearly there is a link between funding levels and work force issues, and I am sure that other people will talk to those issues. I am sure you are aware that most patient care is provided by personal care attendants who are often on low wages and minimally trained. Many of the staff in aged care facilities are not knowledgeable about even normal ageing and are not really able to understand some of the psychological symptoms and behavioural problems experienced by residents and, because of that, seldom seek appropriate mental health intervention once a problem is recognised.

I have just a couple of comments about funding at the individual level—and this is provided through the residential classification system. This is seen as not adequately recognising the support needs of people who have behavioural challenges, especially people with dementia and psychiatric illnesses. Although many of these people do not have high levels of personal or nursing care, the intensity in nature of their needs means that they require more personalised attention because of the impact of their behaviour on themselves and other residents—and I will extend this to include people with down syndrome, particularly because they are at great risk of being chemically restrained in aged care facilities and inappropriately medicated, which can lead to increased risks of pneumonia and premature death. Might I add that it may be the inappropriateness of the placement in the first place which is the more salient problem than the funding levels per se.

There are just a couple of other comments about funding arrangements. There is the old chestnut issue of state-Commonwealth relations and the cost shifting that can occur which can lead to inappropriate placement of people with ABI, intellectual disability and psychiatric disability in residential aged care. Also there is the way the RCS works—in that high dependency attracts higher levels of funding. So the link between financial remuneration and the level of dependency is important in terms of recognising that adequate care is required but it can have the effect of discouraging and undermining a recovery or developmental focus. I am aware that many people with dementia, for example, often improve when they go into residential care as a result of regular meals and just good nursing, good care and monitoring. Service providers are neither rewarded nor encouraged to focus on getting people well or able to return home. Once you get into a nursing home it is pretty hard to get out of it, and we recommend that this is one of the issues that need to be addressed.

Finally there is the funding of the twin cohorts of ageing people with a disability and their ageing parents. This is really critical and it is becoming a bigger and bigger issue. We know there are lots of adults with a disability who are now into their 50s and 60s, and parents who are in their 80s who have been caring for their loved one for over, in some cases, five decades. This is a very big cohort and I think that good collaboration between the states and the

Commonwealth will be critical in terms of determining how this current unmet need will be addressed.

We actually address some issues about community care in our paper. I am happy to take questions on those but I think I will move on to finish on term of reference (e), which is around the interface between acute hospital care and the aged care system. In the absence of appropriate convalescent care we have seen or heard of people who have been prematurely transferred into nursing homes. We are aware now though that there is a national action plan. I am sure you are all aware of the *From hospital to home: improving care outcomes for older people* document. We will keep an eye on that and continue to monitor that, but we are very pleased that that has been launched and is in the process of being implemented. That concludes my presentation. Thank you very much.

Mr Boardman—For completeness, I should have pointed out that Beverley is my representative as an observer on the meetings of the Queensland Community Care Coalition and Lindsay is my representative as observer at meetings of the Queensland Young People in Nursing Homes Alliance. So we are familiar with the work of those two community based networks. I think that is about all we have to say. We are open for questions.

CHAIR—Mr Irons, you mentioned in your submission to us the desirability of having a no-fault compensation or insurance scheme. I may have missed this in your written submission recommendations but I do not see any detail of that. I wonder whether you have a model that you have been looking at that would satisfy that.

Mr Irons—This is not an issue that we have looked at closely. This issue has come up more recently than our submission in discussions with colleagues in the acquired brain injury sector who brought it to our attention. The Queensland Motor Accident Insurance Commission scheme is a fault based scheme, I understand, and through those discussions with that sector it has become apparent that a no-fault scheme would be most advantageous for people who have a range of acquired and other kinds of disabilities. It is not an issue that our office has invested a lot of resources in investigating closely and it may be up to others to provide more detailed advice on the specific type of no-fault scheme that could best work. But I think it is probably clear to say that a national approach would be more advantageous than having a range of different models in different states.

Senator KNOWLES—Mr Irons, I am a bit concerned about the way in which you approach this problem in your presentation. You said the problem is that the aged care subsidy is insufficient to cater for the needs of younger people, that there needs to be a review of the CSTDA to allow younger people access to services that they need in nursing homes and that the rights of younger people in nursing homes need to be looked at.

I am a bit concerned about all of that because it seems to me that you have accepted as a fait accompli that young people are going to be in nursing homes, when in fact they should not be. Young people are inappropriately placed and, according to the CSTDA, they should not be in nursing homes. I am just wondering why—and maybe I am wrong—you are saying it is a fait accompli that we have to change the structure of the nursing homes and the way young people are treated so as to look after them better with the services that they really need. Why aren’t you saying, ‘Where are the places in the community that, under the CSTDA, they should be housed in now?’ Instead, you are saying: ‘They’re going to be in nursing homes. Let’s accept it and change the nursing homes.’

Mr Boardman—The position of my office is consistent with much of what you say—that is, for the most part, nursing homes are an inappropriate residential destination for younger people. I think it is fair to say that there is no consensus as to what should be a reasonable residential destination for this cohort of people. There seems to be widespread debate, at least in the communities of interest in Queensland, about how this issue should be resolved. I do not think anybody doubts that for the most part—there are exceptions—it would be better if people did not reside in nursing homes. But where they go to and what funding arrangements might apply are still very much an open debate.

Senator KNOWLES—I understand that. What I am getting at is that there is an agreement between the Commonwealth, the states and the territories whereby the responsibility rests with the states and territories to provide adequate accommodation for young people such as those with acquired brain injury outside of nursing homes. I have personally seen an example of a state minister with responsibility for disability write regularly to the Commonwealth seeking exemption for a person who should not be in a nursing home to be placed in a nursing home. That creates a problem for the aged, because the beds are for the aged.

Mr Boardman—Absolutely.

Senator KNOWLES—The point that I am getting at is that you play a very important role in this. I am wondering what you and your office are doing about trying to enforce the states to honour their part of the agreement that they have signed off on.

Mr Boardman—My office is an office of influence, not of power. I have no powers to direct government.

Senator KNOWLES—I understand that, but what influence have you used?

Mr Boardman—One thing that I might submit is the excerpts from annual reports canvassing these issues. I have copies that I could submit to the committee and you could have a look at what we have had to say about this. What I would say to you now is that we are dealing with an historical problem—it has been with us for decades—and my concern is that it will become a football between different levels of government.

Senator KNOWLES—But it should not be a football—

Mr Boardman—No, it should not.

Senator KNOWLES—because the agreement has been signed. It is a matter of: this is your responsibility; this is our responsibility, or vice versa. The agreement has been signed on the basis of ‘that is why you get the dough’. That is why I am a bit concerned with your presentation today and even with Ms Funnell’s talk about the people with whom you deal. The view is that it is just a fait accompli: young people are going to end up in nursing homes, so we have to change the nursing home structure.

Mr Boardman—Until such time as there is full agreement between levels of government as to where the responsibility lies, that is the fact.

Senator KNOWLES—But there is agreement. It is not a case of saying ‘until such time’. The signatures are on the paper for the Commonwealth State Territory Disability Agreement. That is why I am concerned that the Office of the Public Advocate is saying to us here today, ‘Oh, well, they are just going to be in nursing homes forever and we need to adjust the nursing homes.’

Mr Boardman—That is not what I am saying. I am saying that there are 1,300 people in Queensland under the age of 65 currently living in nursing homes. I direct the same message to the Commonwealth as I direct to the state government. It is between you other people—collectively—who have the capacity to do something about this. There is the CSTD agreement and that sets out certain responsibilities. The parties have presumably arrived at that and signed up to it. That is a starting point.

Senator KNOWLES—That is why I am asking you what the Office of the Public Advocate has done to try to get the state to honour its responsibility according to its agreement. That is the crucial part of this. To sit here and listen to evidence saying that the problem is in the aged care subsidy being insufficient to cater for the needs of young people in nursing homes and it needs to be looked at and increased because of their additional demands worries the living daylights out of me. That is an acknowledgement that those people are going to be there forever instead of being where they should be. What happens to those beds that are designed for old people and not young people with disabilities who should be, according to the agreement, placed elsewhere?

Mr Boardman—I return briefly to the point I made earlier: there is a variety of views as to what would constitute a reasonable sort of alternative. One of those alternatives—and my office does not necessarily support it—is that there be a congregate arrangement attached to nursing homes. My office’s position is that if we are going to resolve this there is going to be a range of different residential destinations for different people according their levels of need. Some people have very high medical support needs. There is the issue of proximity to family. Queensland is a very diverse state. What do you do? Do you put a person whose family is in Mount Isa down in Ipswich?

Senator KNOWLES—I understand all that. I come from Western Australia.

Mr Boardman—That has the same problem. We are dealing with really difficult human issues. I submit to you what we have put to the state government and we are certainly in ongoing dialogue with the state government. Queensland struggles with its own history around disability funding.

Senator KNOWLES—I would be appreciative if we could have that information. Thank you.

Ms Funnell—I would like to speak to that very briefly just to clarify. When I spoke about the RCS I was not speaking in respect of younger people; I was speaking about older people and their particular needs around dementia or psychiatric illness. I just wanted to clarify that.

Senator KNOWLES—Thank you.

Senator McLUCAS—Thank you, Mr Boardman, for your submission. It is a very practical submission recognising, as you made the point, historical realities. You have made the point very strongly that we need a sense of collaboration rather than a cost shifting argument. That is very clear right throughout your submission. You mentioned congregate care models. In other areas we have heard the words ‘group home’ and ‘cluster housing’. I think the language is different across the nation. When you talk about congregate care, can you give me a visual picture of what that might look like? I acknowledge that you say it might not be the best option.

Mr Boardman—Congregate arrangements carry their own baggage in people’s minds. Some people have a very strong philosophical opposition to any sort of congregate arrangements. A visual picture of what a congregate arrangement might look like could be hell on earth or quite reasonable living conditions depending on what other ingredients there are.

Too often congregation has been accompanied by segregation, as an example. For instance, a small congregate arrangement that I know of is being developed in Brisbane at the moment. It is in the inner city, within a suburban arrangement where there is a lot of community access and people are, or will be, living in individual units. That sort of congregate arrangement may well be very suitable for that particular cohort of people with chronic psychiatric disability. They are supported to live in the community and their medical needs can be attended to on a 24-hour basis in a reasonably cost-effective way. Other congregate arrangements may be a group home in a suburb. That may sound okay but it really depends upon the values that are brought to bear by the people who are working there. What I am aware of without any doubt is that in Queensland we have quite a few mini-institutions which look like ordinary suburban houses. They are mini-institutions because of the institutional mindset brought to them by some of the people that work in them. Some of the other group homes are completely different from those. I have been to group homes that look and feel like homes. It varies greatly, depending upon the ingredients and the mix.

Senator McLUCAS—That picks up your point, Ms Funnell.

Ms Funnell—I would like to make a brief comment on that, which I think is quite important. In these matters there is a danger that we always want to rush to the solution and the model—what will it look like, what kind of building and how many people will live there? I think the critical issue—and this is in support of what Ian is saying—is that we need to have individualised approaches. Where people as individuals clearly will benefit from being together and choosing whom they will live with, that grouping will most probably work. But where people are grouped by someone else and where people or their representatives do not have any say in where they live and whom they live with, that is often where institutionalised behaviour and attitudes come from. It is a critical issue that individualised approaches can lead to individual solutions but they can also lead to small group solutions. I know the office does not support large congregate segregated arrangements, but smaller arrangements that are meaningful and related to the individual needs and aspirations of the people may work—but with lots of safeguards, I would add, where you have more and more people together. I think the research suggests that once you get above three the tendency for difficulties and institutionalised behaviour to come into play increases, so safeguards are really important. I certainly support Ian’s comments about the values, assumptions and leadership around those matters.

Senator McLUCAS—The other issue that is important for us to canvass in this hearing today is the reality that most of us in Queensland do not live in Brisbane. You make the point in your submission about the need for people to live close to where they lived prior to needing an alternative living arrangement. Have you seen any good arrangements for young people in nursing homes or do you know, without identifying the particular facility, where that has worked outside Brisbane?

Mr Boardman—Just for clarification, is it a situation where a person requires fairly ongoing care and that is provided outside of a nursing home?

Senator McLUCAS—Wherever.

Mr Boardman—I know of two situations where a nursing home seems to have provided for the person and for their family a reasonable sort of basis for ongoing care. One of those is where the family lives next door to the nursing home and they have access through a back gate. Even if the young person, who has very high medical support needs, were to be moved to a place like Jacana, which is one of the Queensland health facilities in Brisbane, the capacity for the family to interact on a day-to-day basis would be destroyed overnight simply because of travel arrangements. The other situation I am aware of is in an Aboriginal community. I have not been there but I have been told of it. There is some sort of aged care facility within the community. A person who constitutes one of this cohort lives there. Again, the benefit would appear to be the proximity to family and to traditional networks. They are the rare exceptions, I would have to say.

Senator McLUCAS—But it comes back to Ms Funnell’s point about the values that are brought to that care situation, rather than the funding arrangement or the structure; it is about people.

Ms Funnell—We do in fact have a couple of good examples in Queensland. I am aware of and have worked briefly with a service in Hervey Bay. The young people there were previously part of the Bush Children’s Service, which is basically a nursing home kind of model. That has changed. That nursing home has gone; it does not exist. They now have a community based service which is run by a person who was a nurse—one of the former RNs from that facility. That is going very well. People with very high levels of need are being cared for.

The notion of an almost mobile medical service seems to be a critical part of arrangements that work well for this cohort, because many of the families and the service providers worry that the level of nursing or personal care—those things—will not be able to be met in a community setting. There are programs like the one in Hervey Bay which show that that can happen. These are very individualised arrangements. Two or three people might live together but it certainly has an individual focus. There are arrangements in Canada that I am aware of that work like that. They have a very high level of nursing care. There is another one in Brisbane where young people are cared for at home by a team of people who go out to the family home and support people with their very high level medical needs. We are talking about very fragile people who get that level of support within their own home in the community.

Senator McLUCAS—Is that funded through a disability support package?

Ms Funnell—No. It is actually block funding. In some cases, some moneys come through a previous institutional reform process from the state government. There is a mixture of funding arrangements.

Senator McLUCAS—I have one more question that you may not be able to help us with. I appreciate the data that you provided in which you split the cohort of under-65s into people between 50 to 64 and people younger than that. It is the first time we have got that data. We will pursue that with the department. Do you have any idea of the types of disabilities that young people in nursing homes have? Is there any data on the split of those types of disabilities?

Mr Irons—We have some data. The data we have is national data; it is not state based data.

Senator McLUCAS—If you could just point us in the direction of that I am sure we can find it.

Mr Irons—If you would bear with me, I believe it comes from the National Alliance of Young People in Nursing Homes. From memory, about 20 per cent to 30 per cent have an acquired brain injury. About the same number have psychiatric disorders. Another 30 per cent or so have physical disabilities. Another 20 per cent or so have degenerative neurological conditions. That is off the top of my head. I am sorry that I cannot find those figures in my paperwork at the moment. But I believe those figures are national figures and come from the Australian Institute of Health and Welfare.

Senator HUMPHRIES—You say in your submission that Queensland has the highest proportion of young people in nursing homes of any state. Does that suggest that Queensland underperforms relative to the other states when it comes to providing options for young disabled people?

Mr Boardman—It is more likely to be associated with the demographics of the state and the geographical distribution. I am not sure of the rating scales between jurisdictions. I would not be surprised if Western Australia was pretty high up there. It is associated with the distances that we travel, it is associated with issues peculiar to Indigenous communities and so on.

Senator HUMPHRIES—From your experience, do you think that there is the same range of options, putting aside those demographic factors, for young disabled people in Queensland as there would be in other states of Australia?

Mr Boardman—The impression I get—and we have not surveyed nationally to any degree—is that there is a generalised situation of people under the age of 65 in nursing homes and then there are spots of good practice. Beverley has identified the one in Hervey Bay. We are aware of Western Australia with a cohort with multiple sclerosis that were moved out. You will probably find in each jurisdiction that, hopefully, there would be some good practice, but it has not been addressed systemically to bring that good practice to bear on a fairly major cohort of people.

Senator HUMPHRIES—Ms Funnell, I forget how you put it, but you made reference in your remarks to the need to have mechanisms to encourage aged care facilities to promote healthy outcomes and sort of lift the condition or health status of residents. Can you explain how you might achieve that kind of objective? Would you link funding to improvements in health outcomes? How would you achieve those mechanisms?

Ms Funnell—I think the linkage of funding to outcomes is critical. As I said before, the funding is almost designed to limit people’s development and capacity for growth. I think that the funding link is most probably the most potent one. I think it requires from a government level a promotion of the possibilities and the range of models and most probably some more research in that area looking at models from overseas as well as good practice within Australia.

I do not know if the committee is aware of the Eden Alternative in nursing homes. That is one fairly new style of management within nursing homes which is offering good outcomes. It has a very different approach to that of the traditional nursing home. It is based on valuing the whole of the person’s life. It is about creating environments which include gardens, plants, children and animals. It is more than just a homelike setting; it takes that extra step. It is still not home in the sense that you and I would understand, but it has lots of the characteristics that we would associate with home. It has more control for people. There is more shaping and tailoring of things around the person. It is described as an environment in which both the aged person and the staff member thrives and grows and it is based on positive relationships between all of the major stakeholders.

That model comes from the states, but I think it does translate. In fact, now a group called Eden in Oz has been formed and I think the president of that runs a nursing home in Nambour in Queensland. There are some possibilities there. I think it is really about a change of heart. It is about believing that older people are actually valued citizens. I think ageism is really alive and well and we have to challenge some of those assumptions about that. Those values and principles have to be embodied in a different approach. Maybe the funding link will do that. But that has to be promoted more widely and good practice has to be showcased and encouraged.

Mr Boardman—One of the benefits of the Eden Alternative is that the head and the heart come together, and the benefits to the head are substantially reduced staff turnover in premises that follow that philosophy. So you can actually get excellent values based service delivery with benefits to Treasury bottom lines. They are not in any way inconsistent.

Ms Funnell—Could I finally say that it is still no substitute for people being in a real home, their own home, for as long as possible with all that means to us. But where that is not possible, I think something like the Eden Alternative or variations on that are the next best thing. But home based community care support is No. 1.

CHAIR—Thank you very much for your submissions to the inquiry and your contribution today.

Mr Boardman—Thank you very much. There are copies of excerpts from the report.

CHAIR—Thank you.

[9.53 am]

ANGELL, Mr David, Chief Executive Officer, Aged Care Queensland Inc.

BAIN, Pastor Donald Edwin, President, Aged Care Queensland Inc.

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

Mr Angell—Thank you for the opportunity for us to appear on behalf of ACQ. Since the date of our submission—some time ago now—little has occurred to allay the concerns that we had raised in the submission. In some respects, some of the issues have become more prominent and more obvious. I want to touch on a couple of those that we have covered at least in part in the submission. Regarding the first item in the terms of reference, the actual impacts of the 2004 budget measures are becoming clearer, and the misinformation and misunderstanding about the adequacy of those sorts of measures seem to be increasing—the adequacy of the CAP, conditional adjustment payment, and the $877 million, I think, over four years to address wage differentials is a good example. That represents 1.75 per cent of base subsidies on top of the inadequate COPO indexation of around two per cent, meaning a total of 3.75 per cent at present. Common wage rate increases have been running at around the five per cent mark, so the total COPO, plus the CAP subsidy increases, may not even keep pace with normal staff cost increases, let alone allow the payment of competitive wages. For example, nursing wages differentials in the order of 20 per cent currently exist in Queensland and in other states—the percentages vary a little. But government statements and media releases give the impression that the CAP will address the wage differential issue.

Many in the community, and unfortunately many government members, seem to believe that the issue of competitive wages has been solved by the CAP payments. As well, few seem to be considering what happens after the four years, when the CAP disappears. A four-year subsidy of 1.75 per cent that comes with new compliance costs of its own is not the long-term solution to the problem of inadequate indexation and uncompetitive wage rates in the industry. A related issue is the documentation and paperwork which remain a major burden and, indeed, disincentive for staff to work in the aged care area, particularly registered nurses who cop the brunt of the need requirements for documentation.

One of the terms of reference relates to the agency role. Our submission raised the role conflict for the standards agency. Providers and their staff are, I think, understandably nervous about this issue. The relationship between the student and the teacher in an education setting allows students to display knowledge gaps by asking questions and seeking to learn, but providers and staff are concerned that those sorts of knowledge gaps or displays of things you do not know might be followed by a specific investigation when the same auditors put on their auditing hats and fulfil their compliance roles. There is some conflict in the way that they are seen. The relationship between an auditor, a provider, a teacher and a student is difficult and it is hard to get them together. In relation to the standards agency, we still see that sort of role conflict as an issue.

In addition, many providers provide many different types of services under different aged and community care programs—it may be in residential aged care, in the disability area, in community aged care packages, in Veterans Home Care or in HACC services. All the different sorts of programs at present have discrete accreditation and quality assurance schemes. That means that the one organisation providing these different types of services ends up with multiple surveys, multiple compliance and survey costs, and different compliance requirements. It is a concern, too, that all of these different accreditation or quality assurance schemes have to be met. We have suggested a system of compliance that perhaps falls under the JAS-ANZ framework, where it is possible to have auditors accredited to be able to audit a series of different standards. It might be possible to combine some of those roles into one compliance process rather than having to submit to multiple audits, each for different programs. That is a concern we still have. It is a duplication of costs and effort, particularly when many of the aspects of the surveys are pretty much the same: looking at leadership, governance and management processes, as well as the specifics of the different projects.

The Home and Community Care program is a rapidly growing area in which resourcing is simply not keeping pace with demand. Vital issues such as indexation, service growth and the viability of rural and remote services are simply not being addressed adequately. These are major issues that we have touched on in our submission, which are not really being addressed by the current arrangements.

Pastor Bain—Going back to the issue of the work force, we realise that this is one of our biggest problems in aged care—in fact, it is nationally, as we know. Everybody is talking now about the fact that our work force is not going to increase, yet the demands are not going to be the same. In aged care our demands are going to increase about fourfold in the years to come, yet we only have the same pool of workers to draw from. This is a major issue, as David has mentioned. The inadequate funding we receive to pay reasonable wages is a major problem.

There are other problems too. When we are looking for workers in aged care, the average carer today is probably in the 45- to 50-year-old age bracket. Some of these people can go on much longer than that. There are many people in our community who are quite hale and hearty at 50 or 60 years of age and who could be excellent carers in aged care. One of the big problems we face in employing such people is WorkCover premiums. Employers are very loath to employ older workers because of the perceived risk of them hurting themselves or something like that. Our WorkCover premiums today are reaching such astronomical proportions that they distract people from even doing something in this area, yet I believe there are a lot of people in the senior age group in our society who could well be of great value to us in our work force. I know that the insurance issue is a big and complex one, but it is something that needs to be looked at. We know that in other countries—England, New Zealand and so forth—there are caps put on these things. We feel that that is an impediment to employing a work force that we really are going to need.

As David mentioned, another issue is the amount of documentation our registered nurses in the work force have to do. These are professional people. Our problem with recruiting nurses is that they now go through a university course and they come out as professional people with professional expectations. In aged care we tend to sit them down and treat them like clerks—intelligent clerks, because they are having to assess material—and so much of their time is spent doing paperwork. In some cases they are doing work that could be done by other people, but the system demands that they do it. We have had registered nurses last only two or three days in employment and say, ‘This isn’t what I trained for,’ and they leave. So, adequate payment of nurses that meets that in the public health system is one issue.

We have had a slogan for some years which we devised in Aged Care Queensland and which has been somewhat taken up nationally: put people before paper. We feel that that has to happen. The paperwork is increasing. Just when people say we are getting less paper and less this or that, the paper warfare is increasing. We feel that has to be looked at as a most serious issue. As David has mentioned, we now have all these regulatory bodies. We have accreditation for our residential care and our retirement living, and soon for CACP and community care. Some of our staff, particularly senior staff, are constantly on tenterhooks expecting some accreditation body to descend upon them. We have to do a voluminous amount of paperwork not only for accreditation but also for our resident classification scale. The paperwork that is required for a patient in a hospital is minimal compared with the paperwork we have to keep for each resident in aged care. Somehow, all that recording needs to be stopped. I think the way we are paid almost depends on the amount of paper we produce. It does not seem to be a reasonable system. It may be working, but it is a deterrent to employment and a deterrent to us really getting on with the major job of caring for people. That does not mean to say we are looking for lower standards—no way are we looking for that.

This comes to the accreditation system that David talked about. I believe the accreditation system has done wonders for aged care. I think the way it was introduced was less than ideal. In the hospital system accreditation came in over a gradual period of time based upon the ability of hospitals to meet the needs of insurance companies and so forth. If they were accredited, they were supported by contracts with insurance companies. In aged care the whole industry nationally was brought online at one time, with tremendous pressure on the agency and the individual facilities. We had a lot of drop-out at that time because of stress on staff. Now, as we have gotten into round 2 and we are coming to round 3, things are much smoother than they were. But we are finding that people are still on edge, expecting, asking, ‘When will the accreditation period come?’ We have talked to the accreditation agency and we have talked to many of our people, and we think that perhaps this whole system needs to be looked at. Perhaps we need to do away with having organised visits and instead have spot checks. The accreditation agency would drop in at any particular time and take a village as it is, not superprepared for the event.

Another issue is that in the hospital scheme when people are accredited they stay accredited for one year or, in most cases, three years. In our system, not only do we get accredited but we then have support visits, spot visits and so forth. People are constantly being reviewed. We feel that that is almost an overkill and may be overcome by just having spot visits by the agency. The agency is doing its job. It has excellent accreditors. But the system is perhaps not serving us in the industry as well as it might.

There are other things I could say, but I will perhaps come back to them and allow questions. The questions you have put to us in the terms of reference are very comprehensive and certainly highlight some of the major areas that we face—disability, community care and so forth. We have things to say about those, but it may be better if we respond to your questions.

Senator HUMPHRIES—We have heard from you today, as we have heard from some other organisations representing aged care providers, that the nearly $900 million in the last budget has not been enough to deal adequately with the problem of poor pay in your work force. In fact, you have even suggested today that you might be going backwards based on wage demands. Some of the other submissions we have received—for example, today in the Liquor, Hospitality and Miscellaneous Workers Union submission—suggest that there is a tendency for the providers to cry poor despite extra money being in the system. You mentioned that there was a 1.7 per cent increase in the base funding available from those measures in last year’s budget. Will your members, given the problem of your work force and the poor wage parity, be passing on that full 1.7 per cent to nurses and other workers within your work force in Queensland?

Mr Angell—In many cases that has already been done. The industry in Queensland has quite a large number of certified agreements controlling a fair proportion of the industry. Some of those have been negotiated and are being paid. Some of them are in the negotiation phase now. The sorts of increases that are going on there are more than the amount of funding applicable out of the CAP. So in many cases that is already done and in other cases the wage increases that are going through the system are greater than what the CAP provides anyway.

Senator HUMPHRIES—Some of these other submitters suggest—as, for example, the LHMWU suggested today—that we should actually be tying increased federal funding to better outcomes in terms of efficiency, training of work forces and pay outcomes and not simply relying on what we are being told are somewhat varied and disparate results in terms of passing on wage increases. They suggest there should be a tie between the amount of money provided by the Commonwealth—not just for recurrent expenditure, incidentally, but also for capital expenditure—and better outcomes as far as wages and conditions are concerned.

Mr Angell—We have for quite some time supported the proposition that there should be a linkage between costs to providers, which includes the wage component, and what subsidies are paid and what is available through resident fees—the concept of setting a benchmark of what is supposed to be delivered, what it will cost and what income is available to providers. That concept of linking what it costs to deliver—including the wages—with what providers receive is one that we would certainly support. Cost increases, basic costs, what it costs to deliver and what is expected have never been addressed by the current system, and they need to be—even the pricing review did not address that. But linking income with payments to staff and other payments out is a proposition that we would certainly support. It is difficult, though, when you have no base established to say, ‘If you want any more money, then that has to go into more wages only,’ when there are other unavoidable cost increases which are not being met by the funding system either. So we would certainly support linking the two if it is done across all the expectations by providers and the costs to deliver those expectations.

Senator HUMPHRIES—Setting benchmarks of outcomes is one thing; using money which is immediately available to meet legitimate wage demands is another. The Nursing Federation, for example, suggested that there was enough money in the 2004 budget package to bring nurses up to a comparable level of pay and conditions to those in the acute care sector. Now that is not your view, I take it.

Mr Angell—That is a claim that does not take any effort at all to multiply out—1.75 per cent is what it is. It is cumulative, but so are wage increases. There is a much greater differential than 1.75 per cent. How can it be adequate? It is not.

CHAIR—But the 1.75 per cent was to try to bridge the gap. It was not meant to be absorbed into the normal wage increases. What you are saying is that it is being passed on through normal wage increases. Hasn’t it really just become a wage subsidy?

Mr Angell—Providers are providing services with increasing costs of wages and other things much higher than the COPO indexation and have been doing so since 1997. So when you get a COPO indexation that is clearly inadequate to cover cost increases, including wage increases, a bit extra is only going to make it easier to keep pace with that. The subsidies and the income available to providers have not kept pace with general inflation since 1997—they have fallen behind.

CHAIR—I understand the gap is still considerable, but it should have closed it by 1.75 per cent. It has not, has it?

Mr Angell—No. The gap is widening by more than that each year because COPO is inadequate by more than 1.75 per cent.

Pastor Bain—It assumes that our work force would stay the same and that we would put that money into lifting the wages of our existing work force. In many cases, our work force is inadequate and we have been able to employ people only as we have had finance. As David said, we are fully utilising the resources that we have. You have the choice, when you get more money like this, of paying it to existing people and expecting them to work harder or employing other people. We are having money given to us and being told, ‘That is for wages. Do with it what you want.’ It may be that we give it to the people who are not being paid adequately, but the situation becomes a little more complex than that, particularly when looking at employing more people. It is a very good question, and when capital is mentioned and so forth it becomes a very complex one. But we are endeavouring to utilise this money and give it to the people. It is not going to operations, is it? It is going to the people. But it is inadequate, as David said, because we are so far behind the eight ball in the first place.

CHAIR—Potentially it goes to operators if it is just used to subsidise what would have been a normal wage increase anyway.

Senator KNOWLES—Provided by the operators.

Pastor Bain—That is right. But eventually it goes on to the worker, whether that is an existing worker or—

CHAIR—But it is there to bridge the gap. That is the problem that has been identified: if you do not actually bridge the gap over a period of time, you will not be able to get people and maintain people.

Pastor Bain—Exactly. And it is not adequate to bridge the gap, which I think is what is being said.

CHAIR—Not in one go, we understand that. It is not 20 per cent.

Mr Angell—While the normal indexation is COPO based, the difference between normal wage increases and COPO is not being met. So that means that the gap is widening all the time, and this 1.75 per cent is having the effect of closing it. But the widening and the closing of that gap are happening at the same time, so you might get a nil or a widening net just because the COPO indexation does not keep pace with normal rates. If the indexation process were adequate to meet normal wage increases, then the 1.75 per cent progressively would close the gap for sure. But the normal indexation does not keep pace with the normal wage increases.

Senator HUMPHRIES—I want to go to the issue of accountability and spot checks and so forth. We have certainly heard comments from both you and other providers that the level of accountability is excessive and that there is too much paperwork to have to complete and so forth. You can appreciate that the history of this matter is that there has been evidence of very serious problems in aged care facilities in Australia in the past. The report, which I think was in 1994, suggested that there was a very serious problem with standards in aged care facilities and that better data collection had to occur to make sure that it did not happen in the future. It would be helpful to us, in suggesting as you do that we have gone too far, to know exactly where we should wind back, without running the risk of ending up back in the bad old days before that report was compiled. If you have any evidence that you can take on notice to put to the committee about precisely what kind of paperwork you are being asked to complete which you think you should not have to complete and what kind of information you are providing which you think you should not have to provide, that would help us to determine what level of accountability is actually appropriate and affordable.

Pastor Bain—I do not have the statistical evidence to back this statement about what would happen if we were accredited. As I mentioned, in the public and private hospital systems once people were accredited they stayed accredited for three years, or something like that. The amount of paperwork that has to be produced for support visits, for instance, is considerable. If the support system were stopped, there would be a large saving in paperwork. But then your question would be: would standards be maintained? As we suggested, the spot check idea would mean that there would not be paperwork necessarily associated with that, because that is normal performance. The industry is not saying that we should not be surveyed or accredited, because of the days when things were less than adequate. The professionalism of aged care has grown considerably, and in fact it has come from a cottage industry to being a very professional organisation and industry. But spot checks would definitely save us from the paperwork; a spot check system may largely do away with paperwork through accreditation altogether, other than having to do maintain that regular paperwork as part of a proper operation. If we did not want to go that far and if we were to say, ‘Let’s have accreditation and not have the spot checks and things in between,’ that would be a considerable saving right now.

Senator HUMPHRIES—We have had other providers complain about the spot checks as well, of course.

Pastor Bain—I understand that. Our state conference finished just last night. I took the opportunity while there to talk to quite a few directors of nursing about this. Whereas at one time they may have thought that was bad, they are coming around and actually saying themselves that they think it is a good idea. These are people from large and small organisations. The idea seems to be a bit of a worry. But as people are thinking more about it, they realise that this actually could be a good thing. We have not done any assessment of this. We have not got a statistical report that says that 60 per cent would like spot checks, but on an ad hoc basis the evidence that we are gaining is that this would be perhaps looked upon as being very good.

Mr Angell—Just to respond to the question a bit further, it is not the accountability that is of concern, I suppose. It is some of the processes involved and the way that is applied that puts a heavy reliance on paperwork. Perhaps it is not too much in the way of this type of report or that type of report that could be done away with. Perhaps some of those could be briefer. We do not have any evidence here that we can give you this morning to say that these are the things that could be got rid of. But with the invitation you have given, we can certainly have a look at that. Sometimes it might be a modification of the existing rather than just deleting completely. Accountability obviously needs to remain. I think the process of how that is provided and achieved is what needs to be looked at.

Senator McLUCAS—Continuing with that discussion about accountability and paperwork, it has been put to us that reporting by exception rather than reporting every event that occurs is a reasonable alternative. You start with a care plan and you report only the noncompliance, if you can put it that way, with that plan. The other proposal that has been put to us as being useful in reducing paperwork is the increased use of IT. Would you like to comment on whether those are potential solutions that would reduce paperwork, particularly for registered nurses?

Mr Angell—Reporting by exception is not uncommon in health care systems. It is increasing in use in aged care as well. There are some areas where it really cannot be under the current arrangements. We would certainly say that it would be helpful if more of the reporting could be done on an exception basis rather than having to tick the box every time you did something or write a comment every time, with every detail needing to be recorded. So, yes, we would be supporting a direction that relied more on reporting by exception.

The second proposal was IT. Aged care has been perhaps a little behind many other industries in the adoption of IT assistance. I think there is still some reluctance—even by regulators and by the department, for example—to accept some of the IT assistance and solutions, with a fear that it might be doing things more automatically rather than under the control of the staff. So there is a little bit of resistance to that. But I think it has a lot of potential to improve the situation greatly and it also lends itself to reporting by exception. It is easy for it to identify the exceptions and for those then to be addressed properly.

Senator McLUCAS—When you say there is departmental resistance or reluctance, can you give us an understanding of how that has been expressed to you, in a generic sense?

Mr Angell—There is a fear that you might end up with a standard care plan produced by the system, not personalised enough for the person. So the system is producing a standard rather than the staff directing specific things for each resident. That fear exists. There is a bit of a wariness about things like care plans and progress notes produced out of an IT system. I think it is a developing and a learning sort of exercise to get over that. But that has been real.

Pastor Bain—In our industry, as David said, we are behind the eight ball with IT, I believe, but it is rapidly increasing in its acceptance. However, in rural and remote areas we were told at our conference that some people are doing amazing things with No. 8 fencing wire still—they are lucky to have electricity, let alone IT. The fact of the matter is that we have people in aged care in country areas, and there is a big disparity between expectations of the residents and what can be delivered to them. We are already seeing IT being used very well, for instance, in the south-east corner of Queensland and in other areas in care plans and all sorts of administrative things in aged care. If we said, ‘This is the way we are going to go,’ we would have to have a very good education program and guidance program along with it. Undoubtedly that will come and will help us, but it is going to take time. It would almost freak some people out if we said, ‘Technology is going to be our solution,’ because they feel that they have not got it. That is not saying that these people are not good people—they are doing the job of caring for people. But IT one day will undoubtedly help them considerably, provided the personality side of it is not lost, as David has mentioned.

Mr Angell—The nature and history of the industry mean that in both community and residential care there are many small providers. That has meant that the IT developments in terms of systems have focused on the needs of many small providers, which does not give you the savings and economies that exist if you have broader, more capable systems. So the development of IT solutions has been slow because the nature of the industry is many small providers not able to really afford quite capable systems. With the consolidation that is going on in the industry, there is an increasing interest in more capable systems, bigger systems that apply to multisite providers and that sort of thing. So it is improving but it has been slow because of the nature of both residential aged care and community care industries in the past.

Senator McLUCAS—We have heard that there is a company that is developing a medical director type software package that people can use on PalmPilots and then simply download information to their system when they get down to their desks, so that they are not sitting ticking boxes for the next four hours.

Pastor Bain—There are some good systems coming, yes.

Senator McLUCAS—Thank you for your comments about the education and training role of the agency. I think they were well made. It has been put to us, though, that a move to the JAS-ANZ model of auditing would encourage auditor shopping. It has been put to us that people will be able to find a compliant auditor. But a lot of people have suggested that a JAS-ANZ model is a more appropriate one to pursue. In my mind I am asking this question: are people suggesting that we go down the JAS-ANZ model of audit rather than trying to get governments to talk to each other about coming up with one system of audit compliance? Is it the easy option rather than to try and get governments to say, ‘Right, this is how we are going to do it,’ so we do not have a community care organisation filling out eight different types of audit methodology, as we have heard?

Mr Angell—The objective that we would be seeking is getting rid of all these multiple audits, overlaps and that sort of thing. Is that achievable under a coordinated government system? I think it is a long, hard road to get there, so fitting something under the JAS-ANZ system may well be an easier way. It is also a system that was set up by Australian and New Zealand governments originally to address very similar problems—in different industries, granted. It is a recognised and accepted system in other industries and it is a tool that could well be used rather than going down and recreating the same thing again within each government department—because there are a few involved, and there are a couple of levels of government involved in this too. I think it would be a harder task to get all of those governments to agree on a system, and fundamentally the same capacity would exist under the JAS-ANZ system.

In terms of auditor shopping, I think JAS-ANZ is a system that enables organisations to be accredited to audit under different standards for different segments. An organisation that was not complying with different processes risks its accreditation status, so it risks future business if it starts to do things inappropriately. I guess the same potential exists under all the current systems that JAS-ANZ covers at the moment but, if it occurs in an organisation, it is done at the risk of the future of that organisation, so there are some protections.

Pastor Bain—If we went along the JAS-ANZ route, it could of course well be that the current agency has input to that. It does not mean it would do away with the agency—it could be one of the contributors to such a system. But it is an effort to bring all these different types of accreditations together under one system. As I said earlier, I believe the agency has served our industry well—not perfectly, but well—to date and the standards have been lifted. The complexity of all these accreditation schemes now means that it is time to stand back. This is why we are suggesting that the JAS-ANZ model could be looked at as a way of simplifying the system and making it effective, but it is not meant so that people can find soft options. Some may want to do that but I think that, if they go that route, they will trip themselves up.

Senator McLUCAS—Leaving this briefly, there was discussion earlier about the CAP. You are not suggesting, are you, Mr Angell, that we go to CAM and SAM again?

Mr Angell—No, I am suggesting that we need an adequate indexation system.

Senator McLUCAS—That leads to my next question. You are quite critical of COPO as a methodology for providing indexation. Do you suggest an alternative indexation method?

Mr Angell—I think the component of COPO that is the 75 per cent related to safety net adjustments does not cover wage increases and therefore does not allow proper wage increases. So that component of it needs to be related to an index that has some relevance in terms of the wage increases that occur within the industry. There are a number of those wage indexes, any of which would be better than just the safety net adjustment which is part of COPO at the moment.

Pastor Bain—A major part.

Mr Angell—An index of wages that is relevant to the industry is really all we are looking for.

Senator McLUCAS—Is there such an instrument?

Mr Angell—There are records kept of wage increases, yes.

Senator McLUCAS—But we do not have an indexation measure for residential aged care or community care at the moment.

Mr Angell—No, not specifically.

Senator McLUCAS—What you are saying is that you could develop that quite quickly by looking at current wages.

Mr Angell—You could, or you could use one of the existing indexes that have similar types of staff coverage. There are a number of wage indexes that, at the moment, are probably usable and are pretty relevant to this industry—certainly much more so than the part of COPO that applies at the moment.

Pastor Bain—We feel that the COPO index, which may have worked, is not serving industry well now and to continue with it is just perpetuating the problem. That is why we believe it needs to be looked at.

CHAIR—You might like to link it to the wage increase for senators!

Mr Angell—There have been comparisons done with different parliamentary wage increases and COPO is still below that.

CHAIR—I suspect so. Thank you very much for your submission and for your contribution to the committee's inquiry today.

Pastor Bain—Thank you very much for the opportunity.

Proceedings suspended from 10.34 a.m. to 10.48 a.m.

ROBERTS, Mr Anthony Reginald, Joint Managing Director, Village Life Ltd

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

Mr Roberts—Thank you. Village Life is a listed public company that operates in the area of providing managed rental accommodation for the financially challenged aged. Our company endeavours to provide a lifestyle for those members of our seniors community who are not currently provided for in retirement village facilities, mainly because of financial barriers. Our model is a rental model and our market is for people who have low incomes or low asset bases and who are primarily in receipt of the aged pension. We have about 4,000 residents in about 70 villages throughout Australia. Recent research indicated that the average asset base of our residents, of those who elected to complete the survey, was about $50,000. We provide a fully furnished unit, three meals a day, heavy laundry done for our residents and a secure environment with on-site management and a pendant call system et cetera. That is all done for a percentage of the aged pension and the Commonwealth government rent assistance.

The average age of our residents is about 75. That has the capacity to extend out as residents stay in our villages over a period of time. In America the average stay in similar facilities is about five years before they move into a care environment. Primarily, for our residents, it is not a lifestyle choice; it is a stage of maturity in their life cycle where they need some sort of daily living assistance. This can be because they are not cooking properly for themselves or it is difficult for them to look after a house by themselves or in fact they have inadequate housing.

They are able bodied, and we work closely with ACAT in relation to our residents. For example, they cannot be ACAT assessed to come into our facilities. We continue that relationship with ACAT through the period of their stay with us so that if their health does deteriorate or if there are signs of deterioration we work both with ACAT and their family as they are placed in a care facility. In relation to that, we are very conscious that that segment of the community is physically inactive. Socially, to a great extent, they have lost contact with the community because of their isolation and their limited means of transport. Also, to a certain extent, and somewhat as a result of those things, they have lost some self-esteem. We have our Village Life wellness activity program that we are piloting at three of our villages, through diversional therapists, where we want to get our residents more involved in the community and have them more physically and mentally active.

There are three main reasons for people entering into aged care facilities. They are: incontinence, falls and dementia. We believe that with proper partnering in all of those aspects we can address them while people are at our villages and hopefully delay their entry into aged care facilities. In fact, we have an internal goal of keeping our residents for 10 years as opposed to the average of five years. We believe also that, because of the additional social activity, because of the quality of the food they eat and because of the environment they are in, we do already make a contribution to keeping them out of subsidised facilities. That is anecdotal. It is hard to get empirical evidence on that without qualitative research, but we believe it is a realistic goal.

The interesting thing is that our model is based on keeping our residents healthy for as long as possible. To that extent it is consistent and, I believe, totally in line with the federal government’s ageing in place program. Because the facility is the residence of our residents, they still are entitled to HACC programs. They do not lose any of those entitlements. Also, to a fairly substantial extent, both for ACAT and HACC it is a more convenient environment for those services to be provided in.

If you read the HACC reports, you see that one of the issues they have, for example, is a workplace health and safety issue as their people go out to different premises throughout regional or city areas to service their client base. I think we allow them to deliver their services more efficiently in that regard. There is a substantial demand for this, and I think there is a real opportunity going forward to work hand in hand with the government in relation to not only quality of life but quality of health. I think there are real opportunities in relation to preventative activities that can keep these people healthier and therefore out of subsidised facilities for some time.

We have been fortunate in being able to attract substantial investment from major institutions. We also have a listed property trust. So an opportunity probably exists in Australia that does not exists overseas to attract substantial private equity to help solve what I think is really an affordable housing problem, particularly in the seniors arena. We do that by not only having a listed company, which is the management company, but by having a listed trust that holds the real estate, in the main. The units in the trust are owned by our major institutions throughout Australia. So there is a good capital base there to allow expansion and there is clearly demand.

Our market research shows that, of approximately 2.7 million people in the category in Australia today, if you cut away the areas that we cannot penetrate—such as Sydney areas, Melbourne because of land costs and people who will accept the deferred management fee model, and their resident base is different in profile to ours—then there is somewhere between 800,000 and one million people who are potential residents of facilities such as ours, which provides affordable housing with management and certain services to ensure that they get quality of life. Although we are reasonably extensive, with 70 villages and about 4,000 residents, it is only scratching the surface of what we see as the real demand in this sector.

If that demand can be satisfied, whether by Village Life or by other people who enter the arena, I think it has an enormous potential to impact on delivery of health services and the cost of ageing in Australia. I think it is a wonderful target market, because we have here 4,000 people throughout Australia of a similar age and a similar socioeconomic profile being housed and fed in a consistent way that would give an enormous database of information, moving from anecdotal to empirical evidence that this sort of accommodation and services can make a positive impact.

In relation to ageing in place, in our facilities I do not think there is any reason why we could not have an arrangement where, say, up to 10 per cent of each facility could be extended to a real ageing in place so that people at the lower end of the care cycle could receive care, not from

Village Life but from an approved care provider, in situ at Village Life, thus keeping those people—and that is potentially a substantial number—out of the subsidised facilities and in a social environment where they are comfortable if they have moved into a new environment, made friends and established a support network. As you probably appreciate, it is one of the most difficult decisions when the elderly have to be removed from that network and placed into a nursing home, which I think a lot of them see as the step they least want to take—more so if they a couple, of course, and one of them has to be moved. That is a thumbnail sketch of where we are at. If there are aspects that you would like me to elaborate on, I am happy to do so.

CHAIR—I think there will be, so we will move to questions. Senator Knowles?

Senator KNOWLES—I know a lot about Village Life and have had a lot of discussions with Mr Roberts, so I would prefer to hand over to other senators at this stage.

Senator McLUCAS—Thank you for appearing, Mr Roberts. You say you work with ACAT. How do you work with ACAT?

Mr Roberts—If we go into a new area, our tenanting consultants will communicate with the local ACAT representatives. They will do that during the period of construction to let them clearly understand what we are doing, what we are offering and what our services are. I believe our organisation is reasonably well known by ACAT through the areas in which we operate. Sometimes ACAT can be a referrer of potential residents to us because they say, ‘These people may be suitable for your environment.’ We make sure they understand what we are doing, what we trying to achieve, that we cannot take people who are assessed for care and that we will arrange a monitoring process with them, because we have on-site management et cetera, as we see people deteriorate. So the ACAT people will work with our site managers or our tenanting consultants. An advantage in our villages, because people are attending meals three times a day et cetera, is that there are consistent observations of anything that might be a temporary or eventually a permanent deterioration that may need additional services or care.

Senator McLUCAS—So you have an on-site management team?

Mr Roberts—Yes, we do.

Senator McLUCAS—How do you select those people—are they medical people?

Mr Roberts—No. We do not come under the Aged Care Act and therefore we are not a care provider nor can we call ourselves a care provider. Basically, the team come from a catering background because they provide the meals. The next highest criterion for us is that their psychological testing shows very high on empathy. They do not need to worry about the financial management—that is all done from our centralised office. They are there to make sure that the environment is as secure and as comfortable as possible for our residents.

Senator McLUCAS—In your document you say the benefits to government are a delayed subsidy due to later entry into care, but you did say you did not have any empirical evidence to support that.

Mr Roberts—It is very hard to get empirical evidence. There are available testing mechanisms to get absolutely empirical evidence. We have looked at this, and a ballpark figure is something like $5 million to implement it throughout all our villages. It would give longitudinal research probably second to none in the world, using the Brain Resource group or something like that which could monitor progress with simple touch screen tests at each village. There are arguments that people who are diagnosed with dementia have advanced depression. These tests can pick that up to ensure that people who have depression are treated as such and kept out of subsidised facilities and only people with real dementia access those facilities. It is possible to do it, but it is a cost. The question is whether the government would think that is a viable cost and that the empirical evidence from that research would be worth while.

Senator McLUCAS—The second point you made in your dot points was a ‘lower consumption of medical services and pharmaceuticals’.

Mr Roberts—That is with our wellbeing activity program. If that was launched nationally, that is another thing you could test empirically because as people put in information in relation to other tests they could progressively report on what pharmaceuticals they are consuming. I think it is reasonably well accepted amongst the medical profession that if people are more physically and mentally active then the results would healthier people who would require less medication. Again, that is only anecdotal.

Senator McLUCAS—Village Life has not been operating very long in Australia. I should know how long but I do not.

Mr Roberts—Our first village was opened in October 1999. We have opened 70 villages, which I think is reflective of a fairly high level of demand for that sort of social infrastructure.

Senator McLUCAS—You use an American figure for the average length of stay. You cannot provide that information yet, of course.

Mr Roberts—No. About half the residents of our first villages are still there, which would equate to a longer stay than that.

Senator McLUCAS—It will be 10 years before you have real information.

Mr Roberts—Yes.

Senator McLUCAS—Why are the residents leaving who are leaving now?

Mr Roberts—Predominantly to go to a higher level of care.

Senator McLUCAS—Right. And they will go into a residential aged care facility, by and large?

Mr Roberts—Yes, and that will be just managed through the ACAT process. We have not had any issues in relation to that transition because it is a managed transition. It is not as though something happens overnight. Normally, it is a three or four month process as we pick up that initial evidence of some deterioration.

Senator McLUCAS—Do you see any opportunity—I think you alluded to it—to have community aged care packages delivered in Village Life facilities?

Mr Roberts—Yes. There is an argument that Village Life could be a deliverer of those packages. It is not something that we are necessarily embracing now. The way the packages are allocated probably does not quite suit us. I totally understand the way they are allocated: detailed research is done on a regional basis and they are allocated where the demand is. We might pick up some packages in Hervey Bay. So it may be that there is some potential down the track if there is a restructure of package entitlements, if there is the potential to have uniform delivery nationally. We believe there is a potential to decrease the cost of delivery in our particular circumstances.

Senator McLUCAS—I cannot see anything to stop a resident of a Village Life facility receiving the care delivered in a community aged care package that is held by St John's or something.

Mr Roberts—Absolutely. We have three villages very nearby, in Wynnum. If we went down there, I would be very surprised if there was not a community aged care provider on site at at least one of those villages.

Senator McLUCAS—Thanks, Mr Roberts.

Senator HUMPHRIES—I have some questions about how the residents fund their accommodation. You said that you take a proportion of the age pension. I assume that the people who come into the facility are predominantly or exclusively people who are eligible for age pensions.

Mr Roberts—I think about 95 per cent of our residents receive the full age pension.

Senator HUMPHRIES—You also said there is the Commonwealth rent assistance. How much does that work out to be?

Mr Roberts—About $100 a fortnight. That is an automatic entitlement depending on a rental level.

Senator HUMPHRIES—What proportion of the age pension do you take?

Mr Roberts—Our base model is 85 per cent. We would not have a resident who only has the pension—and I think you may understand that that would be an unlikely event in Australia today. The first thing we do is to qualify them on affordability, to explain that there are residual pharmaceutical expenses et cetera. So we qualify them and if they do not receive the pension we counsel them against coming to us.

Senator HUMPHRIES—I see. Are there any accommodation bonds or equivalent required?

Mr Roberts—No, there are no other costs. It is quite transparent and the documents are simple. If we do not perform to their satisfaction or to what they believe our promises were, they simply give us notice and leave.

Senator HUMPHRIES—So a resident who had a house somewhere, who could not live in it or did not wish to live in it, could retain that house, providing they satisfied the requirements for a pension, and occupy a place in one of your facilities.

Mr Roberts—That is correct.

Senator HUMPHRIES—You mentioned the deferred management fee. How does that work?

Mr Roberts—That is the traditional retirement village model where people pay an ingoing payment to buy a retirement village unit of $200,000 or $300,000. There are a number of different plans depending on who the operators are. Depending on when those people exit, a further fee is taken out of the proceeds of sale by the operator, and that is called a deferred management fee. That is almost a unique model in Australia. In America the model is predominantly a rental model, because they hold the view that at that stage of your life it is probably not a prudent capital investment.

Senator HUMPHRIES—Obviously what you are doing is deferring people’s entry into low-care residential facilities, and that is a good thing from the point of view of the cost to the taxpayer. How can government help you to extend that model? What would you like to see government do to help you achieve what you are trying to achieve?

Mr Roberts—Government could help with cooperative research. If the expansion of the wellness activity program occurs, if our fundamentals on that are right and if we can get that fairly substantial group of Australian seniors more physically and mentally active under that program—and launching it nationally is not going to be an easy task and I think it might be something that would qualify for some sort of innovative grant—then I think it is up to the government to decide whether they want to tack longitudinal research onto that. It is up to them to decide if they want to do that research against those activities so that they can get absolute measures on the benefits that might be achieved from that. That would justify encouraging the private sector to expand into this region.

I think we will see a substantially different environment in the provision of aged care going forward. We will see very major institutions involved and the delivery will be different. Our model has enormous potential for ageing in place, and I think there is a potential for partnering with the government. They may want to look at that a little bit more closely. I am not looking for a subsidy, but they may want to do the cognitive research for their purposes. There is an enormous long-term benefit, and it is effectively the only model that is totally in sync with the government’s ageing in place program.

Senator HUMPHRIES—Have you sought any grants of this kind?

Mr Roberts—No, not really. We have had preliminary discussions with the Department of Health and Ageing, and they understand us, but I think we are still a micro issue, relatively speaking, compared with the issues that they deal with. We are a small organisation, but I think they understand us. What they are mulling over in their minds I am not sure.

Senator HUMPHRIES—Finally, do you call residents of Village Life facilities ‘village people’?

Mr Roberts—Unfortunately, that is the terminology given to employees at Village Life.

Senator HUMPHRIES—I see. Thank you very much.

CHAIR—Probably the biggest obstacle you have to serious expansion with this model is really your inability to move into the main population centres, because of what I think you described as property costs. I noticed—I am Victorian—that you have got facilities in some of the developing suburbs on the fringes, such as Carrum Downs and Melton. People actually want to be around communities that they know and feel friendly with and where their families are. Is there any ability to actually move inwards?

Mr Roberts—It is a very interesting question, because there are examples overseas where a fixed percentage of any rezoning is set aside for affordable housing, to match the demographic growth of the country. There is a cognisance of that and a high level of social understanding amongst town planners, but you get—I do not want to pick up any state—states where, for example, they have land banks for housing programs that they are not going to proceed with. There is defence land and there are whole tracts of land, but they go into Landcom or something like that. Their simple goal is to maximise that for the highest commercial value, whereas you would think there would probably be an opportunity there to get the social infrastructure pipeline in place properly. That is the ideal outcome and a very favourable outcome. Also, when something is rezoned for affordable housing, it pegs its value.

The other interesting thing is that, if you look around the Lake Macquarie district, for example, which is a beautiful area on the Central Coast of New South Wales, there are large tracts of land, and the theoretical potential exists for us to take a large tract and build quite a number of villages. We can still make them discrete communities but we can make quite a number and market those into Sydney. The issue there is that you are really transferring a contingent liability from the Sydney local council’s balance sheet onto the Lake Macquarie balance sheet, because there are additional social infrastructure problems for an ageing population. So that is not the solution, and we are conscious of that. We have put in facilities to service the regions where we operate and in fact we are now in discussions with the largest local governments throughout Australia about long-term partnering programs to address that. So it may be a tempting solution, but there are other issues in doing it that way.

I will give one more example, which concerns me. If you take an area like Balmain, which is a long-term labour—with a small l—third or fourth generation working class area, and you look at what has happened there in town planning in 15 years and concertina that into a day, basically they have taken the buses in and said: ‘All you poor old people can’t live here anymore. We’re taking you out because we are yuppifying this area and converting it to units.’ That is a shame but that is happening. I am not quite sure where people are going but they are being pushed out. Some might have been able to sell properties for good value and got a capital asset out of it.

CHAIR—Those who were in the rental market in those areas have clearly been pushed out and were pushed out a long time ago. Commonsense dictates that this transitional model that you have, which is really an assistance model rather than a care model, does take some pressure off, even though we do not have the evidence so far to say so. We do not want to just be pushing out the availability of that model to the outer fringes everywhere either. Senator Humphries asked what the government could actually do to assist. How we may be able to assist is something we should probably consider.

Senator McLUCAS—I want to pick up on something Senator Humphries was asking you about. I notice that you said 85 per cent of your people are single.

Mr Roberts—No.

Senator McLUCAS—Have I misunderstood that?

Mr Roberts—It is something like that. It is more like 75 to 80 per cent. It is in that region. We initially did not think we had a couples market because we thought that one would be looking after the other, but that has emerged.

Senator McLUCAS—You say on the last page of your document:

> Provision for couples is also available.

How does that work?

Mr Roberts—There are two things. Firstly, there is a lead time in changing our plans but we are now building what we call couples units, which are larger units. Alternatively, in the interim, to meet a demand, we will put an adjoining door through two units.

Senator McLUCAS—I notice that rental is based on the single age pension. What happens when you have a couple?

Mr Roberts—There is a couple pension and we take 72 per cent of that instead of 85 per cent. It effectively has the same—

Senator McLUCAS—Even though a couple rent assistance is less than two singles—

Mr Roberts—Yes, but the financial model works. It has effectively the same impact on the couple in terms of their net surplus after we have taken a percentage of their couple pension and rent assistance and the net surplus for a single pension. It is not the same dollar amount; it is the same equivalent.

Senator McLUCAS—I am sorry; I am not following

Mr Roberts—These figures are very rough but, if a single person had $50 left, a couple would have $100 left,

Senator McLUCAS—So the current accommodation model for a couple is two single adjoining rooms with an adjoining door.

Mr Roberts—No. We have couples units in some villages. They are now included in all villages going forward.

Senator McLUCAS—For those ones that were built earlier, do the couples come in as a couple or do you rent one to the wife and one to the husband?

Mr Roberts—Normally one is a carer for the other and they are entitled to separate residences if they need separate residences. Some do sleep in separate bedrooms. Therefore, that is two units. Some take it as a couples unit and have a double bed in one of the bedrooms and have the other room as a spare room.

Senator McLUCAS—I am getting to understand. The norm is that—

Mr Roberts—The norm is that one will be a carer for the other. That is why the couple will come because that is a strain that they need some relief from in relation to food, laundry et cetera.

Senator McLUCAS—Is that a condition of entry?

Mr Roberts—No, it is not. It is just what we offer and what the market wants. So we would not see a capable couple living together who would choose us as a lifestyle decision.

Senator McLUCAS—So essentially they have to have the carer pension before they enter.

Mr Roberts—No. We do have a condition such as that.

Senator McLUCAS—Do you have couples who are on the couple pension and the couple rent assistance payment?

Mr Roberts—Yes, we do.

Senator McLUCAS—Thank you.

Senator MOORE—Mr Roberts, are the people who choose to use your services buying the whole package? So, if they are in one of your centres, is it compulsory for them to be part of the wellbeing program?

Mr Roberts—Yes, what we offer is a package. That means that we have got a similar community mix and the age groups are fairly identifiable. It profiles people who do need that assistance, so it is a package—three meals, laundry service—it is not a menu.

Senator MOORE—What about the wellbeing project?

Mr Roberts—That is a piloting thing at the moment, and there is no cost. We are trying to see if we can launch it. We are not going to charge for it, because there is no obligation to take it. It is just an endeavour to improve residents' quality of life.

Senator MOORE—In terms of that process, people pay rent to you normally—

Mr Roberts—Yes.

Senator MOORE—Is there a process whereby your organisation can ask people to leave if they do not suit your area?

Mr Roberts—Very occasionally. The interesting issue there, if there is a dislocating resident, is the impact they will have on the village and the effect on the lifestyle. Normally that can be done on a counselling basis. If that is the situation, you are more likely than not to find that they are unhappy in the environment and it is a reflection of that. I think that we have had four or five people, out of 4,000 residents, whom you would class as difficult residents. That is really people who dislocate a community.

Senator MOORE—It is just that, as your model is based clearly on the choice of rental as opposed to going into care—I think there is a distinct difference there—you are actually negotiating a rental arrangement with people, and there is always the possibility of eviction. I was wanting to work through how that operates.

Mr Roberts—There is that possibility—and I think there has to be. We see it, naturally, as the last resort. I am sure we have issued fewer than 10 notices to quit in more than 4,000. We have 4,000 residents now, and there are those who have come and gone of their own volition. It is always an issue if you have a difficult resident, because it is dislocating the community. Normally you need a counsellor. We have had some interesting situations—which I would be prepared to discuss in camera—that needed special treatment, psychological counselling, et cetera, in those issues.

Senator KNOWLES—Mr Roberts, coming back to the transitional period, the committee has had a lot of evidence about the difficulty of people living in their own homes and not being able to go from that level of residence to a level of care, when in fact they quite often do not need care; they just need a bit of nurturing, company, good meals and so forth. That is really your target market, isn’t it?

Mr Roberts—Absolutely.

Senator KNOWLES—You try to keep those people fit and well as opposed to seeing them deteriorate in their own home or trying to look after the quarter-acre block. They have minimal cares when they come to a Village Life facility, because they do not have to be involved in that maintenance of the place?

Mr Roberts—That is exactly right. For a lot of those people, before they come, their only contact with the world is the Meals on Wheels visit. Here they come into a social environment. It is quite interesting when they do arrive. They are socially inadequate—men more so, but everybody. We do little things like getting reminiscing groups started so we can get them talking about themselves and sharing. There have been some wonderful stories. There are some absolutely wonderful Australians with stories about what they have done and where they have been. That is one of our great projects. We would love to capture those stories before they are lost to Australia, because they are part of Australian history. It is great to see them improve after three or four months—and to see friendships develop and romances develop. It is a great environment.

Senator KNOWLES—Part of the problem that has been described to us is that there are so many people living in the community on their own—or even sometimes as couples—who cannot manage, and they just get so depressed and they end up being medicated. Do you have examples where, when they go into an environment where they do have company, good food and so forth, they are actually going off medication?

Mr Roberts—Yes. Again, that is anecdotal, but they do. You can see their quality of life and the colour in their faces improve dramatically. For example, when they come in, some people are inclined to eat a little excessively because they do not believe that this will continue, because they have not been eating properly. When they are living alone, it is very hard to sit down and cook a roast and five vegetables for themselves, do a nice dessert and have a pasta and a salad or something in the evening—they just do not do that. So they are surprised about the quality and availability of food. Then, when they settle down in that pattern, you can see that quality of life—but they are still inactive. To take the Wynnum example, if we went down there now, you would be surprised that down there, in three villages, we have 140 residents, because they will be in their rooms. We are just trying to get them out. You will hopefully see groups in there doing some activities in the community areas. It is hard work, but I think it is very important that we achieve that.

Senator KNOWLES—The change in eating must be an amazing thing, particularly if they have been reliant on Meals on Wheels, which only comes once a day to start with. I want to come to another area that I have not previously discussed with you—that is, what happens when someone does have a home and they are entitled to the full age pension and they leave that home, go to a village and sell the home? Previously, of course, the home has not been asset tested, so they have been entitled to a full age pension. What happens in a circumstance such as that?

Mr Roberts—I cannot remember the figures, but I think people can have in the vicinity of $220,000 before it impacts on the pension. So, if they come to us—and they can come to us for a trial—they can keep the house for 12 months and still get the rent assistance. After 12 months, they have to elect to either sell the house or have it asset tested. I think the figure is around $220,000, and they will still get the full age pension. Over that, there is a potential for some erosion.

Senator KNOWLES—At the end of 12 months, when the house is sold for $350,000, what happens to their status in Village Life?

Mr Roberts—Our rent is still just a formula, so we will collect it. As I mentioned to Senator Humphries, we took these figures about six months ago, but about 95 per cent were still in receipt of the full age pension, so we did not have a lot of examples of that—but it may be on the increase. The rent is just a formula. So, for example, the five per cent who are not in receipt of the full pension still pay the same dollar amount, pursuant to the formula.

CHAIR—Thank you for your submission to the committee and your presence today.

Mr Roberts—Thank you very much.

[11.38 a.m.]

EWIN, Ms Melinda Frances, Systems Advocate, Queensland Advocacy Inc.; Delegate, Younger People in Aged Care Alliance

GRIMLEY, Mrs Glenda Clareen, Policy and Research Officer, Cerebral Palsy League of Queensland; Delegate, Younger People in Aged Care Alliance

CHAIR—I welcome representatives of the Younger People in Aged Care 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. 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.

Ms Ewin—Thank you for this opportunity to appear before you today. We are representatives from the Younger People in Aged Care Alliance. It is a Queensland based alliance with over 200 members, which are individuals from the community as well as organisations. In this introduction I would like to point out a number of key items that we raised in our formal submission. The first thing would be that younger people with disabilities are more increasingly being placed in nursing homes as an option. The aged care culture is not one that suits people with disabilities. It is predominantly for aged care and does not suit the needs and the lifestyle of people with disabilities. The impact of institutionalisation on the life of a person with a disability, because an aged care facility is an institution, is detrimental to their wellbeing. The Commonwealth government needs to take some sort of a stance on this and work collaboratively with the state governments to make sure that people with disabilities are not being placed in nursing homes. We would say that special purpose homes, cluster homes and a nursing home that is made for people with disabilities without aged people is not a solution. We would say that people with disabilities should be placed in the community, should remain in the community and not be taken out of the community.

CHAIR—Mrs Grimley?

Mrs Grimley—I am happy to answer any questions, but I do not have anything to add to what Melinda has said.

CHAIR—Could you explain to us the basis of what I gathered was your fairly strong opposition to cluster homes?

Ms Ewin—Cluster homes are a form of institution. They are an institutional practice. They do not give people with disabilities the freedom to live their own lives. They are a service provision that is imposed on people with disabilities. What we are proposing is a person-centred approach and that is not a one size fits all. That means many sizes according to many individuals. So although people with, say, acquired brain injury or mental illness or any other sort of disability who are placed in cluster homes may have a similar disability, it does not mean they have similar needs. It is about the person, not about the disability.

CHAIR—We actually visited what I thought were some fairly good examples in Western Australia. They were not large homes. There was an MS facility which I think had provision for about eight people. There was also provision for family members to be there. There was 24-hour assistance on site, which just would not be viable if people were spread throughout the community as individuals when they need access to 24-hour care. How do we actually balance up the need to provide that care in a more concentrated area? Again, I am not talking about institutions. I think everyone agrees that we are not. I guess the debate is coming down to whether cluster homes are institutions or not. So how do we balance the need to provide those services to groups of people and having it accessible and economically viable to do so?

Ms Ewin—There are different types of care: medical care and personal care. In the main, people with a disability need personal care. Personal care may mean support to get out of bed. It may mean help in turning at night. It may mean something else. It may not mean 24/7.

Mrs Grimley—I work in the area of cerebral palsy. A number of people with cerebral palsy and related disabilities who have quite significant needs associated with their disability live in the community in their own homes. Some of the models that we have had in place have enabled people with very high support needs to live in the home of their choice. It may have been purpose built through a state housing authority. What they need around their personal care is support when they are getting up in the morning. They may also then go out and go to an activity centre through the day where there is some care needed. Then they need support at the end of the day when they come home. Sometimes, if they are not able to go out to a service, they may need some people to come in at key times when they have basic needs, like when they need a meal—those sorts of things. They do not need people with them all the time. Some people might live in a duplex with another person on the other side. That enables you to combine staff supports and those sorts of things around servicing a couple of people.

Most people that we have placed in the community would prefer those sorts of options. Certainly people who have lived in institutions before tend to see some of the cluster arrangements as still being like an institution—they have not had their privacy because they have lived in groups. These options certainly have been available to people who have been able to access state funding through the disability departments in the various states.

There are many models out there of people with very high support needs living in the community. We are proposing to start from where the person is and what supports the person needs, not from an eight-bed facility or whatever. That is not saying that there are not health needs—and often there are—associated with the disabilities, but the health needs can be met through domiciliary nursing services that come in through regular health systems et cetera. Personal carers are very well trained. They certainly do not overstep the nursing guidelines or anything like that. They are trained in the competency they need. They are also trained to, if there is an issue with somebody, call in a nurse. If they need to do a particular technique they are trained and signed off on by a doctor et cetera. Or nurses might actually be involved to come and visit someone. It is really no different to anybody else being out there in the community.

My feeling is that you do not necessarily need to put all the dollars into waiting for places to be built when there are approaches that you can work around in terms of supporting people. Person-centred planning has been in the world since about the 1970s, in the US and the UK. That stuff underpins the disability services acts, both federal and state. The disability area has been doing a lot of this for a long time, but the problem has been that there have not been sufficient dollars to enable everybody to get those sorts of packages. Because of that, people have ended up going to nursing homes if it has been considered a bit too costly or if they are on a waiting list of 500 to get a package. Their needs do not wait that long, so they go to an alternative that is most restrictive rather than least restrictive—and then they are there by default rather than where they wanted to be. That is where I am coming from.

CHAIR—I was just trying to get at whether you have a blanket opposition to cluster homes. The Public Advocate of Queensland earlier today said that there are good examples and there are bad examples—really, it is much of an attitudinal thing with the carers or the staff of some of the cluster arrangements. If the attitude is wrong it could certainly be considered a mini-institution as opposed to an environment that is a home. A similar organisation to yours, in New South Wales, also was very strong in what I thought was a very blanket opposition to any form of cluster homes. They take different names depending where we go, of course. I take from what you said that it is not really a blanket opposition; it is more about having options.

Ms Ewin—It is a blanket opposition to the term ‘cluster’, where you have cohorts of people with disabilities all living together to be able to access service provision. What we would say is that we are not opposed to communities. The Multiple Sclerosis Society is actually building one here now in Brisbane. There are purpose-built homes within that facility for people with multiple sclerosis, but they are not the majority of people who live there—it is actually going to be open to the whole community. So anybody can go and live there, but it has a few people with disabilities living there. We do not see a problem with that. We do see a problem with just singling out people with disabilities and having them all living together.

Mrs Grimley—We have a similar arrangement happening in our organisation with 30 people—that has been the historical number—who missed out on getting support packages to move out of an institution into the community. We have been working at various levels of departments at a state and federal level to move those people into situations they want to be in. Our model is similar to the one that Melinda has spoken about with the MS Society. We have worked very closely with those people and other agencies and the local community. We will be ensuring that we will own some houses scattered through a normal suburb—a housing development in which there are other people living in their own homes and where there are shops and everything else. Two or three people might live in one house and then in another street there might be two or three more people. Then you move people in, so they are part of and participate in that regular community.

In that model, they will have their carers and they will have someone next to them who does not have a disability. They will have reasonable space and are in an area where they can still get together if they want to. They can form associations but they can live in their own homes with one or two others. I do not call that a cluster. Our organisation probably does not see it as that. Because they are going to be participating members of the community we have built that around a regular community model. That is what people and their families want.

That is different to a cluster. I see a cluster as where eight people are congregated together because they may have similar needs and because there is a building there for it. We have started the other way, because we already have a building and therefore we do not need a new one. People want a life. We can make that life happen but still have arrangements for them—and I would not use the word ‘cluster’—so that you can work on how somebody can be supported in a street nearby and if someone is visiting or checking someone’s nursing needs they do not have too many streets to drive to check somebody else: those sorts of things. You would go there and would not know. One house would not look any different to anybody else’s. That is the sort of path that our organisation is going down. But they are not cluster arrangements—I do not think they are, anyway.

Senator McLUCAS—You said, and the data for Queensland shows this, that people are increasingly moving into nursing homes. Your table certainly shows that. Do you have any data that underpins that? Where are these people moving? Is it a location thing? Is it based on type of disability? Is there more information that would give us a better understanding of why that is occurring?

Ms Ewin—I do not have the data here. I have some ballpark figures in my head. The types of disabilities represented in nursing homes include acquired brain injury, which accounts for about 33 per cent; multiple sclerosis, which accounts for about 28 per cent; and intellectual disability and/or other, which make up the rest.

Senator McLUCAS—Physical.

Ms Ewin—We have cases of people in aged care facilities—when we talk about aged care facilities we are talking about aged care hostels as well, not just nursing homes—because they cannot take medication or because of their short stature. In regional areas, this is because there is no service provision in the area. What we are finding with acquired brain injury and also with multiple sclerosis is that people who acquire a disability enter disability through medical practice. That guides people along the medical practice route, which is towards nursing homes. Usually if you are born with a disability you get to know about disability; you know about personal care and those sorts of things and you are in the disability services side of things.

The other thing is that hospitals—and I will not mention names—if they have a person with an acquired brain injury, will say to the family, ‘You go and find five nursing homes. You will put this person in a nursing home whether you want them home or not,’ and that is what the family will do. If the parents or persons involved say that they do not want that, that they want to wait until he has a package and that they want to look after him, the hospital uses other methods to make the family acquiesce to their decision.

CHAIR—What other methods?

Ms Ewin—Going through the adult guardian: taking guardianship off the parents and giving it to the service provider.

Senator McLUCAS—And you have had evidence of that?

Ms Ewin—Yes.

Senator McLUCAS—Many cases?

Ms Ewin—The number is increasing.

Senator McLUCAS—I do not want you to name the hospitals, but is it the culture of certain hospitals which leads people down that path?

Ms Ewin—It would be the major hospitals that are dealing with significant disability. I can name three.

Senator McLUCAS—I do not want you to.

Ms Ewin—I know, but I can name three where it has happened.

Senator McLUCAS—I come back to the question of regional services. I always try to make the point that more of us do not live in Brisbane than do. What are the options for a person with acquired brain injury, say, through a car accident—which is usually the way it happens?

Ms Ewin—That is going to be a hard one. I do not know if Glenda has information on that. John Dickinson from the Brain Injury Association would be able to answer that. I only know what I have heard from him. I think they just have to come to the major centres. There is not a lot available. There is not a lot available for acquired brain injury anyway. There are two nursing homes, Jacana and Casuarina. There is no formal rehabilitation for people so that they can move from high intensity into the community, where they only need personal care. So it a huge hole for acquired brain injury. It is a very unaddressed area.

Senator McLUCAS—You made a very strong submission about a person-centred response. It is very clear what your views are. In the current funding structures, what are barriers to people getting a person-centred response or accommodation care or care situation?

Ms Ewin—At the moment, the unmet need in Queensland is enormous. Last year over 6,000 people applied for packages. Only 100 were given packages. If you acquire a disability, you are on the end of a waiting list and a nursing home seems the best place for you to go to. Once you are in a nursing home, the way the prioritisation process works in the state government disability services is that, if you have a roof over your head, you are supported and you are at minimal risk then you are okay. So if you are in a nursing home or any form of institution then you are at the bottom of the list to get a package for person-centred care.

Senator McLUCAS—What about carer payments? Is there anything in the structure of the carer payment that militates against a person finding an appropriate care situation?

Ms Ewin—No.

Senator McLUCAS—There used to be a problem if your carer did not live with you, in terms of the ability of that person to get a payment.

Mrs Grimley—That is not the case now, the way I understand it. That should not really be a big issue. I think some of the issues are just that the state and federal funding streams are different, and aged funding is different too, with state funding and the funding under the CSTDA. If younger people are living in federally funded nursing homes you sometimes cannot even explore a person-centred approach because the dollars that are connected with that cannot be pulled out and put together in a flexible way to create a model based around both federal and state dollars. Sometimes, if you can put some of that together, you can come up with a viable arrangement. But the funding parameters do not allow some of those things to happen. I am certainly aware—and you probably are, too—that there are some projects that are happening with the innovative pool funding, so it will be useful to find out how some of those have worked. But my understanding was that they are not necessarily long-term solutions and there was only limited funding to do something for certain periods of time.

Senator McLUCAS—There certainly were pilot schemes.

Mrs Grimley—Yes, piloting. That is why I think various organisations did not put in to do those—because they thought, ‘We could do this for a short time and build up an expectation and then leave people flat, with nothing, without any reassurance.’ We also had to have close working relationships with our state governments on that. It really did not give us enough time to get signed off reassurances of things, so it was a little bit difficult in some circumstances.

Senator HUMPHRIES—I refer to the model of accommodation for young people with disabilities that you describe as a very attractive one with a lot to be said for it. I suppose the most significant thing to say against it is that it would be the most expensive model to furnish. The economies of scale that you might achieve in either cluster housing or a nursing home supporting people with high needs are obviously not as achievable in housing that is spread around the community. Do you have any idea of the average cost of a package these days that would deliver the kind of care that you are talking about?

Mrs Grimley—It really would vary according to the needs of the individual. In some circumstances it has been shown that it is not any more costly; it is just that if you can pool resources it is using those resources in a different way. I would not say that overall it is any more costly. With people that have extremely high support needs, it may be. However, with many people you might find that why they are in the nursing home is because they could not get enough care in the community anyway. In fact, it might cost less for some of those people to live in the community because what they need is about half of what they are actually getting in some respects for their personal care. They might only want their personal care in the morning and afternoon because they are also going to a disability service through the day. However, if you are in a nursing home often you do not get out to go to other things, therefore all your care is being provided through the nursing home environment, so it is a very different way of costing things out. I do not have with me exact figures as to that, but I would not necessarily make that assumption. In some cases the costs have been less; in others they have been more. I think there have been a couple of things done whereby people have been able to use some of the funding that was allocated to the nursing home bed and some disability money. There was one model in the ACT. There was a model on which they did some work to use the same amount of money, money that was there anyway, to allocate to people’s living arrangements very differently.

Senator HUMPHRIES—Where was that?

Mrs Grimley—That was in the Australian Capital Territory. Do you have the names, Ms Ewin?

Ms Ewin—No, but we do have a case on the Gold Coast. It is actually a good question. It is one that we ask ourselves. As Glenda said, it depends on the type of care that is needed. On the Gold Coast we have a woman with an acquired brain injury whom we were able to get out of a nursing home without a package. She lives supported in the community with help from service providers, but she still does not have any dollars on her head. It is just about identifying people and getting them out. It is about making sure that you can massage things so that you are not actually looking at block funding of an institution with beds and a number of people that you employ 24/7. You can actually work it in a way that is more cost-effective.

Senator HUMPHRIES—I am familiar with the ACT model because I come from the ACT. In fact, I was once the minister responsible for those services in the ACT. They are generally quite achievable where the level of disability is fairly low. For example, for a mild intellectual disability you can group people together and they can have a fairly low level of support, but it becomes extremely expensive where the needs are greater and the disability is more severe. Exploring those options is the sort of thing that we should do more of—I would accept that point.

Ms Ewin—Would we be able to get back to you on that?

Senator HUMPHRIES—Yes, please.

Ms Ewin—We actually know Zoran from the MS Society. Their president is totally non-mobile and non-verbal. I think she can only just lift one finger or something like that. She lives independently in the community and she would never wish to go anywhere else. They could actually give a dollar figure as to the support that she would need.

Senator HUMPHRIES—I would be happy to get more information about that.

Mrs Grimley—I have another thing to say on that. When people are living in the community you can often involve family and also members of the community around them that know the person well. Some of the dollars that one might have been needed for formal paid care can actually be supplemented because their family or other members of the community are more inclined to do some of the support. There might be volunteer support because those people are seen as part of their community. So it is really about doing it a little bit differently and acknowledging informal as well as formal support assistance.

Senator HUMPHRIES—In your submission, you make the comment:

> YPACA has come to the conclusion that the Commonwealth Government needs to take a leadership role by linking outcomes (ie no of people no longer in aged care facilities who are leading quality lives in accommodation of their choice) to State Funding levels, which ensure that funds are quarantined for this purpose.

I am quite attracted to that view. I assume you are saying that the funds the Commonwealth provides to support accommodation options for young disabled people should be tied to certain performance levels on the part of state governments and that, if they do not achieve that, they do not get the Commonwealth funding. Having put that model forward, there is the danger, of course—isn't there—that, if the states do not lift their game in that respect and do not provide better outcomes, the states might just say: 'Well, the Commonwealth has cut its funding; that's why we're achieving low outcomes, because we haven't met these certain targets that they've set for us.' There is a real danger that the buck-passing will continue with that kind of model, isn't there?

Mrs Grimley—Well, I do not know what you think. I guess there is, but one would hope that in fact, given that the issue is so prominent now, governments would be able to work together to resolve something, given that disability is a state issue but there is funding from the Commonwealth. One would hope that surely people could get across that barrier and try to work something through. That is my view on the matter. Maybe I have too high an expectation.

Ms Ewin—The CSTDA, the bilateral agreement, does address this issue. Younger people in aged care are mentioned in there, and the number of people under 50 that they can get out of nursing homes is part of their indicators. But the point is that the Commonwealth is paying for over 1,270 people to live in nursing homes at the moment. That is Commonwealth money, and the states are not paying for that at all, so it is buck-passing and cost-shifting.

Senator HUMPHRIES—Indeed. But my point is that, if the Commonwealth said tomorrow—as has been suggested by one party that made a submission to us—that it would no longer pay for young disabled people to live in Commonwealth funded nursing homes, the result would be a huge outcry against the Commonwealth government, saying that it was not supporting these young people anymore. It would not be said that the states have to pick up that responsibility; the blame would be on the Commonwealth. So the point I am putting to you is that it is actually a very difficult situation to resolve.

Ms Ewin—It is.

Senator HUMPHRIES—I will just turn to one other thing. You have referred to the problem of young disabled people being in nursing facilities, and we heard earlier today that, in Queensland at least, about 80 to 85 per cent of disabled people in nursing homes are in that age range between 50 and 65.

Ms Ewin—That is right.

Senator HUMPHRIES—So what is the principal problem with young disabled people being in nursing homes? Is it their age or their disability? I know it is a hard question to separate those two things, but what is the more severe problem, from your point of view?

Ms Ewin—It is the disability. Disability does not mean aged care. It does not mean that that is the most appropriate way of looking after a person with a disability.

Senator HUMPHRIES—So even the 64-year-olds in nursing homes who have a disability should be in another sort of accommodation?

Ms Ewin—They really should be, yes.

CHAIR—I will just come back to our earlier discussion again. We have not heard any evidence from people representing nursing homes that they want to take young people or young people with disabilities. You said something earlier about hospitals saying, ‘Go and find five nursing homes and they will take them.’ Why do they take them in the first place? There is no financial incentive to do so. They do not want them there. I am just trying to come to grips with how it actually happens.

Ms Ewin—Honestly, I am not sure how it happens, but it does happen, and we know that nursing homes do not really want to have people with disabilities. I know of a case where an institution was trying to remove people with intellectual disabilities. These were people who had been institutionalised for a long period of time—for the majority of their lives. They placed them in a nursing home, and the nursing home sent them back. They just did not want them; they could not cope with them.

CHAIR—Where were they sent back to?

Ms Ewin—To the institution. There are people with down syndrome who have been placed out of service provision and into a nursing home, and they have drugged them. A lot of them get medicated because of their behaviour. I do not think nursing homes actually want younger people with disabilities. It is not appropriate. They want to walk around, they want to do things and they want to have a life.

Senator McLUCAS—Play loud music.

Ms Ewin—That’s right. They also want to develop and grow. Aged care is more about maintaining the status quo and making life as comfortable as possible. For a person with a disability it is about increasing their skills, developing and having a life.

Mrs Grimley—I am a social worker by background, although I do not work as one at present. I have been in the disability area for many years. I remember back in the eighties, when there were young people who had been in accidents living in wings of nursing homes. There was no way that those people wanted to live there. They even had compensation payments in those days, but there were no options of other places to live. The nursing homes were not really happy with that either. This has been going on for a long time and neither side has been happy.

My concern about building more and more wings of nursing homes and those sorts of options that have come up are that those models have not been satisfactory in the past. If you talk to the real people about it, they do not want to be there—there is no life, they cannot participate in society and it is about maintenance type things rather than being a citizen and participating. People want to do the things that other people at 30, 40, 50 or 60 do. They do not want to be in a nursing home where people are dying, where there are set routines and where you do not get an opportunity to go out to dinner or do the things that other people do. It is not the option that most young people want.

CHAIR—We have not heard any evidence from anybody that suggests it is appropriate to have young people in aged care facilities. Some of the things you are talking about with separate wings are really based on the fact that it is the reality, that it continues to happen in ever increasing numbers everywhere and that that is a better way for them to manage it. I think it comes back to the point that Senator Knowles made with a previous witness. We have accepted it as the norm now, even though it is not supposed to be the norm. We are trying to address an inappropriate situation and make it better without actually fixing the issue.

Ms Ewin—It is a historical thing. In 1986-87 there was a 325-place initiative by the Commonwealth government to try to address the situation of people going into nursing home care. That sort of died; it only lasted about five years.

CHAIR—One of my fears would be that, as the number of elderly people increases over the next couple of decades, the percentage of young people will probably decrease but the numbers will keep increasing and we will think we are doing well, which will not be the case.

Senator MOORE—Ms Ewin and Mrs Grimley, one of the issues is people getting caught out and not knowing their rights or what options there are. Where do people and families go to have their rights explained to them?

Ms Ewin—That is a good point, because a lot of them do not know, especially in the medical area. In Queensland we have a number of individual advocacy groups that may be able to help them, but they have to know that those exist. There needs to be some sort of collaborative thing between the health system and Disability Services Queensland, so that when a person is under threat of going into a nursing home they are called in, so that families know what options are available. I think it should not be left up to each family to find everything out, but that is the case with disability. Families have to find their ways through the system, and that is where people fall through the cracks.

Senator MOORE—DSQ print a little resource information kit. My concern is how people get that and what they do with it when they get it. In terms of community consultation, is there a regular consultation process involving your group? I see that the people who work in your group are the key people in Queensland organisations. Is there some kind of regular process that takes place between DSQ, Health and you to keep working through these issues?

Ms Ewin—We keep harassing them.

Senator MOORE—That is regular! But I mean a formal process.

Ms Ewin—No, there is no formal process. It is just us keeping on going and knocking on the door and saying, ‘Hey, what are you doing about the CSTDA bilateral agreement?’

Mrs Grimley—And they do have some consultations around reform and have-your-say and those sorts of things. Certainly in the current consultation that is occurring on how they prioritise and assess, we have raised this very issue. I could not see where there was an opportunity for this issue to be addressed in the system that is currently being put up. As an organisation of service providers we have raised that to ensure that people with the higher support needs are considered in the proposed prioritisation assessment systems. So, yes, there is constant dialogue, I guess, with government on that matter.

Senator MOORE—A number of times you mentioned the lack of packages and that people miss out on packages. From your professional positions in the organisations you work in, is there enough training and resourcing for people to work as caregivers in the area? The models you all prefer involve having that specialised, people focused plan that has carers either coming in or cohabiting or in some way providing that service. What is happening now to train people to take on those roles?

Mrs Grimley—We certainly do a significant amount of training in our supported accommodation services, and in all of our adult day services carers are trained in personal care issues and lifestyle issues—there are lifestyle workers. That is done within the organisation. We also have a package whereby clients themselves can train their own workers and are involved in the recruitment, which is really quite empowering for people. There are also certificate courses as part of the national competency standards. There are certificate 3 and certificate 4 type courses that people are increasingly being trained in.

Senator MOORE—Through the TAFE network?

Mrs Grimley—Through the TAFE system, yes, and private providers do that also. So there is certainly a lot of training happening. I know in our organisation we do provide significant training. One of the downsides to that is, because of the way funding has come in an individualised way to people, sometimes those individualised packages do not include enough in them to allow for the training of workers. So, in fact, for a client whose worker needs significant training, it is either coming out of some support hours or out of some sort of organisational infrastructure that possibly is not there. Certainly organisations do try and pull together to ensure that they maximise any training opportunities across organisations. They are some of the things. I can only speak from experience in my own area, which is in a state wide organisation.

Senator MOORE—It is a big area.

Ms Ewin—It is similar with smaller service providers as well—the same sort of thing. Usually it is the person with a disability or the family that helps train support workers when they come through.

CHAIR—You gave an example earlier of getting someone out of a nursing home. Can you outline the process that was involved with that and the difficulties you may have encountered.

Ms Ewin—I was not involved with it, but I know the story and I can get all the details to you. It was more a process of finding out what was available in the community. It was a woman helping her sister. She contacted DSQ and another agency—I think it was Headway—to see what was available and where they could fit the sister in. They were able to get her into a house with another person with a disability, and she is able to use the same support workers. That is about it. She has not actually got a package; it was more about finding where you could fit her in, and she received support.

Mrs Grimley—There was also strong support from a local advocacy agency that enabled that whole process to happen.

Ms Ewin—That is right.

Mrs Grimley—Obviously the family did take a significant risk in moving the person out of the environment. However, both the sister and the person were prepared to take that risk, given informed information, and they still felt that that was a much better option than having the person in a nursing home environment where her skills and other things were deteriorating. They have certainly continued to work very closely to try and pick up the pieces in terms of what other support she will need, knowing that she will need a lot more. That is the sort of risk people are taking to try and get other things to happen.

Ms Ewin—A good outcome from that is that her children who were estranged are now part of her life again. They have moved over from Western Australia and are now part of her social support system. I believe she is also going to be engaged soon. So it is a nice, happy story at the moment.

Mrs Grimley—Which is quite different to the previous one of people dying around her and all sorts of things.

Ms Ewin—And the abuse that she suffered from.

CHAIR—Once an opportunity was found, was there any resistance from anybody, like the nursing home or the department, against that happening?

Ms Ewin—No. Another story is of a young woman who had been in a nursing home since the age of 12; she is 21 now. She was exited from the nursing home. They got fed up with her at about the age of 20, so they kicked her out. She was very happy about that because, even though she had a home and some support package around her, she could not actually move into it because she did not have $1,000 a month for particular medical aids.

Mrs Grimley—She had some medical needs associated with her disability and there was an inflexibility in moving the money that was required for the medical aid support from a nursing home environment to where she was living in the community. That was the issue that made her more vulnerable. A young woman of 20 need not necessarily be living in a nursing home to access that money. It would have been cheaper for that young person to live in the community, presumably, and access that support, if there had been some flexibility in terms of some of that support going with her. You do not need someone to be living in a nursing home in order to supply some needs around their health.

CHAIR—This has shocked me, because I understand now that young people are in nursing homes. I guess the only people on my mind up until now have been adults. How does a 12-year-old get into a nursing home in the first place?

Ms Ewin—This particular woman has spina bifida and has been in and out of hospital all her life having lots of operations. It was thought best to put her in a nursing home—for whatever reason; I cannot answer that—at the age of 12. The main consideration for the nursing home was that she took up all of their $1,000 a month budget for aid. At 19 she had a package but she did not have that $1,000 a month to support her so she could leave the nursing home. In the end the nursing home knew this, got jack of it and said, ‘You’re moving. Somebody will have to come through for you. And that is what happened. But she has had lots of episodes in hospital for three or four months at a time.

CHAIR—How many children are in nursing homes?

Mrs Grimley—We would have to look up the statistics in our application. I am not sure whether we went into those details.

Ms Ewin—No, we did not. We tried to do demographics and we put out a questionnaire to nursing homes to identify the people with disabilities living in nursing homes. We had about a 40 per cent response.

Mrs Grimley—We did our own survey.

Ms Ewin—That was two years ago.

Mrs Grimley—I thought we had about a 40 to 60 per cent response from nursing homes and we got some statistics ourselves on that; however, I probably would not give those statistics over at present because that was two years ago and the state government quoted slightly different statistics to what we did. But at least it gave us an indication that there were certainly children living in nursing homes. Just from my own experience, the reason sometimes children with disabilities end up living in nursing homes is that there is a family breakdown because of the high support needs around the child. They just cannot cope. They cannot get enough support when the child is younger and then as the child gets beyond adolescence they grow heavy to lift and some of those sorts of things occur. They do not have enough support and there is a lot of stress put on the family unit.

Some young people have gone into the care of the state department. When the department has not been able to find an adequate foster family or the foster placement has broken down, a child in care can end up in a nursing home because there is no other option. They can also end up in hospital. The hospital will need to exit the child, but the funding department does not always have a family for that child to go to. The natural family is sometimes no longer around, because when the child was taken into care they may have been moved to another town. So you do not even have the natural family around to try and work out something with.

Going back few years, we as an organisation were approached to try and prevent something happening to a teenager. We were working informally with two funding bodies to see how we could support this young teenager, because he was over 16 but still under 18, to live and share accommodation with another adult in the community. We were putting up a submission on how that might work with the funding, because we were a specialised disability service provider and had those models. Unfortunately, the young person ended up with pneumonia and died of it before we could get the plan in place. This happened while he was still in hospital.

I guess what I am saying is that there are ways around it. You can put things in place, even for people with high support needs. But that is how young people often end up in nursing homes. There is no placement, so they go to a nursing home. They attend school and those sorts of things from a nursing home. They may not even attend school. They are often the issues. With their high physical support needs, it is assumed they will need that level of care.

Senator HUMPHRIES—I want to follow up on that issue. You said that you do not have any current figures for the number of children in nursing homes but that you have figures from a couple of years ago. We do not have any others figures to work on, so knowing what the situation was a couple of years ago would be helpful. If you could supply those to the committee that would be useful.

Mrs Grimley—We did that for Queensland. The Australian Institute of Health and Welfare have some Australia-wide figures. There are tables that break down the age groups of people, right through to children. I have seen those figures broken down in information provided by other alliances and groups. I have certainly had some first-hand experience of knowing that either it is going to be an option or it has been an option.

Senator HUMPHRIES—I have seen figures for young adults in nursing homes, but I have never seen figures for children before. I am quite interested to see them.

Senator McLUCAS—I am glad you raised the issue of the person who needed $1,000 in medical aid. I was alluding to that with the question on the barriers for people to access a personal care situation or a person-centred situation. If you think of any other practical but real barriers, please do not hesitate to come back to us. Sometimes it can come down to some very simple funding arrangements that preclude a person moving into a more appropriate housing situation.

I understand your submission to say that we have to do something and we have to do it now. I was interested in your ‘caveat’ almost, at the end of your submission, where I think you say that we should be careful of an attitude of ‘Let’s go and do something different’; that we should be careful about picking a model and de-institutionalising. Did you want to elaborate on that section at all? I think it is an interesting comment, given the strength of your submission initially and then at the end to say ‘take care’.

Mrs Grimley—‘Do no harm’—that section?

Senator McLUCAS—Yes.

Ms Ewin—We know that similar bodies to ours promote a different solution—a solution that we would not be happy with and we know people with disabilities would not be happy with. It comes from a service provider focus. This particular model is looking at the way it can service as many people as possible. We prefer the person-centred model and the way in which that can be realised in people’s lives. That would be our preference.

Senator McLUCAS—Now I understand the intent of it. Queensland has an individualised disability package model of delivering services. That is not uniform across the nation. Other states have different ways of delivering services. It has been put to me—and I do not have a view one way or the other—that that is an expensive way to deliver services to the disability sector. Do you have a view on whether the model is right and whether that is the way that we should use the Commonwealth-state disability agreement funds most effectively?

Ms Ewin—I do not know whether or not it is an expensive way of doing it. It is not totally individualised. Yes, it is for the individual, but it is administered by a service provider. There are a number of people who manage their own packages. For instance, I do know of a case where two people have similar levels of need and one service provider only gets 30 hours a week and the other, which is not actually a service provider but is self-managing, gets 100 hours a week. I think we need to compare apples with apples and often we are not comparing apples with apples. We are hearing what service providers say but not what actually can be done with money and how it can be far more cost-effective. I think with individualised funding, as long as it remains with the person, the person has a sense of their own identity and what they can do. If you are in block funding, you can be exited from a service, whereas with individual funding you remain your own person and you have that follow you. The only thing is that it does not follow from state to state, which is really quite a human rights issue as well.

Mrs Grimley—I would say that there needs to be a variety of funding approaches—again, not one size fits all. I have seen individualised funding being extremely effective in terms of people moving out of institutions in Queensland in the disability area. The people are now living in their own homes and are actually having a life. I certainly know with our organisation that not everybody got enough to move out, even in the nineties, and we actually put together bits of block funding and did all sorts of things to make a life for people. Some of their packages then became not viable and we had to go back to our funding department and say, ‘These are not viable,’ and renegotiate some viability funding for people so that they would not be compromised in any way or at risk. Certainly things like that have been done. When you have a variety of funding approaches, both individual plus some capacity or block type funding, you can then start to work things through for people, so it does not have to be all of one and none of the other.

I would not want to see the individualised funding go because it certainly has some advantages. Where people have been able to drive their own funding, it has been great for people to have that independence and be able to recruit their workers and make some decisions around that, and also for service providers to do the juggling to support people here and there. I certainly think that DSQ at present are looking at all those different approaches to see how they can maximise on the right approaches—and, again, it is not one size fits all.

Senator McLUCAS—It was put to me that the first year of a person on a package is a very expensive year because that is the year they are essentially recuperating, especially for acquired brain injury, to be frank.

Ms Ewin—It could be.

Senator McLUCAS—There is a high medical need. The costs after that first year do actually decrease, but the current structure of the DSQ packages does not necessarily allow—and I think it would be quite difficult, to be frank—a decrease in the level of funding as the need decreases. I cannot make a judgment on whether that is correct, but I would be interested in your comments on how the packages work for people with disabilities.

Ms Ewin—It depends on the disability. That is interesting. Acquired brain injury is different because of the rehabilitative nature of the injury.

Senator McLUCAS—That is right.

Ms Ewin—Individualised funding is seen by people with disabilities as being a step towards independence, a step towards reclaiming their own lives. As Glenda said, a lot of the packages are not big enough and they rely on extensive family support as well. But it gives them their own life. I think the accountability required for the individual funding also makes it a little bit onerous as well. Sometimes because you have a disability you must use disability services whereas you may really just want somebody to clean your house. You do not want a support worker to clean your house; you want to pay somebody in the community. But they tend to say that you have to have a disability type of thing. So it might be the accountability that is placed on them too that makes them less flexible and more expensive.

Mrs Grimley—And a bit more restrictive. You might be able to do it differently with either the same amount of money or less. It is a matter of being a bit more flexible. I do not work in the area of acquired brain injuries as such, but we have taken on some support for people in those circumstances—certainly with one child in a rural area. The child could not go back home to the mother when he had a severe accident. We came in with the department and provided a model of support where the child could live in an out-of-home situation for part of the time and then back with the family. We costed out a package of support with the department that would have been higher, certainly for the first year when the child was in temporary care as well. Gradually, we worked with that department to reduce the amounts. You often do not know how that is going to work until you assess the level of need and put that in place. Then, on that basis, the department came back and we kept reviewing. We put up set-up costs and then the next year it is less. You get down, then, to a level where the person stabilises in terms of what you think their skill development and maintenance is going to be. Then you get a more realistic view and you reduce that to something that is going to be viable. That certainly was the ideal way to go as opposed to the other way I was saying—where we knew people had higher needs than we necessarily had funding for but we did everything we could, combining different sorts of funding; then, when it started to get not viable, we had to come back and advocate for that. Fortunately, during viability rounds of funding, we were able to get some support for those packages. So there are different ways of doing that. But rehabilitation post an acute injury is not the area that I come from. I can understand that there would be some issues with some of those.

Senator McLUCAS—Was the out-of-home care situation for that child in a foster home?

Mrs Grimley—No, because we were working to get the child back into the family unit. We happened to have some residential flats in our area at the time that were fully wheelchair accessible. We employed carers who supported that young child in that environment. Then he went to school and for so many nights a week the child then went back to his mum overnight. A carer then went through the night until the mum was sure that she could care for her child and had developed skills and felt more assured. We did a combination of things: the school, the at-home arrangement—because the mother was working as well—and then some care in her own home. This is really what a person-centred approach is: you structure an approach around the specific level of need.

That model would not work for someone else. If you came up with a model and said, ‘Let’s all fit that,’ it would either be too expensive for some or not enough care et cetera. So you would not set up a residence for all children in those circumstances or in an area. It would not make sense. You are far better to do it for one, work out that plan and then work closely with your funding body in terms of what is required for set-up. In that one, we had to train carers and we needed particular equipment. We needed to see that the equipment the child was using was the right sort or if we needed something else as he started to recuperate and build up skills after that initial loss of skills from the injury. We needed to know where it was going to plateau out and he was growing—there were a whole heap of things. That is how you build all of those components in. Certainly, it can be done. There is a tendency for that to drop, naturally, once all those things come into play.

Senator McLUCAS—And the funding to support that child was essentially DSQ funding?

Mrs Grimley—It was DSQ and the Department of Families, as it was at the time. It was done because the child was in care or likely to be in care. We worked with those two funding bodies. The statistics go through the CSTDA on those sorts of circumstances, but the funding now comes through the Department of Communities.

Senator MOORE—I have a question about respite services and, when you actually achieve a package arrangement and you have that working through, the availability and openness of respite services. One of the things I have heard about is that even people who have been able to achieve some sense of independence and go into any kind of available situation, as soon as there is a need for respite for any reason, I have heard of them going back to the home and going back into formalised care. I wonder whether you know about circumstances like that and whether there are alternatives you know of. I see there are lots of people in your organisation who have given great evidence about respite in other areas. I want to get something here about the availability of respite services across the board in Queensland, just for the record.

Ms Ewin—I think it is as you say—either they go home or they go into an institution or hospital.

Mrs Grimley—There are some respite services. Certainly, there is a deficit in the funding of respite services for adults with disabilities. There is not a lot. Our organisation is not actually funded for respite for adults, as such.

Senator MOORE—Not at all?

Mrs Grimley—No, not respite type models; it is accommodation models for people to live in a community. We also support some people with their personal care, where they live within their own families. We are not currently funded for out-of-home, staying overnight type stuff. We do provide a centre based program for people. That could be equivalent to something like a day respite, where people go to a centre based service and have all sorts of community activities and things that they want to do. So there is that centre based component. There again, those services are block funded. Unless someone comes with some individualised funding for that, if you get a new referral it is often very hard to take somebody into those arrangements. I think younger people with disabilities often end up in day respite services—they might be HACC funded—that are actually for elderly people as well. That is part of the real problem in Queensland.

In the children’s area, the way we provide the support is in an in-home way for the families, so the respite hours are put into the home. Sometimes there are some host family arrangements. Again, most of that is block funded. Very little of that comes in an individualised way, so agencies prioritise and look at who they can provide that support to. We sometimes do some camps and things during school holidays for children with disabilities and their brothers and sisters. We try to pool some money to do some innovative things like that during school holidays where it is difficult for children with fairly high support needs to access some of the generic recreation programs. There is not enough support for that. Sometimes we might give a family some dollars, because of the way that funding works, for them to have a carer and support so the child can go to a regular activity during a school holiday. So a variety of things happen but there is never enough, of course. There is quite a lot of ‘under met’ and unmet need. That is our own experience, anyway.

Ms Ewin—The Multiple Sclerosis Society offers respite for families, but usually if a person does not have enough support then they go back to the family for a day or two or the family comes into the home and provides that support there as well.

CHAIR—Thank you very much for your submission and your very useful contribution today.

Proceedings suspended from 12.44 p.m. to 1.59 p.m.

HATCH, Ms Sharon, Coordinator, Mobile Attendant Care Service Inc.

MEYERS, Mr Darren Stanley, President, Mobile Attendant Care Service Inc.

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

Mr Meyers—What I would like to do is give a brief history of the service and then I would be happy to answer any questions you may have. Mobile Attendant Care Service, referred to as MACS, started in 1992. The catalyst for the development of the service was that there were three group homes run by what is now the Spinal Injuries Association of Australia. You had within each of those homes five people with a fairly high level of disability who had lived in those homes for some time. However, a change in the funding approach, from a group-funding approach or a block-funding approach to a more individualised approach, gave people the opportunity to consider moving out into their own homes. Of the people who lived in those houses, a majority at that time had had spinal injury. There were some people who had been born with disability, but primarily they were people with spinal injury. So most people either lived with their family or had lived in a nursing home and moved to one of those group homes, or had lived by themselves and then had an accident which meant that the only realistic form of accommodation was to be in a group home.

Most of those people had been used to either having someone living in the house with them or having had people stay overnight in the house so that, should they require any assistance during the night, there was someone they could call upon. The opportunity to move into your own home raised the potential risk of being in your own home and having something happen during the night and not being able to call upon someone to assist you. So we got together as a group and formed a steering committee and contacted a number of other organisations that had people who were in a similar situation. We put together a proposal to start a service that would assist people within, say, a defined geographical area at any time during the night.

The basic element of the proposal was that you have a carer, an attendant, with a motor vehicle and mobile phone and they would visit people in their own homes as required and in a number of instances on a prebooked basis, or on an ad hoc basis, so if something happened during the course of the night you could call upon someone for assistance. That is basically how it started. It started off with just one attendant working from 10 p.m. to 6 o’clock in the morning. Over time, as demand for the service grew, we put on another attendant, so we had two vehicles both operating from 10 p.m. to 6 a.m. As the service progressed and became better known, we eventually put on another attendant working from 10 p.m. to 2 o’clock in the morning to cope with that late-night demand. The basic geographical region which we worked within was the north side of Brisbane and we have been going for something like 13 years now.

The types of assistance we provide are basic issues of comfort at one end of the spectrum through to dealing with some sort of catastrophe during the night, whether it be a personal hygiene or incontinence problem, where there would be someone there to assist you. Rather than in some cases, which possibly could have been the case, people being in discomfort for eight to 10 hours, there would be someone there to assist them and they could go on and get a good night’s sleep.

The basic tenet of delivery was that we would focus in on providing short, sharp visits that were really about enabling you to get a good night’s sleep; it was not about a block of time. For example, if you have support from a day service now, you would tend to find that you would be getting blocks of assistance which would be at the very least one hour or possibly two or three or four hours. Ours was about someone coming in and giving the amount of assistance required, which could be anything from five to about 20 minutes, which is what we like to have as the maximum, although in some instances we do go beyond that.

So, as I said, we have been delivering that service for 13 years now. As far as I am aware, it is still fairly unique, certainly within Queensland. I do know of one other service that is adopting our approach in Victoria, but it is not yet up and running.

Senator KNOWLES—That is a fascinating story and one that is very heartening, I have to say. Why hasn’t it been replicated? You are working on the north side of Brisbane. I have looked at your map and even though I was born here it is a few years since I left, so I do not really get a complete understanding of exactly how far that goes. What geographical distance are we looking at with your map?

Ms Hatch—I cannot say in kilometres. If you know Brisbane, it is basically from the Brisbane River to Chermside and from The Gap to Ascot—all those inner northern suburbs.

Senator KNOWLES—I know the names of the suburbs, but maybe someone could give me an idea in kilometres. Are we talking about a 10-kilometre radius or a 20-kilometre radius?

Ms Hatch—Yes, I would say about 20 or 25.

Senator KNOWLES—That is interesting. If it can be done in the north, why has it not been done in the south?

Ms Hatch—We currently have four shifts that operate every night, with 12 attendants covering those shifts. We have one shift that commences at 6.30 at night and finishes at 12.30. We have another shift that starts at 8 p.m. and finishes at 2 a.m. and, as Darren said, two that start at 10 and finish at six. So we cover basically from 6 p.m. to 6 a.m.

Mr Meyers—There are organisations that were seeking expressions of interest on the south side, in particular. I am not sure what came of that. But whenever I speak about the service—and I have made a few visits to Victoria—or speak off the cuff to anyone, they say: ‘What a great idea. Why isn’t this replicated? Why don’t we hear more about it?’ I know that people were expressing an interest in Mackay about running something similar. Also, at a conference I was at, I knew of another group who were, I think, setting up something in Canberra. You hear about these things from time to time. I cannot remember the name of the lady in Canberra, but I think it was a funded project. But I have heard nothing more of that.

Ms Hatch—I believe the Cerebral Palsy League has just put in a submission for funding to cover Pine Rivers, basically from where we finish in The Gap northwards. So there is a corridor through there—Taigum and around that area. They are looking at establishing a service, and I think they are looking at going from 10 p.m. onwards.

Senator KNOWLES—I see. Your funding comes from Disability Services Queensland, from Queensland Health under the Home and Community Care programs and from donations. What is the breakdown of that?

Mr Meyers—The two services which we operate from 10 p.m. to 6 a.m. are funded by DSQ. The services that we run from six till 12.30 and from eight till two are funded through the Home and Community Care program.

Senator KNOWLES—Why is there a distinction of that kind? Is that just to fill in the gaps that were there?

Mr Meyers—An accident of history? You go where the money is. HACC knew of what we were doing. At that time, we wanted to expand the service. I think that the precursor to DSQ did not have the funds, or we had an application that was not successful. We spoke to someone with HACC and they said: ‘Come to us. We’re more than willing to help you out in this instance. We think it’s a good idea.’

Senator KNOWLES—What is your source of donations; do they come from users of the system or the community generally?

Mr Meyers—We do not have a high donation base but we do have a fee-for-service base. It is a combination of specific instances where DSQ calls us in to help people and our fee-for-service policy of encouraging people with compensation payouts or individualised support packages, which include a specific component for overnight support, to make a contribution where they can; but we do not necessarily say, ‘We’ll exclude you from the service.’

Senator KNOWLES—How much is that generally? I see here a payment of $5.50 annually to become a member of the organisation; I presume that payment is not made as a recipient of care.

Mr Meyers—No, it is not. Because we are funded on a block-funding basis, we have a capacity to assist a certain number of people. That assistance is neatly stratified into probably three different areas: people who receive assistance every night; people who receive assistance on an intermittent basis, maybe once a week; and people who receive assistance on an irregular basis, who just call in when they need support. We have a certain capacity as to the number of visits we can make on any particular night; I think it is something like 47 visits a night. But, of our group of approximately 50 people, you will find that about 20 need the service regularly. That means there are another 30 who we could call in on an as-required basis. When we do charge for our service it is on a kind of marginal cost basis, which is about $28 an hour. Would that be right, Sharon?

Ms Hatch—Yes.

Senator KNOWLES—I have a million questions I would love to ask, but I had better let my colleagues have a go.

Senator McLUCAS—I notice that the people you employ do not have any training other than a first aid certificate, and I can understand why that is the case. What happens if someone calls in and essentially the requirement is more than personal care? What happens with referrals? How do you train your personnel so that they know when the issue is more than they can deal with?

Ms Hatch—Initially, when I interview people who are accessing the service, their support needs are very clear; however, as Darren has said, some people will ring in out of the blue. Part of our criteria for accessing the service is that the person can direct or tell staff what they require. We do not provide medical assistance; it is very basic personal care support. But a person must be able to direct the staff member, whether verbally or nonverbally. That is basically how it is done.

Mr Meyers—Are you thinking of where there is, say, some sort of medical emergency?

Senator McLUCAS—Yes, if someone perhaps had a heart attack or something like that and rang MACS.

Ms Hatch—They would ring an ambulance. When staff are trained they are informed that, should they be called in for an emergency that is beyond basic personal care, an ambulance must be called.

Senator McLUCAS—Have you had difficulty with insurance?

Mr Meyers—We do not have difficulty getting it, but we have had difficulty paying for it—particularly in the last three to four years. Fortunately, we have just received a viability funding increase, which came about primarily because of insurance. Our insurance went up by something like 100 per cent and we really struggled. We have not had any major issues with claims in our entire 13 years, other than some compensation claims for soft muscle tissue injuries and that sort of thing. Also, because we operate on an overnight basis, we have people working what are shift hours. So we have had a couple of car accidents, which I think can be put down to tiredness and those sorts of things. But we have had no major claims as far as insurance is concerned.

Senator HUMPHRIES—You have said that there are 20 clients or so who receive regular care.

Ms Hatch—It is 27.

Senator HUMPHRIES—If neither you nor anybody else were providing that care, would you imagine that most of those 27 clients would need to be in some kind of residential facility?

Ms Hatch—Quite a few would be in residential care, yes. We conduct an annual survey of our service users and one of the questions is: ‘If MACS were unable to provide support, what would you do?’ That has been the response. We had the same response when we put together a book about the service. A lot of feedback from that was from people who use the service and that came up—that, if they did not have our support, either they would be sleeping in a wheelchair, as they did before we started, or they would be in residential care.

Senator HUMPHRIES—Can you extrapolate from the numbers within the region you cover what number of people across the rest of Queensland might need or be able to use this service if it were available to them?

Ms Hatch—I do not have those figures, no.

Mr Meyers—I could make a guess. I am intrigued. I raised previously my knowledge of a service that was canvassing putting up a service on the south side. I did not know about the Cerebral Palsy League, but another group was trying to start a similar service in the Redcliffe-Pine Rivers area as well. Basically, anyone with a reasonably high level of physical disability, whether it is quadriplegia or muscular dystrophy, would benefit from this service. In particular, those contemplating moving from a family environment—where they have elderly parents or they rely on relatives or volunteer support—into their own home could do so with more confidence if they knew such a service was available. To some extent, it is all about conditioning. People, particularly those with a disability, are conditioned to accept their lot and think it is too much to ask others for certain services to be provided and are happy to accept what they are receiving.

Senator HUMPHRIES—If one of your workers is in someone’s home and observes other problems associated with that client—such as evidence of poor nutrition, even evidence of abuse by a carer or something of that sort—what protocols would you use to take up problems of that sort? Are there privacy problems with you referring matters to other service agencies or authorities?

Ms Hatch—Generally there are. However, our practice would be that staff would inform me if they were aware of anything. Then I would probably talk to the person and basically, with their permission, contact other agencies.

Mr Meyers—An underlying premise of the service is that we are there to assist people and people direct us. So we tend not to presume too much about how people live their lives; it is really up to them. However, if there was a clear case of abuse or some sort of criminal situation, we could not keep quiet about it and obviously would observe the proper privacy protocols.

Senator HUMPHRIES—What proportion of your clients have an intellectual disability as opposed to a physical one?

Ms Hatch—A very small percentage, and it would be a mild intellectual disability. Our people predominantly have a physical disability.

Mr Meyers—Our basic funding parameters were people from zero to 64 and, as an integral part of our service delivery, a capacity to direct and take responsibility.

Senator HUMPHRIES—What is the average age of your clients, roughly?

Ms Hatch—About 30 to 35.

Senator HUMPHRIES—You do not tend to have an older age group—why? Is it because they tend to need more care when they get older?

Mr Meyers—The funding guidelines.

Ms Hatch—The funding guidelines are ‘up to age 64’. However, if somebody has been accessing the service for quite some time, we would not turn around and say, ‘Well, sorry, you’ve turned 65; see you later.’ We would continue to provide support until such time as the issue was age related and not just about physical disability.

Mr Meyers—We have had a number of queries over the years from people who are not so much physically disabled as elderly with the attendant physical deterioration who have wanted to access the service. I am not sure about the exact politics of it, but I know that built into the agreements that we have with DSQ and HACC is that we are there to assist predominantly younger people with a disability.

Senator HUMPHRIES—I come from the ACT, and I am not aware of a service like yours operating in the ACT as yet. Do you know of any other places in Australia where a service like this operates?

Mr Meyers—I mentioned the potential for a service to run in Victoria and Melbourne. All the feedback I get is that it will be getting up; it is more likely than not. I think that will be in the Caulfield North area.

Senator HUMPHRIES—But you are presently unique?

Ms Hatch—I believe there is a night-time service similar to the MACS model operating in Western Australia. However, they do not accept call-ins, so the people who access that service have scheduled visits. The service does not have the capacity to take call-ins, which we do.

Senator MOORE—How do you recruit your staff?

Ms Hatch—Generally through newspapers—

Senator MOORE—Just in normal advertisements?

Ms Hatch—Yes. We use local papers like the *Courier-Mail*. We also use word of mouth and place ads on Job Search, but the responses we get are pretty much the same across those three. We also go through the university.

Senator MOORE—Do they come on probation to see how they fit in?

Ms Hatch—There is generally a three-month probation to start with.

Senator MOORE—Do you have problems getting your staff, or is there always good demand?

Ms Hatch—There is not as much demand as we would like. It is difficult. Initially we train staff for three nights on a buddy system, and then there is a supervised night with me or the assistant coordinator. Then we will generally get feedback from the service users and the new staff member to see how they feel. If the service user feels confident that the person can handle it—because, being a night-time service, we cannot have someone running off home in the middle of the night—and if the feedback is all positive, then the person starts doing it by themselves. There is some difficulty getting people, particularly for the 10 p.m. till 6 a.m. shift. It has not always been like that. I think because of the low unemployment rate at the moment and other issues with people's commitments and whatnot it can get difficult. However, it is probably more recently that we have had the most difficulty.

Mr Meyers—It seems to be a little cyclical. We get some really good people who are really committed to us and will work with us for a number of years, then we will go through a phase where we will lose a few people and it seems to churn for a little while, and then we get back to a reasonably steady number of people working for us. However, we have had to do an awful lot of recruitment in the last six months.

Ms Hatch—I think a primary part of that is the disability support workers award, which is probably okay for people who work during the day, but for a night-time service the hourly rate is not really attractive.

Senator MOORE—I should know this, but what is it?

Ms Hatch—It depends on the level. Generally we start people at level 2.1, which receives $15.35 an hour on weeknights and $20.02 an hour on weekends.

Senator KNOWLES—This might sound like a completely and utterly ridiculous question, but if people need help at night why do they not need any help during the day?

Mr Meyers—They do. Most people will be receiving funded support during the day for their morning support, which in most cases will be two to three hours to get out of bed, into their chair and ready for work, study or whatever the case may be. Most people, depending on their disability, will have some funded support for lunchtime assistance, evening meal assistance and assistance in getting to bed. That normally operates within a six to 10 pm time frame. You will find that most services providing daytime support will operate within those parameters. That was one of the things that really brought about the need for this service. Like everyone, disabled people's lives do not operate neatly within those parameters, so we aim to provide a complementary link to what the daytime service providers were providing. I was talking before about how daytime support is normally in the form of a minimum number of hours. We wanted to adopt a different approach where you call in and get the assistance as needed on a five-, 10- or 20-minute basis rather than being locked into a certain amount of time.

Senator KNOWLES—So those who require spasmodic assistance presumably have people at home with them at night. They may have someone at work during the day and so be in need of help, but they do not necessarily always require help at night. Is that the case?

Mr Meyers—You will find there is a range. That is where there is almost a bell curve. You have people who require two to three visits a night. I think we have one person with a very high level of physical disability who has four visits a night. Then you have some people who require no assistance at all for months but, on one particular night, they might go to bed, wake up at two in the morning and realise their chair is not on the battery charger and they have to go to work the next day—or they may have had a high level of muscle spasm and find that they have half fallen out of bed and are about to fall on the floor, and they can just hit the memory button on the phone to call someone to get them back into the bed and get on with a good night's sleep.

One of the beauties of the service, I think, is that we offer a very broad range of assistance. It ranges from the absolutely critical emergency, potentially a life-threatening situation, through to people who may go out to a party, get home at two or three in the morning and call MACS, and there will be someone there to assist them within 20 minutes to go to bed rather than having to sit in their wheelchair for the rest of the night. We have one person who trains racehorses and gets up at 10 to four each morning and goes down to Doomben to train his horses. He does that basically seven nights a week. So it offers a broad range of services, from the absolutely critical to the absolutely magnificent lifestyle sort of opportunities as well, all in one package.

Ms Hatch—To add to that, we also have two young brothers in their early 20s who have quite high support needs. They have had their parents, mainly their mother, providing support as well as a day service provider. Their mother and father were getting up twice during the night to assist both these brothers with oxygen, turning and things like that. The father worked, so that would have a huge impact on both of those people. Initially, we were called in one night a week to give them a break so that they could sleep through the night. We now assist them seven nights a week, so the mother and father can sleep seven nights a week without getting up during the night. Should the service have some difficulty with staff or something, they are in the position where they will provide that visit if we cannot get there. I think that has a huge impact on how they continue with their relationship as a family.

Senator KNOWLES—And their quality of lifestyle. To piggyback a final question onto one of the questions that I think Senator McLucas asked about qualifications: I notice that the attendants can dispense their tablets for them. In hospitals we have this huge demarcation as to who can and cannot give someone a tablet. Have you run into any difficulties with the giving of tablets?

Ms Hatch—We have not run into difficulties. We have an agreement with people who are registered with the service that all medication must be clearly labelled. If a person requests more than perhaps was on the label, we would then, in consultation with the service user, have a letter from a doctor saying that, although the label says four, in a certain situation they might be able to have five. But our guidelines say very clearly that medication must be clearly labelled—even natural medicines can be labelled by a naturopath. Generally, it is a matter of getting the bottle, checking with the person that that is what they want and either handing them the tablets or placing the tablet on their tongue, but we do not provide medications through syringes or anything like that.

Senator KNOWLES—Thank you.

CHAIR—Thank you very much for your submission and your attendance today.

[2.32 p.m.]

GRAHAM, Ms Valda, Assistant Secretary, Liquor, Hospitality and Miscellaneous Union

LEGGIERI, Mrs Sandra Kaye, Delegate, Blue Care, Liquor, Hospitality and Miscellaneous Union

MORGAN-HARRY, Mr Ronald William, Delegate, Salvation Army, Liquor, Hospitality and Miscellaneous Union

ROSENBERG, Mr Stanley Martin, Delegate, Blue Care, Liquor, Hospitality and Miscellaneous Union

SLATER, Ms Jane, Delegate, Anglicare, Liquor, Hospitality and Miscellaneous Union

CHAIR—I welcome representatives from the Liquor, Hospitality and Miscellaneous Union. Do you have any comments to make on the capacity in which you appear?

Ms Graham—As of today, I am the Assistant Secretary of the Liquor, Hospitality and Miscellaneous Union. I was previously the organising coordinator for aged care.

CHAIR—Congratulations.

Ms Graham—Thank you.

Mr Rosenberg—I have been employed by Blue Care for approximately the last four years as a maintenance officer, which means I am part of the support staff.

Ms Slater—I am employed by Anglicare in aged care and have been a personal carer for about 2½ years.

Mrs Leggieri—I am a delegate with Blue Care and I am employed in the community field as a personal carer.

Mr Morgan-Harry—I am employed by the Salvation Army in aged care. I am a personal care attendant and have been employed for 15 years in that capacity.

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

Ms Graham—I am representing Ron Monaghan, secretary of the Queensland branch. My introduction will be very brief. I will be allowing ample time for our delegates to speak about their workplace experiences and for your questions. Firstly, our national office has submitted the document ‘Shine the light on aged care’ and I will make reference to that. I would also like to focus on the Minister for Ageing’s work force committee report entitled *The care of older Australians: a picture of the residential aged care workforce*. I want to state some facts from that submission. I remind everyone that the report only takes into account care staff and that 70 per cent of those employees believe that not enough time is allocated for the delivery of care to their residents. The trouble with that is that it manifests as unpaid overtime being worked by care staff.

Why is this so? It is because our carers have a strong sense of ethics, goodwill and pride, and a genuine concern to ensure that residents needs are met. This in turn leads to increased workloads, with carers working harder and longer to maintain the desired level of care, putting their own health and safety at risk at the same time. Staff retention and the recruitment of staff to work in aged care then become an issue, compounded by disparity between the public and private sectors.

Secondly, our submission talks of our concerns about funding issues. We believe that the 2004 federal budget did not resolve the funding issues in aged care. Providers receive approximately 75 per cent of their total funding from the Australian taxpayer, and we believe that that is still not enough to provide the necessary care for residents. There was a suggestion in another report, by Hogan, that residents’ fees should be increased to cover the shortfall. This is also of concern to us.

The LHMU believe that the federal government should monitor where taxpayer funds are being directed to ensure that the funds are being used for the direct delivery of care and to ensure that providers are made accountable for all money received through funding. We believe that accountability will enable staff and residents to have confidence in knowing that they have been afforded the fairest opportunity to earn decent wages and in knowing that residents are receiving the necessary care and value for their dollars. About 60 per cent of care workers receive less than $500, and this is partly attributable to the fact there are not adequate hours available, so they are mostly part-time workers. The aged care industry estimates that 78 per cent of total costs in residential care go towards the wages of staff.

Thirdly, we believe an office of aged care ombudsperson should be established. We believe that it would provide transparency and accountability in the management of complaints in both residential and community settings. We believe such an office would have a role to educate residents, families and the broader community about the rights of older Australians who receive aged care services. We also believe that the federal government should establish national benchmarks for care. Roles would be to determine how much is required by providers from the government in order to provide the necessary aged care services and to set the minimum staffing levels and skills mix for delivering that care.

Our union participates nationally in a forum that is focusing on the delivery of aged care services. That forum is known as the National Aged Care Alliance, a representative body of a number of organisations, consumer groups, health professionals, providers of aged care services and other unions. I have been informed that a number of those providers have undertaken to test the broader statistical evidence raised about the staffing levels and the skills mix, and they are engaged in a trial of that. Those results are not yet available. Once they are available they will need to be endorsed, but we are happy to provide them to you at a later date.

About mid-2004 we conducted a local phone-in survey, and I provide a copy of that survey for the committee to look at. The survey was undertaken over a short period of time and was held on a Saturday, so overall there was not a large number of calls, but the predominate message we received was quite strong and was shared by workers, residents and residents' families. It highlighted a number of concerns that need to be addressed. I have completed my introduction. I introduce you to Stan Rosenberg, who will begin his statement.

Mr Rosenberg—'We do not do it for the organisation; we do it for the residents.' These were the words of a carer at a staff meeting on Wednesday, 16 March who was referring to unpaid overtime. There is a formula used in the organisation that I work for to determine care staffing levels. That figure is 52 per cent of whatever the centre's income is at the time. The income of our facility is dependent on so many factors that it goes up and down like a yoyo. Lately it just seems to be going down. This formula is supposed to reflect the care needs of the current residents to carer hours. It does not, however, consider carers' needs, carers' commitments, carers' bills or carers' stress levels sustained through higher and higher workloads.

On Wednesday the 16th 2005, at this unscheduled staff meeting, we, the staff, were told that we are currently running at 59 per cent of our current income and that 22 hours a day had to be shed from our carer hours immediately. I make reference to the section in the LHMWU submission called 'Shine the light on aged care'. Section 1.2 says:

> When older Australians can no longer live independently without support, they deserve to be supported by those that have prospered from their toil, the Australian community. If they require home care, community care or residential care they should have access to it. If they require home care, community care or residential care it should be of the highest quality. It should be akin to the level of respect and regard we have for older Australians.

Additionally, I have been requested to share with you today a letter written by our senior registered nurse to the regional management team when she became aware of these proposed staff cuts. Her concerns covered heavy workloads placed on care staff, resulting in resident care being compromised, increased workloads, staff burnout and increased sick leave being taken. She is concerned that residents are paying big dollars for care which cannot be delivered on shoestring budgets and reduced staff levels. The letter says:

> In view of the next proposed cuts to staffing levels I wish to draw your attention that the last staff cuts came into effect from 15-2-05—

that was last month, and they are still to be reflected in the March budget. She says the organisation needs to revisit its motto: the organisation cares. The letter continues:

> This is obviously not the case any more as—

the organisation—

> are NOT caring about

... The undue heavy workloads placed on Care Staff, this is resulting on Residents’ care being compromised.

Do you realise that staff cuts produce cuts in Resident care therefore limited care can be achieved?

... increased workloads will cause staff burnout resulting in increased sick leave being taken.

... Residents pay big DOLLARS to come to—

our organisation—

for the best care possible and this cannot be delivered on a shoestring budget working with reduced staffing levels.

If—

the organisation—

really cares and shows and has respect for their staff ... and before any cuts in staffing hours are made a meeting with a Representative from Regional Office would be appreciated by all staff here and a meeting arranged at a suitable time.

That is all I need to read, I think, from that letter.

Already resident care appears to have been compromised. Allow me to provide some examples, if I may. One carer has to provide seven vitamised feeds to high-care residents in 30 minutes, which is just over four minutes per resident. Three care staff per night shift look after 50 residents. In one of our units two care staff per day shift look after 16 residents, 15 of whom are high-care, requiring two carers at a time at all times of direct care. In two of our units during the afternoon there are two carers for 32 residents, of which 18 are high-care, 13 are low-care and one is respite. This is just an overview of the present situation at work—and that was before these cuts were made, may I add.

Many of us in the industry work five to 10 hours unpaid per week to get the job done. Our service manager made a comment recently, at the staff meeting on Wednesday, the 16th, that she had never requested anyone to work unpaid overtime. This reply came from the back of the room from one of our less assertive carers: ‘We don’t do it for the organisation; we do it for the residents.’ If the formula is wrong and not working, then change it, please.

May I also add that the federal government, in my opinion, should monitor where the taxpayer funds are being directed. The organisation I work for has three levels of management: unit, regional and head office. Some 12 per cent of our centre’s income goes towards our regional office to support our regional team, who we hardly ever see. I would have preferred that the regional team had taken up the offer from our senior registered nurse to personally come out to the centre to discuss those proposed cuts. I would have thought that would have been within their role to do so. To make up some of the shortfall which has resulted from these cuts in our centre, the centre’s diversional therapist and secretary have been seconded during meal times to assist in feeding the residents. These members of staff have not been trained in procedures for feeding of residents. I express concerns as to the safety of that for the residents. Thank you very much.

CHAIR—Ms Graham, I am just concerned about the time because the committee will want to ask some questions. We actually have the other statements. I am happy if you want to persist with that. It is just that we will not have much opportunity for questions.

Ms Graham—Our delegates would love to answer your questions.

CHAIR—Let us go there first and if we have some time left you can summarise your statements for us.

Senator HUMPHRIES—Thank you for that presentation. I want to clarify what you are suggesting in section 5 of your submission to the committee, the ‘Shine the Light on Aged Care’ document. You comment on the fact that the Hogan report recommended that these additional payments by the federal government to aged care providers should be tied to demonstrated productivity gains and better efficiency and training of work forces. I infer from what you say in there that you believe that kind of tying of Commonwealth funding to outcomes—particularly as far as staffing conditions and pay are concerned—is appropriate. Is that what you are saying?

Ms Graham—Absolutely. I think the Hogan report came first and made a number of recommendations. Then there was the second report from the Minister for Ageing. It did not pick up on some of those recommendations either. We do acknowledge that the money received in the federal budget last year was a large sum. However, it was not linked directly back to the delivery of care. There are no accountability processes in place to ensure that that is indeed for the purposes of providing aged care. Wages also are an issue for us. We really need a system that is going to keep everybody honest and accountable for everybody’s sake. We do that in child care. I am aware that we do that with Commonwealth funding for teacher aides here in Queensland. It is extremely accountable. Everybody is informed of the mix of hours and where it actually comes from. I cannot understand why this concept cannot be transferred to the aged care industry. For a number of years now, everyone has been expressing this concern, and still it has not been picked up.

Senator HUMPHRIES—I assume that what was sought by these payments originally was flexibility on the part of the aged care providers. If they are not spending it uniformly on wage increases, what are they spending it on?

Ms Graham—I am not suggesting that they may not be. We want the confidence in knowing that it is tied to certain guidelines. You have the accreditation system—everybody is filling out paperwork madly. But there has to be a fairer system out there. We need to establish that. Having that national benchmark of care and linking that with the staffing levels and the skills mix is obvious to me.

Mr Rosenberg—Obviously, the funding that goes to the aged care providers is not all from the government. The residents pay a large amount of their income to the aged care providers. Also, entrance fees into these organisations are huge for the average person. Families pay—I am not sure what they call it; I am not in administration—an entrance fee for their family members to enter these places, which is all money that is in the kitty to fund the organisation. You are all aware of that.

Senator HUMPHRIES—You talk about the national benchmark being set and you say the Commonwealth government should do that. I assume you are saying you see a setting of outcomes of care levels. How far short of what you are seeking are the present accreditation processes? How much work will have to be done to reach this national benchmark of care?

Ms Graham—I probably could not answer that at this point in time. I probably need to refer back to our national office to see what the progress has been in this regard. I am happy to provide that to you later.

Senator HUMPHRIES—I am thinking in terms of taking what is happening today in aged care and what you think would be a reasonable national benchmark, how far we would have to travel to get there, how much more money will be needed to get there.

Ms Graham—I guess once that is set up then it would be to determine what is necessary out there through consultation with the various community groups, organisations and health professionals—similar to the NACA, the National Aged Care Alliance. That is what they are endeavouring to do. They are trying to push this further along. The results from that trial should be made available soon. That might shed a bit of light on aged care.

Senator HUMPHRIES—What would an aged care ombudsman offer that is not presently available through the Commissioner for Complaints, for example?

Ms Graham—Only that it would seek to educate all concerned and allow a central point where complaints could be directed and dealt with appropriately.

Senator HUMPHRIES—The accreditation agency has a role in educating at the moment. There have been some submissions to the committee about whether it is appropriate to be both educating and accrediting at the same time. You would see an ombudsman having a role in education, would you?

Ms Graham—That would be one of the roles, yes.

Senator HUMPHRIES—Lastly, we have heard a lot on the committee about this issue you raise of paperwork taking up the time of people who should otherwise be caring for people and facilities. We have heard that there is too much paperwork and that some of it is unnecessary and so on, but we have not pinned down exactly what components of the paperwork ought to be eliminated or reduced. Do you have experience of the things that the members who are here today think are unnecessary and could be dispensed with?

Mr Morgan-Harry—As a personal carer, at the Salvation Army we are what is laughingly called ‘multi-skilled’. Multi-skilling in the Salvation Army means we do everything. In my case I look after a unit of nine men. I shower them, toilet them, dress them and do every bit of personal care they need for the day. I feed them, I do their laundry and I then have sit down and do the paperwork, which is normally done in our lunch hour. If we do it any other time we take away care from the residents. Of the nine men I have, seven are high care. You would think I would be able to get a bit of assistance, but they just do not have the funding to do this. As for the paperwork involved, when we are on Residential Care Service paperwork, when they first come in it is 21 days and we do reports on things like their behaviour, their incontinence, their family visits—if the family have something to do with their lives and want input all the time—and medication. In our case we do give out medication.

Senator HUMPHRIES—In your opinion, is any of that information unnecessary? Could it be dispensed with?

Mr Morgan-Harry—It probably could not be completely dispensed with. I am not sure how to put this. It needs to be done—I have no problems with that—but we need extra hours to do it, so we are not taking care away from the actual residents. The paperwork does need to be done.

CHAIR—Mr Morgan-Harry, you make the point in your submission that high-care residents can quite easily be managed but that throwing intellectually handicapped residents or young people with behavioural problems or disabilities into the mix then creates a burden that affects everybody’s care. Can you expand a little bit on that?

Mr Morgan-Harry—Yes. If you have very high-care patients, which we do have in hostels these days—they are not all mobile or fully mobile—you can work out what you have to do for them for the day and what time you approximately have to do that, and you can plan around that so you can look after each resident as they need to be looked after. Say you have people who are usually on low care because of the way the funding is—you get higher points if they are incontinent or things like that. The ones with behavioural problems—the mentally handicapped—are quite often not incontinent, so you do not get high care for them. You get low care, but they can disrupt your whole day. They can wander off, so you have to keep half an eye on where they are all the time, write out paperwork and sign that you have seen them on the half-hour, every half-hour, so that they have not wandered off on you. If they have a tizzy-fit and decide to have a tantrum and attack another resident or a staff member, your whole day is shot because your planning of the day for the really high-care residents who need you is taken away because you are spending too much time trying to control those with behavioural problems. The funding for them is different. They do need care but if they are disruptive in the unit then that takes up more time than you should be allocating to them for the money you are getting.

CHAIR—So you are not talking about someone who is just a little bit difficult; you are actually talking about people with intellectual handicaps.

Mr Morgan-Harry—Yes, but most of ours are actually aged care people with down syndrome. They are in the aged care category. They are over 65. I think one of ours is 76. He is very difficult to manage. That one actually is a high-care patient, I have to admit. Such people do cause problems.

Senator McLUCAS—I thank you for the submission from the LHMU. I want to go to the question that both the submission and Mr Rosenberg raised—the issue of unpaid overtime. It is not the first time that it has been raised with us. Mr Rosenberg, you gave us an indication that it is between five and 10 hours.

Mr Rosenberg—Yes, but that is not for every carer. Obviously some have much more rigid family structures whereby they have to be home.

Senator McLUCAS—I was wondering if we could get a feel from other workers. What can you say about your place of work? Do you think on average people are working unpaid overtime? Mr Rosenberg, I did not mean to cut you off.

Mr Rosenberg—You haven't.

Senator McLUCAS—Then we can go across to the others.

Ms Slater—Where I am, whether it be the personal care staff or the kitchen staff, the average unpaid overtime can be anywhere from half an hour to an hour a day.

Senator McLUCAS—For everybody?

Ms Slater—For everybody—without a problem.

Senator McLUCAS—And it is just because the task is not finished and you cannot really go home—'I'll just finish this off' sort of thing?

Ms Slater—Yes. From the personal care side, I look after 28 residents on my own. I have four or five high-care residents and the rest are low-care residents. Even low-care residents still need you. They still need a shoulder to cry on now and then, and they still want you to do things for them. My residents want and have requested quite strongly to be showered before breakfast. I start at seven o'clock in the morning, technically, and breakfast is at eight o'clock in the morning. Four showers may not sound like much, but one of my residents takes 30 to 40 minutes to shower and fully clothe, which leaves me 20 minutes to try to shower three other residents, do eye drops and BSLs, get my medication out and put on Ventolin for other people. I really do not have the time. A lot of the time I will walk into my facility at 6.30 in the morning to start my job—to get my medication out and to get everything set up—so that my residents have what they want. And what I am there for is to try to make their lives easy and comfortable, as best as I physically can. The kitchen staff have the same problem.

Mrs Leggieri—My area is probably a little unique, because I am a personal carer in the community. We are more one-on-one. We are allocated blocks of time to spend with a client, so therefore in recent years unpaid overtime has not been an issue. However, over the last month in my role as a member organiser with LHMU I have had the great opportunity of visiting many sites throughout the Gold Coast, Brisbane and Sunshine Coast region, and the biggest amount of unpaid overtime is with people working through their breaks, doing eight-hour shifts without a break. If there is only one staff member to a wing, unless somebody comes to relieve them they are not going anywhere for a break—as well as the starting early and the finishing late problem. But certainly a great proportion of the unpaid overtime is just working the whole day and never having a break, and that creates a lot of stress problems amongst the staff—and that is another issue.

Mr Morgan-Harry—At the Salvation Army Riverview Gardens, an average of 98 per cent of the staff would do between three quarters of an hour and half an hour a day overtime. I personally start between a quarter past five and half past five every day when I am on morning shift, and I am not supposed to start until six. We are told not to start until six, but I have residents who are waiting for their shower at that time and you try to accommodate your residents as much as possible. I usually shower seven men before breakfast at 7.30. But, remembering that I have to go and get this breakfast, organise the tables and do everything else, it can be quite hectic first thing in the morning. It calms down later in the day, but if you come in earlier that first block is a lot easier. Otherwise, we would not be feeding those residents at 7.30 and they do like their breakfast then.

Senator McLUCAS—Mr Rosenberg, I apologise for interrupting you before. You said between five and 10 hours a week, but you were going to qualify that.

Mr Rosenberg—I said ‘many’ of our staff, I did not say all of our staff, and that is obviously the case. Personally, I work 10 hours a week unpaid. I am in maintenance. I deal directly with residents in that it is residents’ things and rooms that I am maintaining, but it is not a personal care situation. I find that I have to work those extra hours. I am paid for a six-hour day because the organisation cannot pay me for an eight-hour day, but there is at least eight hours of work to do. I think that is the situation we are in. All of our staff are part-time workers doing a full-time job.

Senator McLUCAS—Ms Graham, you might want to talk from a union-wide perspective. The feeling I get from those comments is that it is almost done for love—it is done because the need is there.

Mrs Leggieri—They care about people; that is why they do it.

Senator McLUCAS—But have you ever heard of situations where employers or residential aged care providers have almost pressured staff into working extra hours? This does not sound like people are being pressured, but there is a mix there.

Ms Graham—Because our carers are the type of people that they are I suppose there is always a certain amount of guilt. As Stan mentioned earlier, his service manager came out at their last staff meeting and said, ‘I have never asked any of my staff to perform unpaid overtime.’ But there is the desire to deliver that type of care; I think it is an underlying, unspoken—

Mrs Leggieri—Expectation—

Ms Graham—Yes, that is right.

Mr Morgan-Harry—The managers do tend to say, ‘We expect you to take your breaks and we expect you to start on time,’ but people do not. They like to say that, but they expect you to get your work done. If you do not get your work done, you hear about it.

Ms Graham—There are difficulties all the way round. Maybe that reference to the shoestring budget is right—everyone is trapped and everyone is screaming out for help. How do we resolve this?

Senator McLUCAS—Thank you very much.

Senator MOORE—I have not read your statements yet; I cannot speed read and talk at the same time. Can I get some idea of how long you have worked in the industry?

Mrs Leggieri—I have worked in the industry for approximately 20 years. I have a background ranging from hospital work to residential care and district nursing in another state as a health aide. I am now a community personal carer. It has been a long time, and I have seen many changes. From this I would like to see good outcomes for clients, and residents and staff. This is our aged community and they deserve to be looked after. The very least they can expect in their aged years is to have good quality care. Surely that is not too much.

Senator MOORE—Ms Slater, how long have you been in the industry for?

Ms Slater—For about five years.

Senator MOORE—You are in the kitchen?

Ms Slater—No, I am in personal care.

Senator MOORE—You are in personal care as well? But you have done kitchen work? You said earlier in a response—

Ms Slater—No, I was just speaking about our kitchen staff. I do work overtime as well.

Senator MOORE—And you have a carer's certificate?

Ms Slater—Yes, a certificate IV.

Senator MOORE—Do you have a certificate IV, Mrs Leggieri?

Mrs Leggieri—I have a certificate III in community services.

Senator MOORE—Mr Morgan-Harry?

Mr Morgan-Harry—I have a certificate III in aged care, and I have been in the industry for 15 years and three months.

Senator MOORE—Mr Rosenberg, you are in maintenance?

Mr Rosenberg—Yes. I have worked in aged care for four years.

Senator MOORE—You have a trade?

Mr Rosenberg—Yes, I am a tailor.

Senator MOORE—That must be really useful!

Mr Rosenberg—I am very good at maintenance too.

Senator MOORE—One of the things that was talked about in the Hogan report as well as staff numbers and levels was access to training and development opportunities. In the organisations in which you operate, is there access to training and development courses on different methods of care, medication and all those sorts of things? Have you got access to those things in your work?

Ms Slater—In my facility we are trained to give medication. We do wound dressings. We are sort of like an unqualified RN in what we do—they get more money than us. I have to admit that where we work they do run all sorts of update training each year. We do competencies each year. If we have trouble with it then they will go back and retrain us on it.

A lot of people outside of the industry find it hard to understand that we do it because we want to do it. We have good days and bad days and so do our residents. I am going to have to walk out in a minute: I lost a resident this morning, which was not easy. It does affect you. We really care about these people. We just want the time to provide the care for these people. I think, ‘My mum’s going to be there one day and I want a darn good facility for her to go into.’ Working in the industry, there is a lot that needs to be done to try and better it for the elderly. This is from what I have seen in the few years I have been in it. I think it is quite sad, actually.

Mrs Leggieri—I would like to add something to that. Have you noticed how all of us have been focusing on our clients? None of us have mentioned the wages we are working for; we are just so focused on our clients. We tend to go without ourselves so that we can do the job that we do focusing on the aged care industry. From sitting here and listening, we have all focused on the residents and the clients. I think that is an admirable quality in an aged care worker. You go without yourself. The hourly rate is not huge. How do you put a price on holding someone who is dying? How do you put a price on that? Not everyone can do it. Like I said, we just really care about them. By the same token, we deserve to be able to afford to pay our bills.

Mr Rosenberg—That somebody who is dying could have been in that facility for five or 10 years, and you have known that person for that time.

Mr Morgan-Harry—I still have four residents who were there when I started—that is all. There has been a complete turnaround, except for four. There are four men left in the place who were there when I first started. And you are very fond of those people. After 15 years, you get slightly attached.

Senator MOORE—I have one last question. As you have all explained, you have been in your areas for quite a long time. Are there people coming along behind you who are much younger than all of us in this industry? I ask that in terms of the future faces in the workplaces.

Ms Slater—As in carers?

Senator MOORE—Yes.

Ms Slater—Carers are getting younger but, where I work, I find that mostly they start off in the dementia wing, which, I can honestly tell you, can be very scary.

Senator MOORE—They start off in the dementia wing?

Ms Slater—Yes. I was initiated in the dementia wing, which is very scary. Violence does occur. I used to come home with bruises on a daily basis, whether it was inflicted on me or from trying to break up residents. A lot of the younger ones coming through see it and think, ‘No,’ and leave the industry straightaway, which is very sad. If they could be placed into another section first off to introduce them to the care that is needed and required and then introduced to that side of it, then I think we would keep a lot of carers. But a lot are leaving the industry, unfortunately—even older ones are leaving it.

Mr Rosenberg—Most of the information I have passed on to you was gleaned from carers 25 years younger than me.

Mr Morgan-Harry—I have one quick point. We have had, in the last month, five start. We have one left.

Senator MOORE—I am sure that is a bad percentage, Mr Morgan-Harry, but I cannot do that.

Mr Morgan-Harry—We have had five new carers start and only one is continuing.

Senator MOORE—Is that a pattern you have seen before?

Mr Morgan-Harry—No, and I am not suggesting it is. It is just because they cannot get the hours they would like. We need the extra staffing, but they cannot be promised, say, 30 hours a week.

Mrs Leggieri—And they need to eat.

Mr Morgan-Harry—Yes.

CHAIR—Ms Graham, the COPO funding model does not work, according to your submission. We will not explore that—we have taken some other evidence on that today. You indicate that the Department of Veterans’ Affairs has moved away from that funding model to a new model. Do you know what the new Veterans’ Affairs model does and would that be more appropriate?

Ms Graham—The submission was launched by the national office and I am not familiar with that arrangement, but if you are seeking that information I can get it.

CHAIR—I would like your opinion. Your submission has indicated that there is obviously a better model and that is why Veterans’ Affairs have moved away from COPO to something else. I would appreciate it if you can tell us whether you or your union has a view on the appropriateness of the Department of Veterans’ Affairs model that they are now using and whether that would be a more suitable model for aged care. Thank you for your submissions and your personal experiences that you have shared with us today and the information that you have provided the committee.

[3.27 p.m.]

GARRAHY, Ms Anne, Professional Officer, Queensland Nurses Union of Employees

HAWKSWORTH, Ms Gay, Secretary, Queensland Nurses Union of Employees

ROSS, Mr Steven Maxwell, Industrial Officer, Queensland Nurses Union of Employees

MORRISON, Mrs Anne, Executive Officer, Queensland Nursing Council

THOMPSON, Ms Maureen Ellen, Principal Research and Policy Adviser, Queensland Nursing Council

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

Mrs Morrison—The Queensland Nursing Council is a statutory body that is responsible for the regulation of nursing in Queensland. The nursing regulation requires that individuals complete a council accredited educational program, practise in accordance with the codes of ethics and conduct that are set by the profession and meet established practice standards. The council sets these standards of practice for the profession in collaboration with key stakeholders. Currently in Queensland—and this is as at midday yesterday, 17 March—there are 51,866 nurses licensed to practise, and of these 43,858 are registered nurses and 7,954 are enrolled nurses. The need for an educated, competent and licensed aged care nursing work force now and in the future has not been the subject of debate. However, the council believes that what needs to be addressed urgently is the model of provision of service by those nurses.

The shortage of qualified, licensed nurses working in aged care is occurring at a time when demands for aged care health services are increasing. However, the rate of decline in the employment of nurses in the aged care sector is greater than the decline in the general nursing work force. This decline has variously been attributed to the use of a social model of care for the elderly. Proponents of this model contend quite erroneously that nurses are more aligned to a medical model of care and are therefore not appropriate employees for the sector. Nursing education has had a health focus rather than a medical focus for at least the last 30 years. Also, because of the low attractiveness of aged care employment for nurses, due to both pay and conditions being lower than in other sectors and the desire by employers to contain costs, employers therefore employ alternative, less costly workers rather than qualified, licensed nurses.

There is a growing need for nursing services for the elderly, whether provided in hospital, in residential care settings or in the community. This is supported by the Australian Institute of Health and Welfare’s publication *Australia’s Health 2004*. This document notes that, while the overall health of older Australians is improving, the onset of long-term, chronic medical conditions in the older age group may result in various levels of disability. In particular, AIHW reports that there is a sharp rise in the prevalence of disability in the ‘85 years and over’ age group. That gives rise to severe and profound restrictions resulting from disability and that also increases with age. Such restrictions entail the need for personal assistance with activities in the areas of self-care, mobility and communication.

Although many personal care services can safely be provided by non-nurses, it is essential—and this is the council’s opinion—that a nurse be involved in assessing the person to ensure that the care being provided continues to be beneficial and that changes in the older person’s condition are identified rapidly and acted on appropriately. The reduction in qualified, licensed nursing staff in aged care is a risk factor for increasing morbidity and mortality arising from late identification of a treatable condition. Early intervention by registered nurses has the potential to reduce the need for residents to be transferred to the hospital sector and to minimise cost shifting to the hospital sector.

The best ratio of direct nursing service to indirect nursing service needs to be established, with direct care by registered and/or enrolled nurses necessary in some settings, while an advisory or educational service by registered nurses may be sufficient in other settings. Whether the licensed nurse should be a permanent staff member or a consultant contracted by the aged care service for specific services is a question that has not been adequately answered in most settings. The answer is highly dependent on the acuity of the client population.

The Queensland Nursing Council is currently in the process of developing principles to guide decisions about when direct assessment and/or care provision by a registered nurse is required. Those principles, which are currently being drafted, focus on benefit for the client and will relate to such things as the client’s capacity for self-care and decision making; the certainty of the client’s condition or diagnosis; the complexity or even interrelatedness of the client’s needs; the predictability of the client’s condition—whether it would be marked, rapid, fluctuating or a gradual change; the range, severity of predictability; immediacy of negative outcomes, if the risk of harm is not identified early; the subtlety of signs of changes in the client’s condition; the complexity and/or technical difficulty of procedures; and, the level of education and competence of other health care workers providing care for the client.

It is on this basis that the council recommends that the funding models for aged care, both residential and community based, take account of the need for qualified, licensed nursing staff. Also, the council recommends that research be undertaken to establish the most appropriate ratio of direct nursing to indirect nursing services in aged care residential and community settings.

The Queensland Nursing Council, in its July 2001 submission to the Senate Community Affairs References Committee inquiry into nursing, made the following remarks regarding shortages in aged care:

> In view of the changing demographic of older persons, there is also concern about the future supply of nurses … Happell (1999) notes that only 2% of Australian nursing students are attracted to aged care although it currently accounts for 28.5% of nurse employment. Strategies need to be developed to make this area more attractive. Higher profile recognition as an area of specialty and the development of career pathways would assist, along with ensuring wage parity between sectors.

The recommendation that council made at that time, and which still remains relevant, is that urgent national attention be given to the development of incentives to attract and retain qualified licensed nurses to work across institutional and community sectors for the improvement of the health status of older people. Strategies which have been and still will be suggested are that there be wage parity across nursing sectors and that the recruitment and retention strategies recommended in numerous national reports be implemented.

I have referred to the need for licensed nurses to be involved in aged care, because registered nurses have the capacity to provide for special needs—for example, for residents who have dementia and mental illness. Licensed nurses receive comprehensive educational preparation for practice with all types of clients and can ensure that the specialised care required by these groups is provided. Qualified, licensed nurses can help to ensure that individual needs are met, regardless of the setting, provided that funding levels are appropriate for the services needed by those individuals.

In conclusion, it is the Queensland Nursing Council's position that the key role of a regulated work force made up of registered and enrolled nurses should be recognised in any model for the aged care sector that is established as an outcome of this review.

Ms Hawksworth—The Queensland Nurses Union of Employees made a submission to the inquiry in August 2004. However, since that time we have been involved in a number of matters that are relevant. Some of them do take some explaining, so, rather than spending this time detailing those matters, we have written a further submission. If it is appropriate, we would like to table that. I will just give you an idea of two of the issues. The first one is the wages disparity that exists. Despite the additional allocation of the $877.8 million over four years that was announced in the budget last year in the form of the conditional adjustment payment, which is said to enable aged care providers to pay more competitive wage rates, we see no evidence of that. Indeed, when officials raise this funding increase with providers during enterprise bargaining negotiations, for example, employers reject the suggestion that they are required to spend that funding on wages and continue to plead a lack of funding as a basis for inadequate wages offers. Since we made the submission, we have had ongoing enterprise bargaining negotiations taking place with aged care providers.

The second issue that I want to mention is a matter before the Queensland Industrial Relations Commission at the moment. It is a dispute that we had with Sundale nursing home on the Sunshine Coast here. We have been involved in arbitration hearings, following dispute hearings in the Queensland Industrial Relations Commission, with regard to considerable cuts in hours in this 117-bed nursing home. We are in the final stages of that arbitration. Steve Ross and Anne Garrahy, who are with me today, have both been heavily involved in this matter. We are now at the stage where all the hearings have concluded, and we now have to have written submissions to the commission by the end of this month. Then we would await the decision, obviously.

Our members at Sundale felt so strongly about these cuts in hours that it was an issue that we simply could not afford to ignore. We really took the only action available to us. It was an industrial dispute at that time. Evidence at the hearings has highlighted how the lack of accountability for expenditure of public funding has resulted in decreased hours of direct care for residents. In this home, hours have decreased from 363 hours per day in 1999-2000 to 342 hours per day in 2003-04. That is a 5.8 per cent decrease. Further cuts of more than 22 hours per day across the facility were imposed in July 2004.

Management wrote to staff advising that this was due to the continued lack of funding by the federal government to meet the real costs of providing care. The QNU presented evidence to the QIRC that the direct hours after the cuts in July 2004 are approximately 20 per cent less than the entitled hours per day that would have been required prior to the enactment of the Aged Care Act 1997. We have seen that continual reduction in hours across Queensland since the Aged Care Act 1997 came in and it is an issue that we deal with constantly. I think we could probably say that every week we would have an issue with regard to hours cuts in aged care. We will table that additional information for you in a bit more detail.

CHAIR—We already have it, thank you. On the dispute you talked about, do you cover all of the carers as well as the nurses in that facility?

Mr Ross—The dispute relates to the nursing home complex run by the organisation only, and we cover the registered nurses, enrolled nurses and assistants in nursing, who are the employees responsible for delivering all the care in that nursing home.

Ms Hawksworth—It is a big complex with nursing home and other residential facilities—like hostels, if you take away the aged care facility. In the old vernacular: nursing home, hostel and retirement village type situation.

CHAIR—Where do you say the extra money provided by the Commonwealth to try to bridge the gap between aged care nursing and acute care nursing has gone? Has that gone into wages at all or has it simply been diverted into the general running costs of the facility?

Mr Ross—To us there is no evidence that it has been diverted into wages. We have been able to gain some marginal wage increases through some negotiations with some employers, but the amount of those increases probably ranges between about 2.5 and about four per cent per annum, depending on the classification, and that is pretty consistent with the outcomes we have been achieving where we have been able to get EBs for some years. There is no evidence before us at all that that money is being diverted into wage increases that narrow the gap with people’s colleagues in the public sector.

CHAIR—So the wages outcomes that you are getting are closing the gap?

Mr Ross—No, they are not. The gap is increasing. There is no evidence that that gap is decreasing at all or that any of that $877 million is being diverted into closing that gap.

CHAIR—The message I got from the evidence we heard from Aged Care Queensland this morning—I will not try to quote them exactly—was that the underlying problem is actually the COPO funding model itself, which just does not provide enough funds to cope with wages at all. What would you say to that?

Ms Hawksworth—I guess the answer is: we don’t know.

Mr Ross—The difficulty we have is that, as part of proceedings such as the Sundale proceedings and some other proceedings we have been involved with, or in EB negotiations, we have had the opportunity to examine the financial accounts of different organisations. Some of them have, quite frankly, been pretty healthy looking sets of figures in terms of surplus funds and where that money is. What does not exist is any mechanism for ensuring that the money that they receive for care is actually spent on the wages, unlike the previous system. It is very difficult for us to say whether or not the funding is at an adequate level, until we can be confident that the money is being acquitted properly and spent where it should be spent.

Senator KNOWLES—Can I pursue that a bit, because what is worrying me is the trend of evidence we are getting that the 1.7 per cent increase might have been paid—we do not know—but, on the other hand, it might have been offset by what the facilities have not paid. In other words, they are giving you a 2½ per cent, three per cent or four per cent increase or whatever, of which 1½ per cent might have been provided by the Commonwealth, but the facilities have said, ‘That’s what we can give you.’ In other words, they have put the rest of the money, which they ordinarily would have given you, back into the till. In your examination of their accounts, is there any evidence that they have kept the money that they would have routinely allocated to wage increases, supplemented it with the 1.7 per cent and moved on? Believe me, it is not a question with a sting in the tail. I am not trying to catch you out. If you cannot answer it, I suggest you do not. But I am worried—

Mr Ross—I personally have to be a little bit careful because of certain undertakings I have given to the industrial commission in those proceedings about some of the material I have been privy to.

Senator KNOWLES—I fully appreciate that and I do not want you to compromise yourself in any way. Maybe someone other than Mr Ross might have an idea about whether or not some of that money is just being hived off.

Ms Hawksworth—We do not know. That is what we do not know the answer to. The situation in the commission on a couple of occasions now is that only some people in the commission have been able to look at the books and they have not been able to report back. As the secretary, I am not even privy to that information because of the legal undertakings in the industrial commission. And I guess the answer to it still is that we just simply do not know. We do not know what they do with the bucket of money. We have been quite consistent about the accountability measures in terms of aged care since the 1997 act came in and CAM and SAM went. They were not a perfect solution but, in our view, the 1997 act simply opened it up to there being no scrutiny at all in terms of how the money was spent.

I note in Jill Illiffe’s evidence before the inquiry that she referred to the graph that the ANF does periodically—it is Australia-wide and is given to the government periodically—where, in our view, we felt that the additional funding would in fact fix the wages gap, but that simply has not happened. Until we can get down and know exactly where every dollar goes, we just have no idea.

Senator KNOWLES—The federal minister made an announcement—I think about six weeks ago—

Ms Hawksworth—Yes.

Senator KNOWLES—about accountability. Do you think that will provide an option to expose to one and all where the money is going?

Ms Hawksworth—No, we were disappointed in that.

Senator KNOWLES—Why?

Ms Hawksworth—We thought it did not go far enough in terms of the accountability measures. I note in the *Canberra Times* this week it was reported that she has had a go at the nursing homes in the ACT because she believes that they should be able to do that. At the time, the ANF put out a press release to say that we were not happy with that, because we still do not believe that it is clear. From what employers tell us, they still do not believe they have to spend that additional funding on wages. They tell us that when we bring it up. We even worked out, based on that, how much money some of them would have got under that additional funding. When we put that to them—or when Steve Ross put it to them—in the negotiations for enterprise bargaining, they did not believe that they had to spend it on wages. There were other issues as well. I think that their funding has to be made public; it is public funding. Until they have to provide the evidence of how they spend every dollar, I think we are going to continue to be in this difficulty. Until we get the wages right and the skills mix right, we will constantly have problems in aged care—and I think it will get worse.

Senator KNOWLES—Can I move on to another subject: the paperwork issue, against the backdrop of accountability. If one thing goes wrong in one nursing home then all the chooks in the pen are crook. We cannot have a situation where that happens, because people want to know that their facilities are the best. Therein lies the question: what sort of paperwork can be removed without compromising the accountability to the families and the people who are coming into a nursing home?

Ms Garrahy—Interestingly, in the dispute that we are currently involved with, we have had an opportunity to do quite a lot of close examination of the documentation system that the facility uses. It has become very clear to me why the nurses say that they have a lot of writing to do: there are about six different folders that a nurse might need to make notes regarding the residents that they are caring for in each shift. There is the time that is spent getting out the folders. The subject of the RCS documentation is constantly coming up from our members. Frequent recording is required for the RCS assessments every year, for example—those sorts of things.

In terms of the care planning that goes on, the nurses believe it is most appropriate. The care planning that we have seen and been exposed to in this matter has been exceptionally good and it provides a really good basis for the care that the residents require. The nurses are most happy to continue with very detailed care planning that provides guidance for the care that is required. The documentation that worries the nurses is the RCS documentation and the repetitive nature of it, where they have to document something more than once.

Senator KNOWLES—What are you saying to me? I am a person who hates paperwork as well. We look at this from the position that you are there to deliver the service, not to pen-push.

If we take that as a given, what do you suggest should be done away with, without compromising the public perception of perfection?

Ms Garrahy—My understanding is that the RCS review that is going on currently is looking at reducing the number of RCS questions to be responded to and reducing the frequency with which they have to be completed. I think the nurses would agree that is a good way to go. The nurses that we have had contact with are quite happy to document about care planning. I do not think they want to do double documentation of any piece of information. The systems in each facility could be looked at. Systemic-wise, there is the RCS documentation, which is being addressed with the RCS review. That will be helpful.

Senator KNOWLES—I would like to ask one more question. You talked about introducing measures to reduce occupational injuries of nurses working in aged care. Quite frankly, I was a bit surprised to see that, because I really thought that there was better lifting equipment and general equipment now to assist with a reduction in any occupational injuries, given that there will always be occupational injuries, whether it is through a lack of equipment or not. Could you just expand on why you put that in there?

Ms Garrahy—Are you referring to our written submission on occupational health and safety issues, page 8?

Senator KNOWLES—I have page 5. That is the Nursing Council’s submission—no wonder you looked very vague.

Mr Ross—I would like to make a brief comment on that point, if I may. For a number of years the QNU has supported the introduction of a no lifting policy and better health and safety mechanisms, and in many ways we achieved the implementation of that in better equipment and things, but to lift safely and properly requires time. What we are finding with the hours cuts, which Gay was talking about and which we are constantly battling, is that there is immense pressure on the employees to cut corners on safe practice. One of the main concerns of the employees in the dispute at Sundale that was referred to was the impact of the hours cuts on their personal health and safety. They no longer had enough time to lift safely, they did not have enough time to provide the care that they wanted to, and they were getting stressed about not meeting their obligations towards the residents, and those types of psychosocial injuries. So we are very concerned that the trends that have been achieved with the introduction of no lifting, with new equipment and the like, are actually turning around as the staffing levels are decreasing. That is a real concern for us as well.

Senator KNOWLES—If I can come to the council: these recommendations have been made before—I understand that you are encapsulating those recommendations that have been made before—but, by including that, you are obviously still suggesting that the problem is not solved.

Mrs Morrison—That is right. What we are also saying by that is that the recommendation that licensed nurses be employed in the aged care sector is to ensure that there is quality nursing care provided to those aged care residents in that area.

Senator KNOWLES—I thought, as I said before, that the issue of minimising injuries to the staff had to a large extent been resolved. Mr Ross has certainly highlighted areas where there might still be a shortfall. Do you have anything to add to what Mr Ross said?

Mrs Morrison—No.

Senator KNOWLES—Thank you.

Senator McLUCAS—Can I go back to the conditional adjustment payment. I understand there were three conditions that were attached to those payments. One of them was that financial accounts would be available. That gives you no comfort that you would be able to track where those moneys are going, Ms Hawksworth?

Ms Hawksworth—No, it did not, because I do not believe they have to be public.

Senator McLUCAS—I understand that is right. Would you recommend that those accounts be made public? I understand they are to be made available to potential residents and residents' families, and I think that is it.

Ms Hawksworth—It is—that is my understanding as well. But how many residents and potential residents would ask for them? I guess if you are an accountant you might know what you are looking at, but maybe you are not. So I do not think that goes far enough, no. That was our disappointment initially, when we saw that.

Senator McLUCAS—I also understand that for large organisations that have residential care on a number of sites but run the operations as one entity there is essentially one set of accounts that will be made available. It would be fairly difficult for a potential resident, who may be a nurse—

Ms Hawksworth—That is right.

Senator McLUCAS—to even track where moneys are going.

Ms Hawksworth—I would think so. I can think of a number of providers in Queensland who would have one central lot of accounts and I do not think you would not be able to pick out how each particular centre was operating.

Senator McLUCAS—So maybe your recommendation to us is that our recommendation should be that there be more transparency. I think you say that in your submission.

Ms Hawksworth—Transparency, yes.

Senator McLUCAS—But let us try and pin that down. Do you mean that accounts for each operation be made available to whoever asks for them?

Ms Hawksworth—Yes. We certainly have great difficulty and, as Steve and I have said before, we end up in very much a legal argument when we try and get access to the books. So if an employer says to us, 'We cannot afford to pay,' we say: 'Well, prove it to us. Show us your books.' We essentially end up locked behind closed doors with a couple of people we often call in, such as a financial expert, and then they have to sign undertakings that they cannot go out there and talk about the books. So the way it operates now is very difficult, and since 1997 our view has been that if it is public funding then there should be much more accountability and transparency about it. There has to be a way of ensuring that the care dollars are spent on care.

Senator McLUCAS—I imagine that the sector would not be enamoured of that proposal.

Ms Hawksworth—No, not at all.

Senator McLUCAS—Rather than putting your financial accounts on the web site, which will not happen in my view—I just do not think that the government or the providers would accommodate that—is there another model? Is there a method that would have transparency, where we as a community—not necessarily your union or nurses generally—would feel more comfortable that moneys that are being allocated by and large, we think, to reduce the disparity in wages are actually being allocated that way?

Ms Garrahy—My initial thought would be that, at present, we cannot even access things like the RCS categories of residents by facility in this state. If we were then able to access the rosters about the rostered hours per resident per day, we could begin to get an idea about the care levels being provided at a facility. The way we got information recently was through an arbitration process in the Industrial Relations Commission. We are not able to access information, say, in a low-care facility that we may think may have lots of high-care residents. While we may be able to access the rosters, we cannot do a comparison about how many hours per resident per day nursing care is being provided. Even that would give us some comfort, I think. If we could have access to that sort of information, it would be a starting point that we could use to measure levels of nursing care being provided.

Senator McLUCAS—In your supplementary submission you talk about one of the agency's standards: that there are appropriately skilled and qualified staff sufficient to ensure that services are delivered in accordance with the accreditation standard. How then do you think the agency makes that assessment?

Ms Garrahy—Our understanding is that the assessors who go into the agency follow an outline that has been prepared by the agency to assess each of the criteria. That is publicly available for anyone to access the criteria that are broadly used. One thing that has come to light, again, with this dispute is that there does not seem to be a consistent approach to how assessors look at this expected outcome and others. An example of how we can demonstrate that has occurred with the dispute matter, in that the assessment team doing a review audit came to a conclusion that there was compliance with that standard, that there were enough staff to meet the resident care standards. Part of the assessment was based on the assessment team's review of an independent consultant's report done by the facility as part of the arbitration process. Under cross-examination, the consultant actually admitted that, when they did the independent review, they did not look at the resident care needs according to the care plans to see whether those care needs were being met. They used other methods: they assessed the outcomes as the agency might to assess whether or not there was adequate staffing. We say that the way to find out whether there is enough staff is to look at the resident care needs according to the care plan and see if those care needs are being met, talk with the staff about how they feel about it and come to some assessment that way. That is not the process that was used in this case. However, in another review audit that was conducted recently at a facility in Sandgate, the assessors took a great deal of detail to this particular expected outcome and spoke with the nurses about how they felt about the care standards, whether they were able to do their job in an appropriate time that they had been allocated. It was a much more lengthy review of that particular outcome, and noncompliance was found.

There are a couple of things out of that. Firstly, there does not seem to be a consistent approach to assessment of the expected outcomes. Secondly, the staff are not always involved in that, which is most important in getting some sort of view about whether or not the resident care needs are being met. Thirdly, my observation of the review audits and other audit reports on the accreditation web site has demonstrated to me that the assessors do not consider necessarily whether the care needs of the residents are being met according to the care plans. They may be assessing whether the outcomes are being met but not necessarily whether the residents are getting their showers every day or every second day as they should, whether the residents are being weighed monthly or whether they are losing weight over time. Those sorts of things are not looked at.

Senator McLUCAS—So how do you think the agency comes to a view about whether that standard is being met—or is it different every time? I suppose I am moving it into the broader question about the operation of the agency.

Ms Garrahy—Included in the sorts of assessments undertaken would be: interviewing the staff each time about how they feel about the resident care standards; asking the staff each time whether they are able to complete their duties in the time they have got allocated; asking staff each time how much overtime they are doing and not being paid for; asking staff each time if they are able to get their tea breaks and so on; and putting a lot more detail into the questions that they are asking at each visit. A lot of the reports you read just say: for this standard, yes, we have spoken to the director of nursing and the HR person and, yes, there are position descriptions for all staff. Performance planning is documented yearly but they do not go into the detail of talking with the staff about the expected outcomes particularly in the care standards specifically.

Senator McLUCAS—Do they look at the roster?

Ms Garrahy—For this particular dispute matter there was consideration given to the roster by the independent reviewer. The agency in reviewing that report would have seen some roster information but I am not sure whether that is a routine thing that the assessment teams look at.

Mr Ross—Certainly if, within that standard, there was a particular staffing ratio or a minimum staffing level it would then be quite a simple matter for the accreditation agency to examine whether that was being met. When the accreditation standards were first being developed we had somebody engaged to participate in the development of those standards, and the debate was had and lost at that time. I think the types of problems that we have been experiencing ever since mean that that should be revisited and that if, within that particular standard, there was a form of minimum staffing levels or a minimum staffing ratios based on the resident classification then that would be a simple matter for the accreditation agency to check against. It would certainly provide confidence for the community and for us in general over those sorts of issues. Also, it would ensure that those funds for staffing—not so much wages but for adequate staffing levels—went into meeting that standard.

Senator McLUCAS—Can I move to another issue, and that is the recommendation from the council—which I am sure the union would agree with—concerning retention. It refers to training but I have written down ‘retention’ because I think that is an issue we are not actually focussing on. What is your advice about how we would better retain nurses in aged care, both community and residential nurses? The other question in my mind is about re-entry. You hear lots about the numbers of people who train as nurses and then do not continue to nurse. Is there something we can do to encourage those people to re-enter the work force, especially into aged care?

Mrs Morrison—In Queensland we have one process by which nurses can actually re-enter the work force. It is called the Competency Assessment Service. That has been in place for about three years. Prior to that we had multiple providers of re-entry or refresher courses conducted by universities, hospitals et cetera and there was a lack of consistency in the type of course, the length of the course, the cost of the course and the experiences that were provided. There was also a process called ‘supervised practice’ as well: nurses who wished to go back to the work force could practise in a clinical setting. Council brought in a recency of practice requirement, so that anybody who has not practised within five years would have to go through a re-entry process.

When the Competency Assessment Service was established 3½ years ago, the accreditation or further approval of the other multitude of courses ceased. So we now have one single pathway for nurses to enter. It is based in Rockhampton through Central Queensland University and CQIT, so it is for both RNs and enrolled nurses. There are provisions for nurses throughout Queensland to enter the program. I know that funding was provided for enrolled nurses to specifically access the service. They could then get employment in the aged care sector.

There is a cost involved and, depending on how much education the individual applicant requires, it will obviously vary as to how much it will cost them to go through the process. Certainly, if funding was made available, it would encourage those who wish to re-enter the work force to access that service. What is difficult is that, when people leave nursing to have a family or for whatever reason and then decide that they need to go back to nursing, it is usually at the very point in their life when money is probably least available because they have children to school, feed et cetera. That is the one thing that probably impedes that process.

Ms Thompson—Anne mentioned the supervised clinical practice model we had. There were some very good reasons for moving from that model, but one of the interesting things that occurred when we did have it was that we had a very high participation rate from the aged care sector in providing supervised clinical practice placements. I was involved in running that process at the time and they said that the reason for their participation in the program was that they found it a very useful way of recruiting staff. It was not a desirable model for a number of reasons, but I think the key thing there was getting people into that sector and developing the knowledge and skills for that context and for them to have a positive experience of nursing in aged care. That was the key thing about that.

Senator McLUCAS—Which is exactly the same methodology that we bring to training rural doctors.

Ms Thompson—That is right.

Senator McLUCAS—If you train them in that setting, they are more likely to stay in that setting.

Ms Thompson—Yes. Before we came here today we were talking about getting the undergraduate students some placements in aged care. By the end of their course if they do not have some positive, mentored experience in aged care then the likelihood of getting them to work in that sector when they graduate is considerably reduced.

Senator McLUCAS—Are there placements in residential rather than community care?

Mrs Morrison—There are, but I think there is a shortage of clinical placements throughout Queensland. One of the issues is that if you have a reduced number of registered nurses already working in that area then they are not there to provide the preceptorship that the students require. Therefore, you are missing out on potential RNs who are going to work in that area because they are not being exposed to that area.

Senator McLUCAS—There is a downward spiral.

Ms Thompson—And they are too busy.

Mrs Morrison—They are not able to provide that supervision. The other thing is that, with the increasing age of nurses in managerial or top-level positions, there is not a perceived clear career path for new graduates. I would suggest that the aged care sector is one area that could be targeted to provide that career pathway because there is certainly the scope there for new graduates to enter into that area, take up positions and continue a career in aged care. But that does not seem to be happening.

Senator HUMPHRIES—The Nursing Council submission states:

> Nurses have the knowledge and skill to plan and provide person-centred quality care for people, whether they are an aged resident with special needs or a young person experiencing a disability.

We heard earlier today from the Younger People in Aged Care Alliance that the aged care culture is antagonistic towards young people with disabilities. Do you think there is a conflict between those statements or can they both be true?

Mrs Morrison—I think the issue is that, whether the individual is aged or young, a residential aged care setting is not the place for the young resident to be placed. Nurses would be well able to provide patient centred care to either type of client, but it is not appropriate to have them both in the same setting. That would be what I would take from those statements.

Senator HUMPHRIES—So do you agree that aged care settings not only are not appropriate but are actually antagonistic towards young people with disabilities? Is that going too far?

Mrs Morrison—I cannot answer about whether it is antagonistic. I just think it is quite inappropriate for a young person to be nursed for a length of time—and it would be; that would have to be their primary place of residence—when in fact the care is focussed on aged care.

Senator HUMPHRIES—Both your submissions argue for a ratio of nurses to clients to be established or for there to be minimum nursing requirements for a certain number of clients. With the exception of child care, where I can think of government legislating for those sorts of ratios, I cannot think of any other occupational area where that kind of ratio setting occurs. Can you think of any others?

Ms Hawksworth—In Victorian public sector nursing there are certainly mandated nurse to patient ratios.

Senator HUMPHRIES—In acute hospitals in the public sector in Victoria?

Ms Hawksworth—Yes.

Senator HUMPHRIES—Do they stick to those ratios?

Ms Hawksworth—Absolutely; without a doubt. There is also Californian legislation that Arnie Schwarzenegger is trying to knock off. There are also class sizes.

Senator HUMPHRIES—Where do they do that?

Mr Ross—In New South Wales.

Ms Hawksworth—In New South Wales and Queensland.

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

Committee adjourned at 4.17 p.m.