COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

Reference: Aged Care

WEDNESDAY, 27 APRIL 2005

MELBOURNE

BY AUTHORITY OF THE SENATE

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COMMUNITY AFFAIRS REFERENCES COMMITTEE

Wednesday, 27 April 2005

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

Substitute members: Senator Allison for Senator Lees

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

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

Terms of reference for the inquiry:

To inquire into and report on:

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

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

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

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

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

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

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

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

WITNESSES

Committee met at 9.04 a.m.

KURINCIC, Ms Helen, Executive Director, Benetas (Anglican Aged Care Services Group)

TENNI, Mrs Colleen, General Manager, Aged and Palliative Care, Melbourne City Mission

GRUNER, Mr Alan John, Manager, Residential Aged and Day Care Programs, Brotherhood of St Laurence

MORKA, Ms Christine, Manager, Brotherhood Community Care, Brotherhood of St Laurence

CHAIR—Welcome. The Senate Community Affairs References Committee is continuing its inquiry into aged care. Information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. The committee prefers evidence to be heard in public, but evidence may also be taken in camera if you consider such evidence to be of a confidential nature. The committee has before it your submissions, and I now invite you to make an opening statement to be followed by questions from the committee.

Ms Kurincic—Benetas is one of the few not-for-profits that is solely focused on aged care. We are a specialist community care and residential care provider. We do not see ourselves as housing providers. We care for people at home from the time they need it through to the time they die, either at home or within a residential care facility. Our major focus has really been on a financial turnaround strategy to ensure our sustainability for the next generation and also a growth strategy, which has been embarked on. I will largely address three items from the terms of reference: (a), (b) and (e). I will make some key points in regards to those.

For item (a) the key issue I would like to bring out is the number of reviews that have occurred in aged care, particularly in regards to work force and nursing issues, without substantive change that affects direct-care and nursing staff that are providing the care services. IR regulation is certainly an issue here in Victoria in terms of the way in which we can use the skills of our labour force in aged care. Availability of staff will increasingly be an issue, but it has not been an issue for our organisation with recruitment of staff at all. We were affected some years ago by the Victorian acute care sector recruitment strategy, which targeted nurses coming back into the work force and nurses going from the aged care sector to the acute care sector. But since then we have not had any problems at all recruiting staff. So we are not feeling any effects of work force shortages yet, but I have no doubt that, in the decades to come, given the general work force demographics of our population in Australia, that will become increasingly difficult. A part of what we are doing about that is looking at targeting an older work force and what strategies we need to implement in that regard. We are working with researchers in the ANF to see how we can be attractive for older workers so that we are prepared for the effect of the 2020s. The other major factor affecting the work force's leadership in aged care—and it is the most important factor in determining both financial and client care outcomes—is the management of programs, services and facilities.

In terms of item (b) we make our comments as an organisation that is very proud of receiving four commendable awards in the last accreditation round. As an organisation we received the highest results in the country through that process. One of the things I have seen more evidence of compared to the first round of accreditation is the steps towards trying to identify best practice in the sector, which is very much needed by all of us—learning from best practice and evidence based practice in aged care. Documentation is certainly an issue—and it does not just arise from funding. It is a part of every component of aged care, which is a very regulated industry. The paperwork burden also extends to the accreditation process, given it is driven by a documented evidence process. It is a lot higher than you would see in acute care, even in areas such as looking after intensive care patients.

The other component I would like to highlight is the cultural diversity issue. At the moment that is addressed only under one standard, 3.8. We auspice a project called Partners in Culturally Appropriate Care. That is a Commonwealth funded project. A lot of work has been done on how cultural diversity should be addressed across all of the standards. This is increasingly important, given that we are not talking about a special needs group. We are talking about over 30 per cent of our market in terms of the people that we look after.

In terms of item (e), transition between programs can be significantly reduced through rationalisation and consolidation of services. We spend a lot of time with focus groups, with our clients and with family members. The greatest struggle they have is that every time their care needs change they go from provider to provider, which is why our ambition is to be able to provide that whole gamut of services in a region, to ensure as much as possible that we can smooth out the differences that we experience with different levels of government and with the different programs that are funded to care for people.

The second item which I referred to in the submission, the MGap program, is actually coming to a conclusion. That was a two-year trial and that concludes on 30 June this year. The new transitional care places will be very welcome but I understand in Victoria that will be done through the metropolitan health care services. A focus of that appears to be largely bed based.

A key issue in terms of transition and community understanding is how rapidly community care is changing. Our ability to look after people at home is changing year on year through advances in how we care for people from a labour skill point of view, from a technological point of view and from a pharmacological point of view. The things we are doing now in terms of providing high level care for people at home is progressing rapidly. We are looking after people with more complex issues than we were even able to do a year ago. The acute care sector and indeed often the community does not understand that we can actually provide that solution for people. Rather, we often think that we need to put someone in a bed and so they go from a hospital bed to a residential care bed.

The other component is that we actually researched issues in terms of location decisions for people and how those decisions are made—given that often the entry is from acute care into residential care—and how we need to plan for our services in the future, given that that is not necessarily the way in which the government formula is driven in terms of supply. What we found through those who had made the location decision was that in just under 50 per cent of cases the location was near where the older person lived. In just over the majority of cases the location was driven by a family member—usually the oldest daughter in the family. They decided where that person would get their services provided. If they needed entry into residential care, the facility would be close to that relative to enable easier visitation access to the facility. That concludes my opening statement.

Senator McLUCAS—I want to talk to you further about the transition program. My understanding is that it was intended to be far more flexible than you are telling us it is. What makes you think it is a bed based program?

Ms Kurincic—From the figures that I have seen in the plans that have been submitted by this state to the Commonwealth, more of the places are being used for residential based transitional care than community based transitional care.

Senator McLUCAS—Using the language of step down, it is acute care into residential aged care without the option of considering community care?

Ms Kurincic—It depends on where the person goes—residential or community care—but bed based transitional care seems to be allocated the majority of places in the planning from this state, which may be different from other states. I have not seen what has been submitted in the plans yet in that regard. But often you will find that from an acute care perspective people do think bed based care is the solution.

Senator McLUCAS—In terms of the agency—congratulations on your success; you have done very well—the issue that has been raised with us a lot is the consistency of the assessment process. Regularly witnesses have talked about the lack of consistency, saying that the agency's success in meeting a standard at one point will be met by failure to do so at another point, and in their view nothing has really changed. Do you have any views about consistency?

Ms Kurincic—I think it is a very difficult issue when you are talking about human behaviour and human beings' interpretation of what they see and the experiences with which they come to the facility. I think that actually determines the greatest variations that you do see amongst the teams that visit the facilities. Given we have so many, we do see variations in people's assessment skills and their ability to understand complex systems. I am certainly aware of a lot of steps that the agency takes to try to iron that out—through its training and peer reviews, for example. The agency has implemented a lot of measures to do that.

Rather than seeing it as a problem, I am not sure that I can think of any measures that could be put in place within the current system, with the current standards and focus on outcomes, to guarantee that there would be greater consistency—and that would be for the general accreditation process. In the high awards process, because it had changed from the first round of accreditation to the second round, there was not necessarily much knowledge, certainly not within the sector, of what you needed to do to prove that you were worthy of a high award. I am sure that, given we will now be in the second round of that system, that will improve.

Senator McLUCAS—You also talked about documentation. I am sure you are aware that every single other person has talked to us about documentation as well. It has been put to the committee that reporting by exception rather than reporting every event would be a way to limit the amount of paperwork. Yesterday we heard some evidence that urged caution in that area, so I am interested in whether you as a provider think that reporting by exception would ease paperwork issues.

Ms Kurincic—Undoubtedly it would, because if you are only reporting by exception you are not reporting every single item. But it would take substantive change to the accreditation process, for example, to enable that to happen. At the moment we have a system where, if you cannot prove that you have provided care to a resident and say what the outcomes were of that provision of care, you would not actually pass accreditation because you have no evidence to back up what you have done. So at the moment the burden of proof lies with the provider—we have to prove that we are innocent, so to speak, and that we truly have implemented what we said we were going to implement.

Senator McLUCAS—The witness yesterday said that because of the movement of staff—simply the number of agency staff going through and the natural movement of staff—she was concerned that if you did not report every event there would be a breakdown in the system. She thought it was potentially dangerous.

Ms Kurincic—In our organisation we use very few agency staff. Our staff are all permanent, and we also run a bank of casuals to ensure that for periods of leave—when someone is on sick leave or annual leave—we have our own trained staff who understand our systems so that there is that continuity of care. So our agency usage is actually minimal, but again it is incumbent upon us when we do use agency staff at a facility that we have processes in place to ensure that that agency staff member understands and is oriented to our system and to the documented processes that are required for them to be able to do their job effectively for that shift.

Senator McLUCAS—The other part of the whole documentation question is IT. The take-up of IT in the residential aged care sector has been very slow. Do you have any views on why that is the case? If in fact there were an investment in IT, might that relieve some of this whole paperwork question?

Ms Kurincic—I think the use of IT would be fantastic. I am a big supporter of it, if it is accessible to all staff, because that is the main driver. You would then have a lot of staff who would need access to that if it is to be used truly effectively at a care level. The level of investment needed to be able to achieve that would be quite significant, even for an organisation of our size. At the moment the return, so to speak, on that investment would not be there in either efficiency or productivity, so we are reliant on a document system. It is difficult enough to cover all the issues such as indexation and how care, particularly high care but also low care, is funded against the majority of the expenses, which are labour costs—and the labour costs increase year on year, as does the expense of insurance and every other item—as well as ensuring that your managers, community coordinators and admin staff have access to IT and systems. So that has been the focus of our investment, rather than saying, ‘Yes, let’s.’ For us—or for anybody—it would take a massive investment across the whole organisation for that IT access to be enabled.

Senator McLUCAS—I suppose the point I am getting to is this: putting the question of the cost to one side, if you were to put your care provision into an electronic format, would you see that there would be any great benefit for the residents?

Ms Kurincic—Yes, if it freed up time. If the format of the software was very much a click-and-tick type process, yes, it would. It would free up time for someone to be able to provide care to residents instead of sitting down with paper based systems and writing out in longhand what they had done that day.

Senator McLUCAS—Considerably, or would it be at the edges? Would it be a big change in care workers’ and nurses’ activities?

Ms Kurincic—I do not know that it would be considerable. I think it would certainly make some shift but it would be very hard to quantify what that would be. I say that, knowing that we are going to be changing the funding model as well and how that is to be driven with the new ACFI. The computerisation of that in itself will mean that there would be some reduction in time, so we are really only looking at the care documentation side being affected by that. Until that ACFI is in, it would be hard to measure what the addition of the technology would be in driving the care or how big a component that would be once you have made the funding model electronic.

CHAIR—Thank you, Ms Kurincic. We will let you escape now.

Mr Gruner—The Brotherhood of St Laurence is a charitable organisation based primarily in Melbourne and the surrounding suburbs. Its main focus is on low-income people and its aim is to have an Australia free of poverty. Its services are very much targeted to people on low incomes and often people with insecure housing or homelessness. There are a couple of points I would like to draw out of the submission we made. The first one has no doubt been dealt with in detail already, but it is a work force issue. We have two residential aged care facilities in the inner city of Melbourne and we have particular difficulties in recruiting all types of staff. We find there is great competition from the acute health areas, where there are more favourable pay and conditions for these workers, particularly for nurses and personal care attendants.

We have had quite a deal of success with using the traineeship project. We started that about four years ago and in that period of time we have had 12 trainees find permanent employment with our facilities. That has been a big help to us but, nevertheless, we do have this tremendous problem, particularly in the inner-city. With regard to our residential care facilities in the outer suburbs, we find there is not such a great difficulty even though recruiting nursing staff continues to be a problem. We have found that people do not have a very high opinion of the aged care services in general. Working with peak bodies, we have done our best to promote the sector. I think that the promotion of the whole of the aged care service sector is something that needs to be taken on by the industry.

The second area I would like to deal with has already been covered. You mentioned excessive regulations and administrative requirements—particularly in residential aged care. I would also like to bring up community aged care. We have a program in the outer suburbs of Melbourne called Banksia Services for Seniors which primarily provides respite and day-centre services. It gets three sources of funding. One is from HACC, one is from the Commonwealth National Respite for Carers program and the third one is from the state government carer respite and coordination program. All of these programs have different accountability requirements and different sets of reporting and all use completely different reporting formats, so we cannot transpose the data across from one to another. In effect, we have to keep three separate sets of data for one program, which is an integrated program so the same people are obviously using it.

We find that a couple of days each month are required to compile those reports, and it takes one day each fortnight just to divide staff time into different programs so that we can do the timesheets. That time being spent on administrative matters and reporting is taking staff away from their direct care duties. We currently use the HACC quality framework for the respite program and we will soon have to measure up against the new Commonwealth quality framework in the respite area—so, again, we are going to have two different types of accountability with our quality framework. This duplication of reporting and accountability is really costing us in the industry.

The other area I will talk about, which I did not include in the report but which has come up since we did our submission, relates to the community care reforms—particularly coming through with the competitive tendering process for a range of carer support services. Again, our service at Banksia has been operating for over five years now through Commonwealth funding. We have built up a very close relationship with the local community and users of the service. A number of the clients were quite distressed when they heard that we had to go through this tendering process. They felt that there would be a breakdown in the community of care and also in the relationship we had built up over that number of years.

We have also put significant resources as an organisation into the program, particularly at Belding and other areas. While we understand the main aims and the tendering process and we certainly support the overall thrust of the government's reform agenda in community aged care, we are concerned about the process of competitive tendering, which we find is causing quite a deal of distress amongst our service users and staff and, again, a lot of paperwork and extra work, taking people away from the direct care requirements.

I would also like to mention what we see as the inadequate response to special needs groups. I think the issue of younger people being inadequately catered for in residential aged care facilities has been mentioned before. We have one 30-bed high-care facility and we have four younger people in that facility with various disabilities, including intellectual disabilities and acquired brain injuries. We also have three people in one of our low-care facilities with Huntington's disease. They are aged in their 30s and 40s. Again, these placements are completely inappropriate for dealing with younger people and, while they receive an excellent level of care, it is really difficult to meet their particular interests as they are in such a younger age group. It seems to us that there is certainly an urgent need to establish more residential care facilities for younger people with disabilities.

With regard to the special needs group, I would like to focus on homeless people, a group for which we have particular expertise and focus on with our services. In general, homeless people or people at risk of homelessness lack proper accommodation, have poor diets, experience multiple health problems and are subject to social isolation. All of these factors combine to produce a lifestyle which hastens the ageing process. We have people in their 40s who have the appearance and characteristics of people in their 60s or even 70s. However, these people can be excluded from Commonwealth funded aged care programs because they do not meet the age criterion. We would argue strongly that these people, because of their special needs, do meet the criteria and that the Commonwealth Aged Care Act should be changed to include homeless people as a special needs group so they can become eligible for these programs. Similarly, we believe that the HACC guidelines need to be expanded so that younger people in this category are eligible for HACC services because of their premature ageing.

Being a special needs group, homeless people often require services that are not generally available. For example, homeless people have often learned different types of coping behaviours which are not suitable when they come into a normal community setting. Extra resources are often required to assist them and retrain them to deal with other people. This applies particularly in HACC settings but also with aged care packages and residential aged care. We have also found that homeless people coming off the street after many years are very suspicious of people, and particularly of mainstream services. It takes quite a deal of time to actually build up trust with these people before we can encourage them to access the services. Often it is a case of our workers going out in the streets and spending time with these people. None of this is funded through any of the aged care packages or other Commonwealth funded services.

The extra resources required with residential age care, again, are not picked up in the RCS funding instrument. We have one example in a residential care facility of a couple of people who have been living on the street for a number of years and have not been used to toilets and who defecate in their room every day. We have the added expense of steam cleaning the rooms each day, which obviously we cannot claim through the RCS.

The final point that I would like to make is about transitional care, again focusing on homeless people who are discharged from the hospital system, often inappropriately in terms of not being ready to go back into their homes or into supported accommodation. We are very keen to set up some transitional programs which allow these people time to make sure they can care for themselves adequately before they go back into the community setting. An excellent model operating in the Fitzroy area in Melbourne by the St Vincent’s Hospital is the cottage. It allows for four or five days or even more transitional care for people coming out of hospital to provide them with support to ensure they are ready to look after themselves when they go back into the community. Christine would also like to make some opening remarks.

Ms Morka—I would like to comment a little more on the community side of things and *The way forward*, the document from the federal government on the review of community care. The Brotherhood supports the model of having different tiers of service provision for frail aged people. The bottom is the HACC basic, the middle is deemed to be the package level of care and the top is the complex, high-needs level of care. I want to stress that we often have people on community aged care packages that are not deemed to be high level in terms of the amount of service and the $39,000 that is applied to the high-care needs level, but who actually require more than the $11,400 for the package care. We believe there should be another stage—you probably have to make it a tier—at around $15,000 to $20,000 if we put it in financial terms, for people whose health condition is deteriorating. Generally, as providers of services, we carry the level of support that those people need because there is nothing else for them. That needs to be addressed in some way.

With regard to the issue of younger people with disability, under the Linkages program, which is under HACC funding—and I am talking about people who might be 30 or 40 years of age—we certainly also see that the neurological areas do not seem to be addressed through the funding and service level need. We believe that those people should be at a higher level and perhaps have a category to themselves. So we are seeking some identification that neurological problems really are very complex, and we are trying to source resources within the community from across a multitude of programs to assist those people.

Another issue is whether the HACC services themselves are adequate. The difficulty for programs such as CAPS programs or EACH programs is that more commonly now HACC services basically will say, ‘You’ve got a package of your own, so you do not need the services that come through local government et cetera.’ What is occurring is that they are saying that a full fee for service should be recouped. If somebody is actually going to a day program such as a planned activity group, that can amount to between $80 and $90 per day for a person to be able to do that. So it certainly is reducing the amount of time that that person can socialise, get out and do other things. Respite has the same issue. Often organisations will say, ‘We can provide respite to you, but it is going to cost X number of dollars.’ For somebody to have overnight respite, you could be paying $200 to $300 for that respite—if it is continuous care. So, out of the $11,000 that you have for each client, that does not leave an amount of money to do much for that client.

One aspect that is really important to my heart is that older people really should not have to just endure old age. It really also should consider other aspects of their lives, and that is what we try to do through our case management model. Case management really is not identified as a service in itself. There is no data collected in regard to case management services, and we believe that is more than just coordinating home care, personal care and those types of services for our clients. At Brotherhood, we also identify that people have social needs, belonging needs. We see, especially through our own target group, people who are isolated and lonely, people who have not been out of their homes sometimes for many years or who have not seen their relatives for many years. We are trying to address some of those issues, but funding itself really is not allocated for that purpose. Although there is a socialisation component, it seems to be addressed at the level that somebody might be able to go down and do their own shopping and have a personal carer assist them to do that. There is not enough funding to look a broader issues. They are the things I wanted to add to Alan’s remarks.

CHAIR—Ms Tenni, would you care to make your submission?

Ms Tenni—Thank you. First of all, I apologise profusely for being late. I came from the leafy suburb of Eltham. As the crow flies, it should have taken me half an hour but it took me an hour and a half. I think there was a blitz on the city this morning. I do not want to repeat the things that have been said by previous witnesses, because there is duplication in the system and obviously there is duplication in some of the complaints that exist across our industry.

I would like to start by saying that I have been in the health and welfare sector now for 30 years—which does give my age away, so that is not very pleasant! Across that time I have been in subacute, local government, not-for-profit and acute systems. I have been across the whole range and raft of systems out there for elderly people. Probably the most difficult one is aged care, residential care.

Our submission to you is about the ABI clients, so I have to stick to just that particular issue, although I would love to go on to a range of things and I am sure you would love to hear it all. We have a nursing home in Fitzroy. For anyone who does not live in Melbourne, it is certainly not the leafy suburbs of Eltham; it is inner city Melbourne. We have to close down that nursing home because of the cost associated and meeting the 2008 certification. We have three ABI clients who live there. Without giving away their privacy, we have one particular ABI client whose social fabric is around inner city Melbourne. It is not really the issue of funding and it is not really the issue of living amongst people who are elderly; the issue is around how you can actually make a life for ABI clients that is suitable and appropriate.

Our argument in our submission was around the ABI clients that we look after. We have a case management program that looks after ABI clients, and we have three currently in existence at Harold McCracken House. I guess the issue for us is: where can younger ABI clients go where they can have quality of life and are not surrounded by the older members of our society? It is a different way of living.

I have a couple of other things to talk about. I just want to pick up on the issue of IT. My last job was as the director of a coordinated care trial for the Commonwealth government. We introduced an assessment form on laptops. I said to the nursing staff: ‘You will not use a pen again. You’ll take it into the person’s home.’ We have done that. We have put what is called the interRAI assessment form up onto a laptop successfully, and it has been picked up by the state government in paper based form. I believe that form can actually go across the community sector and into the nursing home sector and stop all this fragmentation and duplication of assessments. I think if I were an older person and had eight different professionals coming to assess me over a period of time, that would start to get a bit wearing, so I have been practising the minimental for a long time.

I think it can be done. It takes tremendous commitment and it does take a significant amount of money to put that sort of technology into facilities. I agree with Helen that it needs to be made as simple as possible, but the fact is that it has been done for a community care setting and it can be done across all of those settings. Professionals have to trust each other’s judgment. So, if you have done a community care setting assessment on someone and they have been on a package, living at home and they now have to come into your nursing home, you should be able to take that assessment form and not duplicate it. You just change the elements now that mean that person requires nursing home care.

Again, the primary focus for our submission was on younger people living in nursing homes and the need for very professional support and therapy for those people. I will just add again that I am hoping that the coordinated care trial will come out with some of those answers for us across range of services and not stop at residential care. It seems to me that we get to the door of residential care and then it is all a bit too hard.

I wondered if I should give an example of how much it costs, because one of the problems with ABI clients is that there is a lot of anecdotal information about how much it actually costs to keep younger ABI clients in nursing homes. If you will just bear with me, this is one example. We get a bed subsidy from the Commonwealth in excess of $40,000—currently $44,037 per annum. Further, we get enteral feeding subsidised by the Commonwealth, currently at $15,848 per annum. The Commonwealth also provides the pensioner supplement, currently $4,440 per annum, and the transitional supplement, currently $5,930. The total funding from the Commonwealth for this resident is currently $66,255. We also receive reimbursement from the ‘slow recovery’ program of $21,860.

This is a person who does cost a lot of money and who has a strong advocate, and there are a number of other people in a similar position. The problem is that the money comes from different areas, so we need to look at how we can set up a suitable program for younger ABIs and fund it at the level that it needs to be funded at in order for the families and for those younger people to feel as though they are getting the best quality care. Thank you.

Senator KNOWLES—To come to where you finished: you said that is what we need to do. How do you propose it be done?

Ms Tenni—It is so hard. As I said, having been in the industry for 30 years, one of my jobs was to construct a framework for aged persons' mental health services across Victoria. When it came to the ABI clients, it became very difficult: their behavioural disturbances were very different to mental health issues and, in some cases, they were very similar. An ABI unit was set up at Royal Talbot some time ago. I think that, if we can look at the number of people who sit in that category across the state, then we probably do need to set up a specialised unit or we need to put it out to tender to organisations prepared to do it, but at the moment most organisations would anecdotally say they cannot afford it. So they may be able to have a 10-bed unit that is specifically for ABI clients, but unless the funding follows they just will not put their hand up.

I am in that predicament at the moment with three ABI clients who need to be transferred out of Harold McCracken. I went to a nursing home the other day and said, 'I've got three ABI clients; would you be prepared to take them?' They said, 'Yes, we have absolutely no problem with that. We don't care how much it costs.' I just about fainted because that has not been the response elsewhere. You could set one up in Ballarat and that would not suit the people in inner city Melbourne. You could set one up in inner city Melbourne and it would not suit the country people. It is about looking at where the ABI clients are coming from—because I think there are some predominant areas—and seeing what we can do to ask some of the proprietors of these facilities to show empathy but also back it up with support.

Senator KNOWLES—You said 'unless the funding follows'. By that do you mean that unless the funding from the nursing home follows to the new facility it is not going to work?

Ms Tenni—Unless the funding follows the resident—if the funding can be packaged so that it meets the requirements of that particular resident. The assessment should be based around that ABI client and what their problems are, because across that range of ABI clients you will find different issues, different behavioural problems and different areas of the brain that have been affected. So there should be a complete assessment done of that resident and then a decision made about what level of funding is adequate. There are some ABI clients who recover to a certain level and there are some ABI clients who do not, so hours and hours of physiotherapy are probably not going to make a significant difference to that person, but that is a judgment that needs to be made by professional people and then backed up, while the funding follows the client.

Senator KNOWLES—We have a problem in this area with the 'funding follows' issue. A lot of people have said to us that, if a young person who is currently in a nursing home could just switch to another facility that is specifically designed for younger people with disabilities, and that money that has been spent on them there just goes with them, all would be well. The difficulty with that, as you would be aware, is that the funding that is being provided in the inappropriate setting is provided by the Australian government and the funding that would be provided for a disability position should be provided by the state government.

Ms Tenni—Agreed.

Senator KNOWLES—Therefore, as I understand what you are saying, for funding to follow is actually letting the state government off the hook for their area of responsibility under the Commonwealth-State/Territory Disability Agreement. How do you see we can overcome that problem?

Ms Tenni—From my time in coordinated care I learnt that, unless you talk about the resident or the person and nominate the amount of money that they need to stay at home—if that is what they want to do—or stay in an appropriate setting, it gets awfully confusing. It is hard to standardise. Anyone trying to make up some sort of funding regime for these people makes it very difficult. You are asking me a specific question about the state government, which I am not sure that I can respond to at this point. I think it would be excellent if the state and the Commonwealth government could talk more about this issue and come to some arrangement that suits, but at the moment it is quite fragmented and it does not pick up the issue of the unhappiness that surrounds the families and people with ABI.

Senator KNOWLES—I think that is right. There is obviously a huge problem with the CSTDA because it seems that there is no accountability for the way in which the money is spent. Mr Gruner, can I ask you about the problems with homeless people? How would you see those problems best being solved given the at times unsociable and difficult general behaviour of some of those specific people who (a) do not want to be in a facility and (b) whose fellow residents do not want them there? It is almost unanimous on both sides that they do not want to be there, but at the end of the day they need and deserve care. How would you see that best being resolved?

Mr Gruner—One of the things we have found with a number of homeless people coming into our low-care facilities is that, while they meet the assessment requirements in terms of health, in many ways they are really seeking accommodation. We have found that they often come in as a category 6 or 7, but they are actually after accommodation. We provide some accommodation facilities, and it is not unusual when one of those flats becomes available for a person to shift out of low-care residential care back into community care. It is more of an accommodation issue than a health issue in lots of ways with a number of those homeless people. Also we have found with a number of them that, while their behaviour has been quite difficult for a number of the other residents, they do settle in very quickly if they can strike up a relationship with staff, particularly the staff who have empathy for them, understand where they are coming from and can work with them very closely. We have found that with those people it is more about resourcing and having staff dedicated to them. Often it is only for a short time; it is just to get them back into the feel of the community and to realise that they are trusted and they do have some worth in our society. It is giving them that feeling of self-worth again. Once that comes, they do start to fit back in. I think initially it is a resourcing issue for them as well as an accommodation issue.

Senator McLUCAS—Thank you for the information about the interRAI assessment form. Can you tell us more about that?

Ms Tenni—There is an interRAI web site, but we were the first to manage to get this up onto laptops, and it was done through the Commonwealth government.

Senator HUTCHINS—So there is an actual form?

Ms Tenni—Yes.

Senator HUTCHINS—Is there a possibility that we could get a copy of that?

Senator McLUCAS—Is it on the web site?

Ms Tenni—Most definitely. I would love the Commonwealth to get excited about it because one of our major issues is that we are constantly duplicating assessments right across the field—from HACC in the home right through to the nursing home—and we have to stop that. It is too time consuming. It does have a web site. Professor Len Gray is the interRAI Australian representative. It is a tool that has been validated by a group of highly skilled professional people. Getting it up onto a laptop was the most difficult part. Trying to use the written form is very difficult. It is quite comprehensive.

Senator McLUCAS—You are suggesting that this form be used in community care and residential aged care. How do we breach the acute-to-care interface? Is it possible to use that?

Ms Tenni—When it was on trial we were allowed to share the information across the acute and subacute areas. We could give people a print-out of that particular care plan so that once a person entered hospital the staff there did not have to reinvent the wheel. Everything that was being provided for the client they could read off this form. We could give the same to the GPs. Some of the privacy issues were starting to get in our way in relation to trying to web-enable the interRAI form. We were working through that as best we could but, in the end, the GPs would say, ‘Just fax it to us.’ From a privacy point of view, when you have a stumbling block called the web but you have a fax machine where the forms can fall off the fax machine, it seems a bit ludicrous. We were struggling with that one; it was a huge issue for us.

Senator McLUCAS—Is the question of privacy to do with the doctor privacy questions, or is it a broader privacy issue?

Ms Tenni—It is the broad issue of privacy. People are confused at the moment about what they are allowed to share and what they are not allowed to share, and to whom they are allowed to give what information. There is quite a bit of confusion about that and it needs to be sorted out amongst health professionals.

Senator McLUCAS—Is that linked at all to HealthConnect or MediConnect?

Ms Tenni—No.

Senator McLUCAS—But there is potential for an interface there?

Ms Tenni—Absolutely.

Senator McLUCAS—We might contact you further about that, or I might myself.

Ms Tenni—I would be very interested. The documentation that staff have to deal with in any sort of facility, or even out in the community, is quite outstanding. There is a lot to be written and I do not object to that at all. But I think that, unless we have a generalist approach to this, you get the human variable and then the Commonwealth cannot really see whether what has been written is reasonable. Does that make sense? It is taking that objective view of the client and being able to say, ‘From what I have seen here you’ve assessed this person as requiring this, and this form is valid so I accept that,’ or I don’t accept that.

Senator McLUCAS—And then you can have the discussion about that.

Ms Tenni—That is right.

Senator McLUCAS—Thank you very much.

CHAIR—Mr Gruner, how many volunteers do you rely on to provide your services?

Mr Gruner—Across aged care?

CHAIR—Specifically, and then would you give me a broader picture.

Ms Morka—Under community care, when you are asking about volunteers are you also talking about informal carers who are the daughter or son or whatever of one of our clients? That would be a large number of people. In some of our other programs for community within our organisation, however, it is not a huge number of people, but we are starting to build on that. That might be more from my point of view in our socialisation area, because that is the area I am saying that we do not have funding for. There are a lot of people who really want to assist us by providing some help, so we do it there.

Mr Gruner—We probably have over 100 volunteers. We have four aged care facilities and two day-care facilities, so it is a bit over 100 registered volunteers.

CHAIR—Have you done any work on what the value of that would be in dollar terms?

Mr Gruner—Not in dollar terms, no. We have not done any costings. A lot of it is value added. The staffing meets all the requirements in terms of accountability, but the added care which people require, and which volunteers provide, is not captured in any accountability documents. We have not captured that financially.

CHAIR—Ms Tenni, do you have volunteers operating in your area?

Ms Tenni—We have fewer and fewer. I think the baby boomer generation are less likely to get into volunteer programs.

CHAIR—Those baby boomers seem to be a problem in almost every instance, don’t they!

Ms Tenni—I happen to be one of them and I am ashamed to say that I do not do any volunteering.

CHAIR—I am far too young to be one, but there are a few around here.

Ms Tenni—Over the years, I have seen fewer and fewer volunteers and that is because of accountability, responsibility and what you can allow volunteers to do. Again the issue of privacy breaks down the relationship you should be able to have with volunteers. I also know lots of families, and again it is usually the eldest baby boomer daughter who goes in and feeds mum or dad at lunchtime and dinnertime because they are afraid that they might not get fed. So their volunteering is an absolutely huge component and I could not even put a dollar value on that. I would like to make them feel reassured that the quality of care is good enough for them not to have to do that. That has been one of the issues in transferring residents from Harold McCracken House to Eltham. A number of the relatives live in Fitzroy and they come around at lunchtime. They cannot do that anymore. That has created significant anxiety for people who do that sort of volunteering work. We have lots of people who give concerts and things like that, and they are more than happy to do that, but we have fewer and fewer who go anywhere near any sort of direct care.

Senator McLUCAS—Mr Gruner, you have made a very strong case for changing the eligibility criteria for homeless people to access aged care support. Are you also suggesting that a homeless person needs an extra stream of funding? I think you said that in your evidence, but it is not so clear in your written documentation.

Mr Gruner—I would not see it as an extra stream of funding. I think it is more about tapping into the funding but creating a special needs group within the Aged Care Act. I think Professor Hogan recommended that homeless people be taken into account with special needs funding. I think the Commonwealth’s response was more or less that they saw that as a state government responsibility and that it was already being well catered for. We would strongly argue that it is not being catered for at all and that there is a need for a funding stream for homeless people.

Senator McLUCAS—I think Professor Hogan indicated that there were three areas that required special funding. I do not know whether he used the word ‘homeless’, but I think he used the term ‘socially disadvantaged’ or language like that. And that is the one that has not been picked up.

Mr Gruner—That is right, yes. A lot of people live on the streets but it is often a case of them coming in and out of accommodation. They go into public housing but they do not stay very long and they move out. So it is social disadvantage but focusing on the lack of appropriate accommodation.

Senator McLUCAS—Finally, you have been through the competitive tendering round for the national respite money. Would you like to share with the committee your experience?

Mr Gruner—As I said, I think it came as a shock to a number of our clients when we understood what was involved. The Banksia service could cease to exist. A number of our paid carers have been working with the Commonwealth program for over five years. They have built up a very strong relationship with a very vulnerable group. There was a great deal of concern that the continuity of care, that linkage and trust they had built up, would be lost. From a staff point of view, there was obviously a great deal of consternation about what it would mean for them, especially with the short time lines. It was only a couple of months, I think, from the time the submission went in to when the new programs would be starting. We knew it was coming, but we did not know the date. When it came, we had to work very quickly. It took us about three weeks of extra time. We had to bring in a consultant to help us, which was an extra cost, and also a number of staff had to be taken off duty and we had to bring in relief staff to cover for them. So there was certainly a large cost involved in preparing the submission.

Senator McLUCAS—Would you estimate what that cost was? You have the consultant’s bill, obviously, but there is the staff cost as well.

Mr Gruner—It would certainly be in excess of $10,000.

Senator McLUCAS—Are you happy to share with us the value—

Mr Gruner—I think our submission was $650,000.

Senator McLUCAS—Have you been advised of the time frame from here on in?

Mr Gruner—No. We have just been advised that the new service will be starting on 1 July.

Senator McLUCAS—But you do not know whether you are successful in that tender yet?

Mr Gruner—No.

Senator McLUCAS—So between 1 May and 1 July something is going to happen.

Mr Gruner—That is right. That is our concern. If we are not successful and a new organisation comes in and takes that up, they have very little time in which to pick up our clients and build up that relationship.

Senator McLUCAS—The service you currently operate out of this building that you own has three streams of funding, so if you were to be unsuccessful in the national respite program you would still have HACC money and the state government respite money.

Mr Gruner—That is true, but we would lose half our funding overall.

Senator McLUCAS—You would not be able to operate the service with just the two streams of funding, one would imagine.

Mr Gruner—Not as it operates at the moment. It would make it very difficult to operate the service at all.

Senator McLUCAS—Would you like to make some comments about the value of competitive tendering? Is it a useful mechanism to ensure accountability?

Mr Gruner—Personally, I do not think it is. Within aged care, particularly in the not-for-profit organisations, I feel that something like selecting organisations that have built up a certain regard in the community and inviting them to make submissions would be a much more preferable method of dealing with, particularly, clients who are particularly vulnerable and not aware of the issues involved. There is an emotive attachment to the term ‘competitive tendering’.

You could talk about ‘selective submissions’. I think it is a softer term, and people are more attuned to that and understand that there is a need to put forward your best case for presenting the service.

Senator McLUCAS—It has also been put to this committee that collaboration, community organisations actually working together, and the notion of a shared responsibility and shared set of work has been completely lost in some places.

Mr Gruner—Yes. The need for confidentiality certainly breaks down any notion of partnerships and working together with different organisations and puts up walls between organisations which were working closely together before.

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

Proceedings suspended from 10.08 a.m. to 10.22 a.m.

SPARROW, Mrs Patricia Lee, Secretariat, Community Care Coalition

HARGREAVES, Ms Clare Lynette, Senior Advisor, Social Policy, Municipal Association of Victoria

WALSH, Mr Peter, Director, Policy and Strategy, Municipal Association of Victoria

CHAIR—Welcome. Information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. The committee prefers evidence to be heard in public, but evidence may also be taken in camera if you consider such evidence to be of a confidential nature. The committee has before it your submissions. I now invite you to make an opening statement to be followed by questions from the committee.

Mrs Sparrow—Thank you for the opportunity to provide evidence today for the coalition. I am representing the national Community Care Coalition, a coalition of 22 national peak bodies representing consumers, carers, service providers, professionals and volunteers. It was formed in late 2003 because of the need to highlight the strategic importance of community care, to raise the profile of community care, to highlight the need for increased funding and to ensure that system reform occurs over the next three years to make it a more effective and simple system for everyone to use.

Our submission focused only on one of your terms of reference, (d), which was specifically around the Home and Community Care program. I would like to highlight the key points from that. Basically, there is a growing number of people who are going to require support in the home, and most often people prefer to be supported at home. We know that by 2006 there will be 1.3 million people with severe and profound disabilities, and of course we all know the statistics and demographics about our ageing population.

The other key point that we make is that there is a need to ensure an adequate level of care in the community. An analysis that we undertook of recent HACC data for 2002-03 shows that the majority of clients—around 45 per cent—actually only receive one service, and only around 14 per cent of people receive around three services a week to assist them. The average per week service for a person with domestic assistance is around 38 minutes, which is pretty quick. The average for 47,000 frailer clients receiving home and community care is 50 minutes per week for personal care. It is not a lot of time for an increasingly complex group of clients needing support.

The other key point to highlight is that the community care system is very complex both for consumers and carers who need to access the system and for service providers to manage and ensure that the best use is gained from the resources going in. So we really need to reform that system and make sure that it is much more effective, efficient and easy for people to access.

Our last point is that we need to have some designated funding for community care research. Very limited research has occurred around community care and we do not think that we have a good understanding in the Australian community of what the current demand is, let alone what the future demand for community care is going to be, which makes it very hard to plan and fund services across the country. So we are arguing that there needs to be some special recognition of that and funding put into community care research. That is just a really quick summary of the submission. I would be happy to take questions later.

Mr Walsh—Thank you very much for the opportunity to appear in front of the Senate committee. The MAV represents 79 local government councils in Victoria. Our focus is twofold: one is councils being advocates on behalf of their communities and the other is the service delivery aspect that local government in Victoria provides as distinct from other states. The first major point is that, as advocates, local government by and large is the closest to its community—that is what it claims and asserts. As a consequence, when there is a lack of provision at one level of government then local government can respond proactively to fill a gap that exists temporarily or permanently. The way that local government in Victoria has evolved as compared to other states is that in Victoria a lot of statutory authorities were developed to provide infrastructure and basic provisions such as roads, sewerage and water. In other states that was left to local government, for example in Queensland. As a consequence, the evolution of local government in Victoria has led it more into a focus on social services. Hence, in Victoria there is a very high level of involvement in aged care and child care and service provision to those groups.

The difficulty that local government in Victoria has comes about because it has such a strong focus on social services, in this particular instance on the delivery of aged care services. It is unique relative to local government entities in other states. As a consequence, we often find that the system—which has just been articulated by Pat—is complicated and lacks flexibility to recognise the service delivery capacity that local government has in Victoria vis-a-vis in other states. What you get from the service delivery in local government in Victoria is a very strong focus on home and community care—a position that philosophically, on the advocacy side, local government is strongly supportive of: that the quality of life for older people is better whilst they are in their home and well cared for than it is in residential or other forms of accommodation.

The focus at a federal level has, by and large, been to address first the residential aged care issue, and community care has lagged behind. As a consequence, we are now getting to the point where we recognise the endeavours of the federal government and the opposition and, by and large, the agencies of federal government in focusing more on the home care aspect and the important role that that plays in the future of an ageing population.

In terms of the service delivery capacity of local government, rather than present evidence we have a bit of a sales pitch for you: ‘Have we got a deal for you!’ Local government does something particularly well—something that coordinating at a national level is particularly difficult to do—and that is to leverage the value of volunteers. Home and community care in Victoria, run via local government and via other agencies—but focusing specifically on local government—leverages on the willingness of volunteers to participate in the provision of these services. The Productivity Commission has put out reports—and I am sure all the senators here are aware of all the volumes of evidence that are coming out—talking about the ageing population and the importance of volunteers in the community et cetera. Local government is the corraller of those volunteers. The frustrations that Victorian local government experience are because of its uniqueness and its incapacity to present that argument and have it acknowledged and have flexibility within any federal arrangements to seize that opportunity and actually enhance it.

Within local government we are firmly of the view that we can have a meaningful role into the future in the provision of home and community care, along with the other providers, and that the leveraging that you get from the volunteer aspect of it delivers a bang for the buck. So we even think that we can appeal to the bean counters and the people who want the numbers to add up. That is a little bit of a sales pitch, but that is what we would like to impress on the committee: that the complex evolution of home and community care and the myriad of different arrangements across states and within states require some real lateral thinking in terms of being flexible in policy arrangements that can seize opportunities when they are there. That focuses on the service delivery side of local government.

Referring specifically to our submission to you, we focus quite specifically on the last two points, which is where the government has a role in its service delivery and also a role in its advocacy. The submission violently agrees with the proposition that the ageing population is an issue and that it is being addressed at the margins at present and is not being sincerely addressed in terms of a significant remodelling, refocusing and reorganisation of the arrangements that have evolved over time. The service fragmentation which I have just pointed out is one of the significant issues from a community perspective, with local government often stepping in where there are identified holes.

Again, I stress the point that local government believes that quality home and community care creates a better quality of life for ageing people than residential or other forms of care. Work force shortages is an issue with the ageing population from the model that local government uses which involves a lot of volunteering. We do not have great statistics on the nature and the demographics of volunteers at present, but as time goes by, over the next 20 years, the nature and the capacity to leverage off that volunteer group will be a significant issue. That pretty much sums up where we are at.

CHAIR—Thank you. One of the interesting things to me is the different philosophical approaches taken by different groups. You have indicated that your organisation very strongly believes that—and I think you stated words to this effect—home care is a better quality of care than residential care. Why have you come to that conclusion so strongly? We have received a lot of evidence to say that, when people are not in the position to look after themselves completely and need outside assistance they are often lonely, have no social networks and lack their nutritional requirements. Yet there is this philosophical push that you have to stay at home at any cost. A lot of the evidence suggests that, when you go into a nursing home, the quality of your health improves, your social network improves and your wellbeing generally improves. Can you comment on why there are very strong differing philosophical approaches?

Mr Walsh—I think it highlights quite clearly that there is a point in time at which home and community care is no longer the right answer. The assertion comes in particular from the anecdotal evidence that we have in rural Victoria where there may be an absence of quality home care. I do keep emphasising the word ‘quality’ because another assertion by the Community Care Coalition and local government in Victoria is that, in the absence of adequate funding, you can only provide a certain amount. The anecdotal stories we get from rural Victoria are where the person has to move out of their small home town or something like that and into a regional city. That sort of dislocation has the opposite effect to what you are referring to.

What you do point out is just how complex the system is and that one size does not fit all. The strength of our assertion is that there has been a lot of focus on residential care. There has been a lot of investment in residential care. I noticed in an article in the *Financial Review* yesterday that Julie Bishop was saying that members of the banking community are tripping over themselves and opening new aged care facilities all over the place. The home and community care side, we think, should have an equal focus and role in that. I am not in any instance trying to say categorically that home and community care is the answer. It is a vital part of a complex jigsaw. In the absence of an appropriate focus on that, you have a big hole in the provision and progression of the best quality of life for people as they age.

Senator HUMPHRIES—You talk in your submission about there being 42 different community care programs in Victoria. Are they principally geographically based or are there people in different parts of Victoria that could access more than one of those programs?

Ms Hargreaves—We do seem to have a stream, as you would be aware from the studies that have been done, of what you might call duplicated programs, to some extent, between the Commonwealth and the state and between Commonwealth departments and state departments as well as what is probably provided locally on the initiative of organisations such as councils and non-government organisations. My experience, certainly over the last 10 to 12 years, is that, while Victorian councils perhaps 12 years ago would have been dealing with perhaps one brokerage arrangement or with an outside agency, some councils are now reporting they are dealing with up to 17. This means that, to provide a service for one person in the community, they might be accessing a variety of those.

Sometimes other organisations are purchasing services from us and sometimes we are purchasing services from other organisations. Essentially, there is an enormous amount of behind-the-scenes work that needs to be done by the assessment staff to patch together sufficient services, often for one person, out of a range of services and adequacies. It is something that has evolved. We understand that it is often in response to governments seeing a particular need and deciding that there needs to be a particular service for a particular group.

I suppose from our perspective it would be good, once we have made that needs identification, if the programs can be rolled back together wherever possible so that we are not putting people through duplicated processes. Our assessment is that one of the areas where possibly cost savings could be made is in the streamlining of administration of some of these programs. You can imagine the amount of staff time that is involved on the ground between the agencies, sorting out arrangements which often are actually buying the same service. We have been through that. I will not go through the Department of Veterans' Affairs experience here, but often the same service is being purchased at the end of the day. So instead of one hour of home care, it is three hours of home care because the funding has been put together from various arrangements.

Mrs Sparrow—There are actually 17 Commonwealth programs. When you then layer in the state programs, that is where a lot of the complexity comes in. It is exactly what Clare was saying—it is often for the same client and it is coming from different pools. I would like to reiterate that there are potential cost-saving in terms of administration and quality reporting. One organisation that I am aware of received $1 million and had to do 18 or 20 different reports, basically asking the same questions and gaining the same information, and some of those were going to the same department. So there are clearly some administrative costs there.

Senator HUMPHRIES—Ms Hargreaves, you referred to streamlining the administration of these programs. Is it a matter of streamlining administration or reducing the number of programs and consolidating a number of them? Is that the answer?

Ms Hargreaves—Certainly from where local government sits. We prepared a report with the support of the Myer Foundation and the work they have done in the last couple of years and we would certainly recommend a reduction in the number of programs and, I would have to say, also in the number of providers, because the proliferation has been the other aspect of the complexity. We understand that this is no easy issue, but I suppose it is the people on the ground who are putting it together for a resident and a family in the community who actually see the effects of the policy and program development that we have at the moment.

Senator HUMPHRIES—Who are the brokers that you refer to?

Ms Hargreaves—They would be a range of providers who have tendered for various programs or organisations that already had it within their mandate to be running particular programs. I do not know whether Pat can elaborate on that.

Senator HUMPHRIES—So providers can be brokers as well?

Mrs Sparrow—Yes.

Senator HUMPHRIES—How does that work?

Mrs Sparrow—Through, say, the Community Aged Care Package program or the extended aged care at home package, they would receive package funding for an individual client. They might provide some services directly or they might purchase other services from other providers to do that. It is a component of the funding that they can do that. In Victoria there is another one, Community Options, which is part of the Home and Community Care program. Providers can receive funding and then tender and purchase services from other providers. It is a purchase of service model.

Senator HUMPHRIES—So it is really the providers going out in the marketplace and purchasing other services as well as providing them themselves.

Mrs Sparrow—Yes.

Senator HUMPHRIES—I am still not clear on how exactly we would reform that system. If we were making recommendations, what specifically would you suggest we recommend to deal with that problem of multiple services and having to shop around to find what is appropriate?

Ms Hargreaves—The vision we have is that there would be one community care program in which all the funds were pooled and we would go back to the start. I realise this would probably be seen as unrealistic from your perspective, but there have certainly been comments around the field that we are almost back to 1985 again, when the need to integrate the various pieces of legislation and so on was identified—the Home and Community Care program in the first instance. People who have been through the history of all that are actually feeling that we are at the stage where we would benefit from a reintegration. It is partly because the package programs, as you are aware, are designed to target a particular individual. The largest program—the Home and Community Care program—is not funded on that basis. It is a service that is available.

Our experience is that it seems to have become the sink for everybody that does not fit into a specialised package program. Where in the past we would certainly have seen people on package programs getting a higher level of service, that is perhaps not the case anymore. So there now is really no equity between the people in the two areas. I liken the experience of local government in the last 10 years to the fact that we have been stretching an elastic band further and further. So with a certain amount of funding that the councils have, which they contribute to themselves, what they have chosen to do is provide some service to most of the people who come to them so that they are assessed and maintain contact. But, as we have said, where we might have thought that two hours of home care a week was a satisfactory level 10 or 12 years ago people are now having to manage with three equal quarters of an hour a week or something like that. We have sort of stretched the elastic band thinner and thinner and in no way do we necessarily think that an adequate level of service is being provided to some of these people. For us, it is better to reintegrate the resources that are available and make the best use of those.

Mr Walsh—Further to that, Clare’s response was probably focusing once again on the Home and the Community Care side of things. I am not sure if your question was a broader one about how you streamline the administration across the board for an aged care scenario. Certainly we could not enter that discussion meaningfully because once you go beyond the Home and Community Care aspect you have got such an intermesh between public and private provision and things like that that it is a very different space to our fundamental focus, which is the home and community care area. The assessment we make of Home and Community Care is that it is a public service because it delivers a public good which a private provider could not meaningfully capture; hence, it will continue to be purely in the domain of a public good. The focus at a broader level on the ageing population and aged care where you have got some very different philosophical approaches to public and private provision does not exist in the home and community care side of things.

In relation to streamlining the provision of the Home and Community Care package, what Clare pointed out is pretty much what our philosophy is: that the types of services that are provided in that package could be amalgamated in a more meaningful way and the administration of them could be delivered in a more streamlined way. The difficulty of that would be that you have a federal-state relationship and that local government does not play in that space. This is how federal and state governments might make arrangements to streamline delivery of a one-stop shop or a one-stop set of packages around Home and Community Care. I can understand your difficulties in trying to focus on those things, because it is not apparent from local government’s level, which is focused on the service delivery and the complications that arise out of the different streams coming from above. When you are at the bottom of the chain, you look up and all you can see is just a great series of spotlights and you are not quite sure which one to focus on at any particular point in time.

Senator HUMPHRIES—We could certainly recommend that there be cooperation between state and territory and Commonwealth governments to streamline these processes, but that in itself is not a terribly helpful suggestion without more detail. Both organisations might like to take on notice the question of whether there are specific amalgamations or streamlining exercises which might be focused on in this process. Ms Hargreaves, you talk about the rubber band being stretched thinner. I note that you were talking particularly about HACC funding. HACC funding, I understand, has been increased by more than 73 per cent in total dollars in the last nine years, which obviously is a larger increase than the population growth. Has that actually had the effect of satisfying some of the demand there, or is it skimming the top of the bucket?

Ms Hargreaves—We certainly appreciate that the HACC program is one of the few growth programs. While it started with its original intentions of having 20 per cent growth a year, it is not quite at that level at this stage. But I certainly appreciate your point. The growth funding has enabled services to take on extra clients. There are a couple of aspects to this. The ageing population and the increased frailty of some of the clients mean that they require more services. Obviously the key point that we keep coming back to is that, in a program where the outlays are predominantly on wages, and with an indexation level within the program between 2.1 and 2.5 per cent, we have a gap every year in the indexation and the actual cost of the delivery of the program. So it is really inevitable that, despite the fact that local government in Victoria have traditionally put in an additional 20 per cent to whatever the Commonwealth and state were putting in, over time we are not able to provide the same number of services each year with the same level of indexation. You have the two factors working together. I know that is a point that Pat wanted to comment on too.

Mrs Sparrow—The Community Care Coalition would support exactly what Clare is saying. In effect, the cost increases are not adequately being taken account of and indexation sometimes does not even match CPI. That, combined with the growing dependency and increasing acuity of people being supported in the community, means they are falling further behind.

Senator HUMPHRIES—You are saying that for continuing programs the indexation level is not as high as the inflation in costs.

Mrs Sparrow—That is right.

Senator HUMPHRIES—Are you saying that is a Commonwealth decision? Is the state government increasing its contribution to HACC by the same rate? Does it use the same indexation level?

Ms Hargreaves—Through the Commonwealth-state HACC agreement the state, I understand, is bound to provide the same level of indexation that the Commonwealth does. They may, of course, separately choose to put in additional dollars, as they are in Victoria, but that is probably a separate issue given the size of the program we are talking about in Victoria.

Mr Walsh—Further to that, local government in Victoria is quite appreciative of the fact that there is growth funding in the HACC provision and we think that is a major step forward. It highlights the leverage that the federal government has. If it puts a growth fund on it then the states will reciprocate through that existing arrangement. To re-emphasise Clare’s point, using CPI is not necessarily meaningful when you are providing services where the sensitivity is on wage costs. The minister has released a paper recently and that focuses on these very issues. In local government we have done some research of late and there is quite clear evidence that wage costs are increasing beyond CPI. I have seen some evidence coming out federally along those lines.

This is not an issue for this committee, but the cost shifting inquiry was conducted and local government is very sensitive to cost shifting arrangements. Local government can commit on day one to the provision of 100 units of HACC under the cost sharing arrangements organised between the feds and the states. Over time the cost of delivering that service is not kept pace with by the funding arrangement. Local government then begins to cross-subsidise that product and then you have an assertion of cost shifting. Local government does make a contribution, but the difficulty for local government is that if there is a pull out from, a removal of or a reduced effort in a program, local government finds it particularly difficult to reduce its effort because it is so close to the service recipient. That makes it a particularly difficult exercise.

Local government will bang on forever about this: there should be an appropriate escalator for service provision. It is a public good; it is not a private good. On the day the money stops rolling in from whatever level of government it is very difficult to stop providing the service. If you are an electrician you can do that but if you are providing home care to an aged person who actually needs that then local government finds it stretches the elastic band. Then you are using a rate base, which is a wealth tax, to cross-subsidise a program service that is basically being delivered on behalf of or in partnership with other levels of government.

Senator FORSHAW—What are the projections for income for local government given the ageing population? You just mentioned the rate base. In the Hogan report they talk about what it will cost overall for the ageing population in 10, 20, 30, 40 years and the multiplier of that. Local government presumably is facing, I would have thought, problems into the future about maintaining or increasing its income with the ageing population.

Mr Walsh—Your question goes outside these terms of reference.

Senator FORSHAW—But it goes to what you see as the future in HACC funding if you are getting squeezed now.

Mr Walsh—Local government is particularly sensitive about the ageing population for a number of reasons. In particular, outside metropolitan Melbourne the work force is ageing. The work force in local government is older than the state work force, so that has impacts.

Senator FORSHAW—I am talking about local government having fewer ratepayers—this may not be true but I would have thought that it will follow logically that you may in the future have fewer full ratepayers with an ageing population. I know that in other states, for example in New South Wales, pressure on local government to have more urban consolidation may lead to increased rate income but it also has a huge impact on the level of services that have to be provided. They are trying to accommodate an increase in the density of population but may be trying to derive their income more from non-residential rating. Is there any research being done about the capacity of local government in the future to continue to fund HACC at an increasing level?

Mr Walsh—There is. The MAV, for example, has an economist who is working on building up some of these issues. Again, there is a certain crystal ball element to it, but the way you have put that argument is exactly the same as the sorts of discussions that have occurred and are occurring within local government, in particular in non-metropolitan Victoria, where there are some council areas that are older than the demographic of the state. Local government does provide rate concessions to older people, which in turn reduces their revenue, and then there is an increase in demand for some of the services provided. You have encapsulated cost shifting in a very nice way, Senator.

Senator FORSHAW—I am not sure I got the answer, but at least you agree with the problem.

Mr Walsh—There is research. You can get an economist to do econometric models on these things based on a series of assumptions. Ultimately the rate base of local government is a wealth tax—it is a property tax. There are lots of philosophical discussions about the appropriateness of a property tax given that most people have their wealth in shares these days, but that, for the foreseeable future, will be the ongoing modus operandi of local government. Your point does raise another issue that is close to the heart of local government and that is a share of another level of taxation revenue based on income tax or the GST. But that is a different debate for a different forum.

Senator McLUCAS—Am I right to think that Victoria is the only state in Australia that has such a strong involvement in the delivery of HACC services?

Ms Hargreaves—Yes. Of course there is some involvement across other states, but local government in Victoria along with the nursing services make up about 80 per cent of the HACC system.

Senator McLUCAS—I used to be in local government in Queensland. There is very little involvement in human services in local government in Queensland. In fact, there is a desire to withdraw—not that I shared that, but that was happening in the 1990s in Queensland. Do you perceive any resistance from ratepayers in Victoria to being involved with the delivery of human services or in particular HACC?

Ms Hargreaves—I think the community responses, customer satisfaction surveys and all the various measures indicate very strong support for local government involvement. People identify the council as one of the first points they go to find out what is available. They are able to work directly with the council. In fact, I think that is now an expectation that has been built up over a number of years.

Mr Walsh—Further to that, local government is the focus for the provision of services within the local community. We do not have any evidence on whether the community is aware of exactly where the money is coming from or who is paying for it.

Senator McLUCAS—From a Victorian perspective you could argue quite strongly that Victorians are doing better out of HACC than anyone else because of the additional contribution from local government in Victoria. If you are a person who needs support you would probably ring the local council because that is where you think the services are going to come from. Given that, can you tell me how Care Link works in this state?

Ms Hargreaves—We think we have a well-constructed system in Victoria. That is probably why we have some difficulties when national arrangements are imposed for the sake of improving the situation in other states. I think there has been a disjunction here between how the local service system works and the intersection with Care Link. I think there has been difficulty for councils in obtaining information about who accesses Care Link and the links back to local services. That is certainly what has been reported to the MAV from the local government point of view.

Mrs Sparrow—My understanding is that in Victoria it is like anywhere else. They are a service that is separate from local government. That is exactly the issue that Clare is highlighting. They exist, so people can ring them, but people often go to local government for information. So they operate the same as they do in other states.

Senator McLUCAS—Was Care Link in Victoria one tender or a series?

Mrs Sparrow—I am not 100 per cent sure about that. I would need to check that for you.

Senator McLUCAS—No, that is fine. Both witnesses have said they supported the initial discussion paper and then *The way forward*. Do you also support the response to that, the introduction of competitive tendering in at least one program and potentially in others? Is that what you thought would occur through the consultation processes and *The way forward*?

Mrs Sparrow—I do not think that that was necessarily what we thought would occur as a result of that. There was talk of streamlining the system, and that is the sort of thing people were supporting in giving support to that document. The Community Care Coalition do not have a specific position on the tendering process because they have not met since it happened, and we only meet two or three times a year, but individual organisations within the coalition would have a position. I work for Aged and Community Services Australia. I believe you heard from Greg Mundy yesterday exactly what our position is around that.

Ms Hargreaves—I suppose our clear preference would be to work on *The way forward* process. We understand that the Commonwealth and states have between them a whole series of working parties working on the arrangements and we are very happy to cooperate as ideas are discussed and to look at how they apply in Victoria. Our preference would be to go through that process in a logical order before the tenders were being announced. We understand, though, that there are always time lines and imperatives relating to some funding programs in terms of the time at which they run out, but a fair bit of anxiety was created in Victorian local government around reapplying under the tendering process for services they already run.

Mrs Sparrow—I think it would be fair to say generally that *The way forward* is a fairly high-level document in terms of what it proposes and so it is quite easy to say that you support the general principles, but a lot of the details underneath that are not being openly discussed. I think what is missing is the discussion between Commonwealth and state, service providers, carers and consumer groups about what that means on the ground and how you would make that happen. A lot of that is happening confidentially at the moment, and we are only seeing things like tendering, perhaps without seeing what is going on behind the scenes and having that discussion at that level and with that involvement.

Senator McLUCAS—I think you are right to say that no-one can disagree with *The way forward*. It is like motherhood.

Mrs Sparrow—We need the more detailed proposals. We need all of the brains of people who work in community care looking at how you actually translate that to make sure that you get a better system on the ground. That is an opportunity that is possibly being lost at the moment.

Senator McLUCAS—Thank you to both of you.

Senator ALLISON—Mr Walsh, in your submission you call for the discontinuation of the productivity increases that are demanded of community care programs. Is that still running at one per cent a year? What effect does that have on your programs?

Ms Hargreaves—It has been the general principle that we have enunciated in submissions over a number of years now around the difficulty of productivity savings, that when you are paying staff for an hour of the work they do—providing a shower or whatever it might be—there are only so many corners you can cut, while of course always being mindful of continuous improvement being necessary. We would have to go back and check the current way that that is being applied, but I think it has been one of the links into keeping the indexation at a fairly low rate as well.

Senator ALLISON—So that is a factor in reducing the indexation to the level of two per cent—did you say two per cent?

Ms Hargreaves—I think it is 2.1 per cent currently.

Senator ALLISON—So that has been discounted already in terms of productivity. It would be useful if the committee had the details of that.

Mr Walsh—Further to that, at a philosophical level I think the call is that productivity gains are an accounting exercise in many respects. It is a bit of an affront to actually seek a productivity gain in a half-hour for a shower. We think that perhaps the accountants have failed to recognise the issue of productivity gains in human service provision of this nature. Unless they can produce a dalek that can do it they should perhaps rethink the productivity gain model.

Senator ALLISON—There are not too many robots around that are able to do showering at this point in time! You mentioned earlier the duplication of services. To clarify that, you are not talking about the same people getting a duplicated service from two organisations; you are talking about two, three or more programs that do the same thing, but they are not actually delivering duplication on the ground—or are they?

Ms Hargreaves—I would not have thought that was out of the realms of possibility either.

Mrs Sparrow—It is not necessarily duplication, though, in terms of the need that an individual client would have. You might have a number of programs providing similar services. But, in terms of the need that that client has, that is how they put together a package of services to support that person in that home.

Senator ALLISON—I recognise that Victoria is a bit special in terms of local government's involvement in home and community care programs, but it has always seemed to me to be the most sensible provider of all of the programs to do with this service. Why shouldn't state and federal governments simply fund local government to manage and deliver the lot? The reason I ask you that is that in your recommendations you are still talking about Commonwealth and state programs in a three-tiered community care system. I would have thought it should be one tier.

Mr Walsh—In terms of the provision, we are a part of the Community Care Coalition. Local government, as an advocate, wants the best quality of aged care to be provided. Local government's role in service delivery, which it does well, is probably a portion of that. Local government does not have the capacity to provide the solution across the board, particularly the financial capacity. Local government is completely—

Senator ALLISON—I was not suggesting local government pay for it and deliver it, just deliver it.

Mr Walsh—As has been stated, local government is the largest provider of home and community care.

Mrs Sparrow—An example of a service that sits out of that, for example, is the Royal District Nursing Service. Whether or not local government would be the best place for nursing services to be delivered from, I do not know. But certainly we need a system where the providers are supported to work well together.

Mr Walsh—The providers in Victoria do work well together, which is evidenced by the fact that there is a coalition of providers making submissions and organising themselves. But I do not think that the answer is just: 'There you go: have local government and you do it all.' In this state there are some really cooperative and useful relationships between the various providers. In terms of the administration of it, we keep highlighting the complexity of it above us. The complexity is often in the financial relationships—different packages and things. Local government is always ready to continue to provide and expand its service in an appropriate way, but within the context of multiple providers of different services creating the complete picture. Local government does not assert that it is capable of providing the complete picture.

Senator ALLISON—Who ought to do research into home and community based care?

Mrs Sparrow—It is important for there to be some independent research undertaken. A lot of the research that we have at the moment would be tied to existing government programs, so I do not know that we get a true picture of what the demand is or what the issues are for people who are not getting any support—and there are people who do not get support.

Senator ALLISON—The Australian Institute of Health and Welfare, for instance—would that be the sort of organisation?

Mrs Sparrow—Possibly. I do not know whether that is exactly the right one or not, but I am referring to that type of institution—one that has some independence from particular government programs.

Senator ALLISON—I have a fairly general question about non-English-speaking groups, particularly in aged care. We all understand that English that might have been acquired is often lost in older people. Is local government able to cope with this well? Can you comment about what needs to be done to make sure that services meet the needs of those people?

Ms Hargreaves—In Victoria at the moment the MAV, in conjunction with the Ethnic Communities Council of Victoria, has been funded to work on something called the culturally equitable gateways strategy. So investment is being specifically made in Victoria around looking at what the issues are for people from non-English-speaking backgrounds in either using or not using the services and, I suppose, also looking at some of the myths that possibly surround that in terms of what the reasons might be. We have embarked upon a three-year strategy at this stage, both with leadership centrally and with individual councils and individual ethnic organisations being funded to develop partnerships and look at what the issues are for their communities, raise awareness of the services in their communities and encourage them to come forward. It will look at whether our general services can be more responsive to them and tell us something about the models of those services and whether some of those models need to be adjusted as well. Certainly, with the population ageing, we are going to see, as you would know, an overrepresentation of people from non-English-speaking backgrounds who arrived here just after the war. There is a real peak—certainly in Victoria—of that group. We are running with the philosophy that the universal services should be able to deal with, represent and respond to their whole population and that we should not need to set up a whole lot of duplicated small programs for various different ethnic groups.

CHAIR—Thank you for your submissions to the inquiry and your presentation today.

[11.16 a.m.]

DEANS, Mr David Randall, Chief Executive, Councils on the Ageing National Seniors

ACTING CHAIR (Senator Knowles)—Welcome. Information on parliamentary privilege has been provided to you, and you would be aware that the giving of false or misleading evidence may constitute a contempt of the Senate. The committee prefers that all evidence be taken in public but evidence may also be taken in camera if you consider such evidence to be of a confidential nature. The committee has before it your submission. I invite you to make some opening comments. I am sure the committee will have some questions for you at the conclusion of your comments.

Mr Deans—Thank you for the opportunity to appear before the committee. While COTA National Seniors acknowledges the $2.2 billion allocated in the 2004-05 federal budget for delivery to the aged care sector over the next four years, we believe there are some fundamental issues to be addressed. These include development of a benchmark of care against the adequacy of funding provision for both residential and community care so that it can be measured; ensuring competitive pay and working conditions for aged care workers comparable with staff from other sectors; provision of quality care to those with specific needs, including those with dementia; and adopting an integrated approach to the provision of health services and aged care.

We are concerned about the apparent deterioration in the ability of the aged care sector to attract and retain staff. We are conscious of the emerging skills shortages across many sectors of the work force, and this includes the staff in the aged care sector. These general skills shortages could make it even more difficult for the aged care sector to compete for the staff that they need if the issues are not addressed as a matter of priority. COTA National Seniors has been told that government requirements for extensive paperwork have contributed to high staff turnover and low morale in aged care. Addressing these problems requires government commitment and support to providing competitive salaries and conditions in order to attract and retain highly skilled nursing and other care staff and ensuring that the skills and knowledge of the aged care sector are up to date by providing appropriate and ongoing support to training for staff.

COTA National Seniors strongly support the need for accreditation services to the residential aged care industry. However, we believe that the system needs streamlining to reduce the requirement on providers for extensive amounts of paperwork. Greater efforts need to be made to involve residents and their carers in the accreditation process to achieve significant lifestyle improvement for residents.

With regard to younger people in residential aged care, COTA National Seniors is of the opinion that they should be located in a community setting and provided with the support required to maintain them in that setting. Having younger people in residential aged care is certainly less than ideal. We also need to provide appropriate support for those with dementia, to enable them to continue living in the community. This is less stressful and would also take pressure off residential care services. We are of the view that it is not possible to consider home and community care services in isolation from residential care, acute care and the health needs of seniors more generally. We know that there has been significant growth in the demand for home based care due to a number of factors, including changes in hospital systems, resulting in a greater focus on acute rather than convalescent care; increased survival rates amongst people with severe or profound disabilities; and increased numbers of people aged over 80.

The government could ensure that there is an increase in the level of funding for home and community care services through the HACC program, in line with this increasing demand, and improve targeting and resource allocation to ensure that seniors with low, medium and high care needs have access to funding which allows them to age in place in their own homes for as long as they choose. Funding imperatives encourage hospitals to discharge seniors before they are fully recovered, and this increases the risk of readmission or premature or inappropriate permanent residential care. Good rehabilitation services support older people to gain the strength required to retain their independence. Post discharge community care services are inadequately resourced and poorly planned. The government could develop, in conjunction with the states and territories, a national framework for discharge planning and the provision of post acute and convalescent services and facilities, including those in the community. They could ensure that adequate discharge, post acute, convalescent and rehabilitation support services back up acute hospital services and facilities. Finally, they could ensure that hospital patient discharge remains a medical decision, not a financial one.

Senator McLUCAS—Mr Deans, I am interested in your recommendation that goes to the question of residents, carers and advocates being provided with more information from the accreditation agency. That seems to be saying to me that people do not feel informed about the process; they do not feel as if they are a part of that accreditation process. My understanding of the process is that residents and their advocates, usually their children, are meant to be involved in that process. You are saying that it is not really happening.

Mr Deans—Our view is that it is a real challenge to get the information out to the consumer. It does get out in some way, but, from the feedback we get from people who are going through the process of looking for a place in an aged care facility, just the word ‘accreditation’ is wrong. How does the normal consumer know what the terms ‘certification’ and ‘accreditation’ mean? As a consumer organisation, with the ability we have in all the states and territories, we provide information, but still people are at a loss when it comes to knowing about accreditation. I think one of the pluses is that there is going to be the ability to look at the financial statements of aged care facilities. In a strange way I think that may well reinforce or bring out in front of people the fact that there is some ability for them to be involved in choosing a bed rather than taking the first bed that is available to them, maybe close to where they want to be.

Senator McLUCAS—We have had evidence from previous witnesses about where a person will eventually be located. That evidence was that the choice about where the person is located is usually very much a geographical one related to the elder daughter’s location. I recognise that potentially there will be more information provided to prospective residents through the condition that providers display their financial situation; I just do not know that it is really going to change decisions about where a person is located. The imperative of being close to family will be a higher indicator.

Mr Deans—Certainly, I would agree with that. The No. 1 priority is to be close to where they live now or close to their family at least. That is not always possible, of course, and that is why we have waiting lists. The occupancy in aged care facilities is less than 100 per cent, so there are beds somewhere but not necessarily in the right places. Certainly, there is a need for a significant information program—more than there is now—through, I suggest, the seniors information services and Care Link and those structures that we have in place now. It is a challenge to get out to all the community and to the families. Until you have a parent who is in that position you are probably not too interested in what is happening in aged care. Then all of a sudden it is landed on you.

As an organisation we write articles in our magazine that goes out to membership highlighting the issues, so people do know what is happening with that age cohort. As many people have said before me and will say again, with the ageing of the population we are going to have a greater demand for information. We may not necessarily have a greater demand for beds because—and this has been suggested already—there will be a greater demand to have the services brought to the home. Ask anyone, and they will say that they would prefer to be at home than in an aged care facility. The aged care facilities are certainly attractive in some areas but not as attractive as home.

Senator McLUCAS—Does COTA have anything to share with us about their experience with the complaints resolution process offered by the accreditation agency?

Mr Deans—The process seems to work but, again, it is knowing about it. Going back a step, in residential aged care there is the worry about actually complaining because they are worried about some effect on their residency, so they may not complain. We understand that when a complaint goes through it is dealt with in the appropriate way. It is up to the providers to inform residents that there is that mechanism. But in the general public or the families of the residents there is again a lack of knowledge of the process. It seems to be working when there is a complaint. We have not had any negative feedback to suggest it is not working.

Senator McLUCAS—Just that there is a fear of even making a complaint amongst those people who are vulnerable.

Mr Deans—Yes. They believe it may affect their residency in the aged care facility. That is the feedback we get. Obviously, we do not go into aged care facilities and do surveys, but that is certainly the feedback we get, and that has been discussed for some time.

Senator HUMPHRIES—Your submission is quite important to the committee because it really is the closest we have to a submission from an organisation representing consumers of aged care services. Lots of providers have made submissions, but very few umbrella organisations for consumers have, so thank you for what you have put on the table today. One of the issues we have been addressing is whether the level of surveillance of and vigilance about standards in nursing homes is right, whether it should be eased off a bit or ramped up. Certainly, there is a lot of evidence that the paperwork associated with the overview by the accreditation agency is excessive, but, putting that issue to one side, do you have a view as to whether this is the appropriate time to be easing off on the monitoring of standards by the accreditation agency and taking up, for example, what the umbrella organisation for the providers suggested yesterday—more self-regulation by managers in nursing homes?

Mr Deans—With enormous respect to the providers, I would suggest no. Like any self-regulation, particularly in the state we are sitting in, with great respect to the Victorians, when you think back on the last seven or eight years we have had great difficulties in the aged care area. Mind you, a lot of it is a media beat-up—this is from first-hand knowledge—because it makes good headlines and sells newspapers, but that does not help a family that is affected. I think we have a little way to go before the accreditation agency should pull back. I am not sure whether they should ramp up their activity, but I would like to think that in the short term we would have a situation where the providers can self-regulate. However, there is always going to be the odd one—and that is all we are talking about, the odd one that gets into the media. Generally everyone performs very well; however, you have to set the setting at the worst one. Those people will be around for some time yet. Although I understand where the providers are coming from, I would not suggest that the sector is ready for that as yet.

Senator HUMPHRIES—Turning from the question of how you monitor the standards to what the standards themselves are, I note this comment in your submission:

> A greater attempt needs to be made to involve residents and their carers in the accreditation process …

By that, do you mean that when inspectors come to aged care facilities they need to spend more time in communication with residents and their families, or are you saying that there should be a greater role for bodies like COTA in setting those standards and actually determining what those standards will be across Australia?

Mr Deans—I do not think it is up to us as a consumer organisation to set the standards. We can recommend standards, but we certainly would not be setting them. I think the point we are making with that comment is that the visits, as we understand them, basically are an audit of what is happening with the administration, care plans and so on, with little contact with the residents. This would also overcome the issue that I highlighted before, about people being in fear of losing their spot in the aged care facility, as they would be able to give comments to the accreditation agency. The accreditation agency, I am sure, will tell us that they do speak to the residents, but it is not at all times. That is what we are suggesting—that there be more involvement of the residents, as well as of the carers, of course, because we know large percentages of the residents have some form of dementia and so they need their carer or their family there with them to help speak to the accreditation agency. It is a situation where a man or woman comes in a suit, dressed in a way that is not necessarily friendly; so how do they sit down and talk to this person if they have not done that before? So we believe residents and carers should be more involved in those spot checks.

Senator HUMPHRIES—On the question of them setting the standards themselves, do you know if COTA or National Seniors—they were separate organisations when these standards were first set up—were consulted by the accreditation agency about what those standards should be?

Mr Deans—We set the standards on committee before the accreditation agency was in existence. Both organisations have been represented on those committees and still are to this day, except it is now one organisation. Yes, we certainly were involved in setting those standards. There is the normal provision of service in a facility and then there is extra service—and this is where it gets a bit fuzzy. I have been on a committee where we have been talking about what is extra service. It is amazing that some other providers on those committees say some of the things that you would normally expect would be a normal service. So if you are looking at service standards that certainly needs to be looked at. It is quite clear what standard services are—and you need to set those benchmarks—and then what extra services are that people can pay for. That is coming in; there is no doubt that that has changed over recent times. There is still a way to go.

Senator HUMPHRIES—One criticism of the standards is that they do not contain a benchmark of the ratio of staff to residents and the certain number of staff necessary at any given time. Would you see that kind of benchmark being appropriately incorporated into the standards?

Mr Deans—In our submission we recommend that. Because of a change to legislation over recent years that does not exist. It is a matter of managing it as the provider sees fit. There certainly needs to be a benchmark of at least the minimum standard of staff and the ratio to residents.

Senator HUMPHRIES—I want to put the intergenerational equity issue to you. You have a number of recommendations that entail spending money in this sector. My assessment is that you will get many of those demands being met if only because as our much maligned baby boomers move up to retirement age they will be demanding and getting those sorts of services. What is your response to the argument that we are creating a more comfortable and generously funded set of services for people in retirement than previous generations were afforded and that this will come at the expense of a smaller number of taxpayers proportionately in the future, who will have to bear the cost of those services to those people in retirement?

Mr Deans—Senator, this is beyond aged care—

Senator HUMPHRIES—It is beyond aged care but there is a very specific element of it in aged care.

Mr Deans—I want to comment that it will be broader than aged care. This is a subject that is close to our heart of course. We place a lot of importance on the tension between the generations. There has been discussion only recently—and there is one journalist who writes about it quite often—that seniors get too much. As advocates, if you like, trying to persuade you to agree with those services, we are thankful that those services are there; however, we are well aware that if, say, a local government gives a rate cut to a senior who pays for it—and this is what I argue it at our conferences. Some of the resolutions would go down the track that you are suggesting—that we want more and more. In discussion that resolution is lost because there is only one pie and if you give a reduction in rates to everyone of a particular age—let us say 70—the person who will be paying for it is the 28-year-old next door with two children and a single income. They will be paying the difference. Councils are not going to reduce the funds that they want. So it is a fine balance that we are going to walk for some time—probably for 40 years, as the Productivity Commission sets out—and we have been conscious of that for some time.

In the United States they have a term ‘the greedy geezers’, and the organisation which is similar to us is fighting against that. We are fighting to have that saying not enter Australia. I think there is a danger of it, and we are very conscious of this as the organisation that is out there, trying to convince you to include things for seniors. I do not think there are any of those items by the way in the submission, because you are right: the baby boomers are going to be demanding much more than we are giving seniors today. But there is certainly the intergenerational tension possibility. However, I do not agree with the reports that have been written that it will be a huge problem that there are going to be fewer taxpayers, because there are going to be more mature age people in the work force. In fact, in aged care there needs to be education of mature age people who cannot get a job because they are the best carers normally. They could well take up a position in aged care.

Our view is that there needs to be a shift in increasing the average retirement age. Of course, there is no official retirement age but the average retirement age is about 58 years of age whereas the pensionable age is 65. If we can keep people in the work force through to 65, or 63 for women—not necessarily to get the pension—and increase the average retirement age to, say, 64 or 65 there is going to be a significant change in the income to government. That has been calculated—I do not recall what the difference is. It is something that needs to be dealt with and something we will be seeing in headlines for some years yet as we work towards the difficult times.

Some sectors are experiencing ageing of their work force right now, and that includes the aged care area. If you look at the average age of people in aged care it is mature. Mining is in the same position, and there are difficulties getting people into retail and hospitality. It is all because of the ageing population and not enough young people coming through to working age. It is going to finish up in aged care. In terms of provisions for seniors, I think there is a danger that when we get to local government level, in particular—and we all know what happened with the tension between the state governments and the federal government in trying to get the seniors card to be used in every state; it did not work and so it has been done another way—we go one step too far in providing benefits.

Senator ALLISON—You draw our attention to the federal budget allowing for new supplements to be developed for people with dementia to support the provision of high quality care for residents with dementia et cetera. Was your organisation consulted at all on this program? Do you have any insights into where that is at?

Mr Deans—It is early days. I cannot comment on that particular funding, but it is certainly early days in facilities having dementia specific areas. I think we are a few years away before we can provide for the number of people who require that type of accommodation.

Senator ALLISON—But, as you point out, it is 60 per cent of the residential aged care population.

Mr Deans—Yes, for dementia. Of course, not every one of those people requires dementia specific accommodation. It is probably closer to, say, 10 or 20 per cent. The funding that has been provided is encouragement for the providers. There is quite clear from—I was going to say evidence but I cannot disclose who has made these statements—meetings we have had with providers that there is a tendency not to accept people with behavioural problems because it is going to upset the whole facility. If they do not have a dementia specific wing it is a real problem for them. It is most difficult if a person has severe dementia to find a facility who will take them.

Senator ALLISON—By extension, would you argue that all aged care facilities—or perhaps those over a certain size—should have a dementia-specific facility?

Mr Deans—I do not think it needs to be put in legislation. I think it will happen, because that is going to be the client base. The people who do not have dementia will be more likely to stay at home in the coming years. And it is changing very quickly. Ten or 15 years ago an 80-year-old person would have said something totally different to what an 80-year-old person would say today. We are generalising, of course. I think we will see a lot more people staying at home. What we are suggesting in our report is that there be provision to let them stay at home even though they have dementia.

Senator ALLISON—You have reiterated your submission to the Hogan review that bonds should be introduced as part of a user contribution to capital costs. You have cited a number of provisos for those bonds. Do you get any sense that the debate about bonds is likely to reopen, or is there too much opposition? I must say I am surprised that your members are so supportive of them. If there is opposition, where do you think it is coming from?

Mr Deans—First of all, I would rather say ‘could’ introduce bonds than ‘should’ introduce bonds—as we know them. ‘Bond’ is a dirty word. Unfortunately, the term ‘bond’ is a no-no politically. Senator, I could ask you why we don’t do something about it, because obviously I have spoken to everyone about bonds. When we came together as two organisations it was an interesting process because one organisation did not agree with bonds while the other organisation did, with certain conditions, and we came to an agreement. So long as we have those conditions we have no problem with—and do not take this too broadly—a user pays systems if someone can afford to pay a bond. If that is what necessary to raise the money to have a bed so that I can get into an aged care facility later in life, then maybe that is what should be available. However, you have mentioned the list of issues that we would see introduced. We believe it will be necessary, and Hogan says it will be necessary. But it is a challenge for the decision makers sitting in Parliament House to come to grips with it—and I am being very frank. I do not think anyone says we should not do something like a bond—and, for a start, we have to call it something else. I do not believe the general community of senior consumers will object to it. That is what we are saying. We have done surveys of our membership, which is 300,000 people aged 50 and over. But, after the late nineties, it is now a huge step politically.

ACTING CHAIR—Have those seniors asked their family members, who are the most vocal in their opposition to it?

Mr Deans—It is interesting. The average age of our membership is 61, though our members are up to 100-and-something years old. We are talking to the families as well in those surveys. As I think you would have experienced, most people say to their mum or dad, ‘Please spend the money that you are trying to keep for us.’ But there are people who see their parents’ home as their inheritance. They are still around, alive and well. It is like discrimination: they will always be there.

ACTING CHAIR—And they are very vocal.

Mr Deans—They are. And they are the ones that march on parliament. They do not really march on parliament, but they are the ones who get the headlines. My personal view is that within the next 10 years we will have bonds by another name. It is necessary to be able to build the facilities that will be required.

Senator MOORE—I have listened to you on these issues before, but I would like to get something on the record about the role of volunteers in the area of aged care—across the board, community and residential—and the possibility of changes in the role of volunteers.

Mr Deans—I was listening to the previous witness talk about volunteers and community care. It was worrying me to hear that we are relying so much on volunteers in community care. There are different areas that the volunteers sit in but certainly they are very active in community care. But a lot of professional people work in community care as well. I do not think we know whether in the future we will have the numbers of volunteers that we have today. I do not think anyone knows that the baby boomers will be active volunteers. We are talking about, first of all, keeping them in the work force until they are 65. There will always be volunteers, but it is whether there will be the number, particularly if we want to keep people at home. Aged care facilities do not use volunteers as much as community care, of course. We have a policy of recognition of volunteers and the hours that volunteers work. This country, we all know, would not operate without volunteers. It makes me nervous to think of what is going to happen in the future. We do not know as yet, even though we have surveys—I was looking at one yesterday—that we currently have sufficient volunteers. Will younger people, as seniors and as they retire, go into volunteering? We do not know.

ACTING CHAIR—Thank you very much, Mr Deans. It is always good to see you. Thanks for your contribution to our inquiry.

[11.52 a.m.]

LAU, Miss Marion, Immediate Past Chairperson, Ethnic Communities Council of Victoria

NGUYEN, Mr Phong, Chairperson, Ethnic Communities Council of Victoria

GOGOROSIS, Mr Peter, Chief Executive Officer, Fronditha Care Inc.

ACTING CHAIR (Senator Knowles)—Welcome. Information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. The committee prefers evidence to be heard in public, but evidence may also be given in camera if you consider such evidence to be of a confidential nature. The committee has before it your submissions. If you would like to speak to the committee first, I am sure committee members will have some questions for you at the conclusion.

Mr Nguyen—We have realised we have a very short time to summarise our submission, so the Ethnic Communities Council would like to prioritise in order of importance, in our view, the three areas that the committee wants to look at. First is the adequacy of the HACC program. That is our first priority because HACC has been a very important program for the ethnic community due to cultural and other reasons. For many ethnic communities, the HACC program fits in with the cultural backgrounds of a lot of people who would like to stay at home and who would like to remain with their families within their own communities, where they are supported linguistically, where it can be done by the local community that they are familiar with and where they are surrounded by a familiar environment. It would be our priority to look at HACC.

In terms of the second priority, we would list the adequacy of training and the increase in the aged care work force of bilingual workers and incentives for our community to engage in the aged care work force. We believe that, if we have adequate aged care training, as well as improving the number in the work force, that in itself will help to improve the performance and effectiveness of the aged care standard in both the HACC and the residential areas. In summary, in an addition to our submission, we would like to highlight that those are the priorities as far as we are concerned.

Mr Gogorosis—I would like to restate and reinforce with the committee the importance of language and culture in providing care to elderly people. This issue often gets cursory coverage in public policy documents and, in reality, the practice and administration of programs very often simply does not attend to the substantive issues that elderly persons of ‘cold’ backgrounds face when needing support and care. I would like you to think of an extreme case, perhaps, of a Greek-speaking elderly person who is perhaps in their mid-80s and speaks very little English, if at all. They might have some dementia and, in fact, might have forgotten the English that they did learn in the 40 or 50 years that they have lived in Australia. They are in a mainstream nursing home for 24 hours a day, 365 days of the year. The question that I would like you to think about is: how does this elderly person connect with their carers and with the social system that forms that nursing home or hostel? If you do not have the language and if you do not share a common sense of history, values, music or food—the whole range of phenomena that make up who you are—then it is an extraordinarily isolating experience. For them, it means alienation, and it manifests in depression and withdrawal. I want to make that a starting point to the discussion or the questions, because it seems to me that we need to understand what this really means to the elderly who struggle with the language and who have a different cultural background.

Senator HUMPHRIES—Obviously the services provided by Fronditha and DutchCare are ethnic specific, and I assume there are a range of those services in Victoria, as there are elsewhere, for particular people of a particular ethnic background. Do you have any information about the proportion of retired or aged residents who are in those sorts of facilities who have a non-English-speaking background, as opposed to those who are in mainstream facilities for whom there will obviously be a more acute problem with language?

Mr Gogorosis—I am not aware of those statistics being readily available. It is an interesting question. Certainly within the Greek community in the state of Victoria there are probably 350 ethno-specific beds for the Greek community. I also know that in my organisation our waiting lists for residential care, in particular, run into hundreds of elders who very clearly are saying, ‘We want to be cared for in an environment that shares our culture and language.’ I know that certainly DutchCare provide a Dutch-specific service in that sense, and there are a number of Italian facilities in Melbourne. There is a Turkish facility and a Chinese facility in the northern suburbs.

Miss Lau—Yes, and there is one Russian-specific facility up in the mountains.

Senator FORSHAW—Are these all nursing home residential accommodation? You are not talking about retirement villages as well, are you?

Mr Gogorosis—I am not aware of retirement villages that are ethno-specific. These are residential facilities.

Senator HUMPHRIES—So is it the case that the people on the waiting lists you referred to are people in the community waiting to get into your facilities, or are they people in other nursing homes who are going to move over to an ethnic-specific facility?

Mr Gogorosis—It is both. There are a substantial number of elderly who are already in mainstream nursing homes and hostels, a substantial number who are in hospitals waiting to be placed and a number who are in the community being cared for by their families.

Miss Lau—I can also support that—I am a practitioner as a consultant in aged care—by saying that in the course of my work I get involved with a lot of facilities, looking at their waiting lists. A number of them do have waiting lists of people who are trying to look at an alternative to the lack of ethno-specific aged care facilities, as Peter has indicated. There are not many of those around in Victoria—or around the country, I suppose. In my own community, the Chinese community, we have one 31-bed Chinese-specific hostel catering for the whole of the Chinese-speaking population in Victoria, so a lot of our community are waiting in mainstream facilities to get access to our low-care facility. When our low-care clients deteriorate and want to go into a high-care facility, we are unable to place them other than into a mainstream facility.

The other indication is that, where I am at the moment in the northern suburb where we have just commissioned a 60-bed facility, it is theoretically a mainstream facility, but, because it is sitting in the middle of a fairly culturally diverse community group, over 40 per cent of the people on the waiting list that I am working through at the moment are from a non-English-speaking background. To be able to cater for that is a great challenge for the proprietor. On the one hand, he wants to make sure that he gets back his capital for putting up a facility, but on the other hand we have this large proportion of not only a non-English-speaking-background clientele but also a financially disadvantaged group. At the moment, I am juggling, trying to fit 130 people into a 60-bed facility. That is how extreme this situation is at the moment.

Mr Nguyen—Furthermore, may I also add that, similarly, you have the situation of emerging communities that have been here—for instance, the Vietnamese community, which is quite a large community that came in big waves in the early eighties—and all of a sudden now they have no infrastructure, no facilities whatsoever. They are similar to the Chinese community but worse off in terms of language and long-term residency, if you like. The Vietnamese community here in Victoria has a population of over 65,000. One low-care 30-bed facility in Keilor East caters for the entire community. As a result, that is a very similar picture, but it is worse when we have young brain-injured people being referred and sent by hospitals to these nursing homes, which are already stressed to the limit and have long waiting lists. That facility is quite a derelict place, because it does not have the ability in terms of capital funding to improve its capacity.

We found that, among 30 beds, there were at least three seriously brain-injured young Vietnamese males living among elderly females. This is unacceptable in other places, but the system really gives no choice to a community of this size. This is an emerging issue, not only for the Vietnamese community but also for other upcoming communities.

Senator McLUCAS—Mr Gogorosis, in your submission you talk about the range of different service models, and I think you are just stating what is currently there. The question that is coming to my mind from all of your comments is that of the viability of smaller operations—for example, a 30-bed hostel. You must be very close to not being able to make ends meet. For those smaller ethnic groups wanting to have an ethno-specific facility, you are getting very close to not being viable on a lot of occasions, I would suggest.

Mr Gogorosis—I think that is a case that is often put. I would like to respond to it in a number of ways. Firstly, I want to emphasise that the change that could be happening is around policy, not necessarily around additional resources. We can achieve an enormous amount by simply rejigging the way administration of these services is being managed. That means a policy change, and I will give you a couple of examples of that. Secondly, it seems to me that viability is very often used as a reason not to do anything. For example, there is the argument that the 30-bed hostel for the X, Y or Z community is not viable. My response to that is that there are alternative models that we can consider. It does not have to be a stand-alone 30-bed facility. There could be a cluster model that brings together 15 Vietnamese, Greeks or Italians in this locality in this region that could provide a much more culturally responsive service to that community than a mainstream service provider could.

The third point I want to make is that very often we automatically tend to think of ethno-specific services only being provided by ethno-specific organisations. In fact, there is absolutely no reason why a mainstream organisation cannot approach the Vietnamese community or the Greek community and say, ‘We have the resources, the capacity, the knowledge and the skills to be able to provide your community with a service response that better meets your elderly people’s needs.’ Unfortunately, there is not a lot of evidence to support the idea that mainstream organisations, particularly community based organisations, take this as a fairly serious responsibility that they have. In one sense the assumption that ethno-specific services can be provided only by ethno-specific organisations is reinforced in the way administrators couch policy and talk about policy implementation. So there are many different ways, it seems to me, that by changing policy and the way we administer the programs we can bring about quite an enormous amount of change at minimum cost to the Australian taxpayer.

Mr Nguyen—My daily job is Director of the Springvale Indochinese Mutual Assistance Association, a welfare organisation. In facing this problem, we came up with something that I think you could call a business community partnership model. We approached a private provider, TLC Aged Care, and we talked with them for nearly 18 months trying to convince them that, as we had the need and they had the capacity, perhaps we could form a partnership—that they could put their investment out, that we, the community, could work with them in managing the place that they built and that, if we applied together and worked it out in partnership, we could see how we could meet the needs of the Vietnamese community.

Finally after 18 months we signed a memorandum of understanding and we applied as partners. This is the first time in Australia that we know of that a private company has signed up with a community. It will be a 100-bed facility in Hallam. We have already put in the application. The model is that SIMAA will be the managers of the place and TLC will train and mentor us. We will manage the place for the Indochinese people. After two or three years, if the community is happy with it and it becomes more professional, they can negotiate the ownership or otherwise of the project.

This is something that is very innovative and very different. There is a willingness there in the community. Nowadays it is very difficult for an ethnic community of any size to have the capital investment for land and buildings. It is almost impossible to go forward without some kind of partnership with the existing providers. So there are some initiatives that are worth while to look at. Like my colleagues, I absolutely agree that there is the willingness and we must look at innovative ways of dealing with the issues and supporting the struggling, small low-care places to give them the capacity to expand to meet the increased needs.

Miss Lau—We also need governments to dispel the myth that providing ethnic-specific facilities is more costly; it is not more costly. There is evidence that, by linking in and providing a cluster with ethnic-specific groups within a facility, the cost goes down because the volunteers who come from the community groups to support and look after the elderly with the support and assistance of professional providers within the facility will help that facility and proprietor break even.

My own community has had a 31-bed hostel functioning for the last 12 years. We are still viable and we are still able to survive because we have a lot of support from our community. This is why I am saying that government perhaps needs to review this and see what the community is doing as volunteers and perhaps provide them with adequate support so that they do not break down, because if that group breaks down it would cost the government a lot more to run these places.

Senator FORSHAW—Earlier when you were talking about those figures for residential facilities I asked you to clarify whether or not you included retirement villages. Part of the reason I asked you to do that is that what happens and what is happening now—and my own view is that there should be more of it—is that community organisations, whether they be religious based organisations, community based organisations such as the RSLs or service clubs or indeed ethnic community organisations, are investing in multitier accommodation from retirement self-care to residential. I am aware of this happening in the area where I live with the Greek community and others. Can you comment on whether or not in Victoria there is much opportunity within, say, your particular ethnic community to do that? Essentially that is how a lot of the aged care facilities developed in this country anyway—through the activities of the Catholic Church, the Anglican churches and a whole range of other community based organisations—rather than necessarily by the government.

Mr Gogorosis—I can talk about my organisation, Senator. Fronditha has a very deliberate regional structure, so we have a presence in the four metropolitan areas of Melbourne and we provide a whole range of services—community based services, residential care, dementia specific services. We intend to expand on those. We provide housing, for example, in a property at St Albans and that housing service is for not just the Greek elderly but also other elderly in that local community.

Senator FORSHAW—Is that subsidised housing or is that actually housing that these people can purchase?

Mr Gogorosis—It is actually public housing. We received a grant from the state government to develop 20 independent livings units for the elderly. I want to say that Fronditha grew out of a particular set of historical circumstances at a period in Australian history where there was a lot of support for diversity in our community, and that was reflected in a whole range of policy initiatives. In fact, we had the establishment of the SBS, as an example, and a whole lot of other policies that encouraged diversity and community based organisations to think about their role and to encourage ethnic communities to think about how they might play an active part in participating in the care of their own community. So organisations like Fronditha and DutchCare have grown out of a particular historical circumstance. Now, for all intents and purposes, Fronditha Care is a large organisation and is able to play a very active part in looking after not just Greek elderly but also other elderly in our community, across a whole range of services.

It seems to me that what we are missing in the current policy environment is this sense of perhaps encouraging ethnic communities, in a whole lot of ways, to play a much more active part, to create the environment where minority groups can play a part in establishing community based organisations and be encouraged to pursue developments that look after their communities.

Senator FORSHAW—But it is a bit more than that. I am not sure what the scope is. There might also be arguments against it from a social perspective or whatever. What clearly is happening is where an organisation establishes, say, a retirement village, which is effectively a money making or a profit making enterprise, to cross-subsidise an associated high-care facility in the same location. There are those that argue that that is a very effective and desirable way of approaching aged care accommodation in total, where people can go and live in their own unit—they do not necessarily own it outright but they purchase it on an agreement for a buyback—and they maybe stream through when they need to go into the nursing home facility later in life. I do not know whether that is an option. I am trying to explore an option in which ethnic community groups can be involved, in the same way that a range of other aged care not-for-profit providers are involved.

Senator McLUCAS—Mr Nguyen, I was a little concerned where, in your submission, you say that there is a lot of data to say that access by non-English speaking background people to Home and Community Care is at a lower level. Has anyone done any work on why that is happening?

Mr Nguyen—Yes, thank you for the question. I think that is going back a step. While we have this residential care, in our surveys and in talking to our communities, everyone seems to be universally agreed that residential care is the last resort. People still prefer that they are helped at home in their community, therefore HACC becomes very important to start off with.

In terms of access, we still find that because of the language problem and information issues—for example, the lack of understanding of what HACC is about—councils in certain areas are doing better than others. We have representative figures that reflect the community's composition in terms of the demographics and cultural diversity of the population, but in most councils there is an issue of access and even understanding what HACC stands for.

A lot of social or ethnic-specific elderly groups, because of their lack of support and because they have no funding whatsoever, see HACC as an alternative activity group for them, so they join. Because of that lack of proper assessment, resources and communication, they are desperate for the figure to fill up. In many instances, the healthy ones got into HACC, whereas the ones who really needed HACC got in later on because the places had already been filled, so they could not move in. Where there are social clubs that can help prevent that—those people can stay with the social club but not healthy ones so that the right place can be given to the right people—that is not happening. People see that as an alternative to the social clubs. Many of them, because of a lack of government funding, cannot survive. I think that is an issue.

On top of that, there are language and access issues. Information about HACC is not readily available in languages that people can understand. Also, the situation of many ethnic-specific welfare agencies is that they have funding but never receive any funding specifically for aged services. Therefore, the priority is quite low. It is not in their brief to look after the information or the access issue of aged care. That is why we welcome the Victorian state government's initiative, the CEGS, or the Cultural Equitable Gateway Strategy to help in the area of aged care—it is almost like the old access and equity officer. This was only initiated last year.

That shows the need to improve access and the way the community works with their existing services, the so-called day activity centres, to make them more available and to improve people's understanding. That would mean that you could move some of the very healthy ones out to go back to their social groups and clubs and give the waiting list a breather so that we could move in those who are really in need of HACC. It is mostly because of a lack of understanding and information.

Senator ALLISON—Mr Gogorosis, you said that studies have demonstrated that CALD elders with dementia in generic residential facilities are overmedicated with sedatives. Is it possible to give the committee some references of studies that have shown that?

Mr Gogorosis—A relevant reference is a PhD by Dr Susannah Runci of the school of medicine at Monash University. I think I might have provided that reference in the submission. If not, I will make it available.

Senator ALLISON—I could not see it.

Mr Gogorosis—I do apologise. It is not in there.

Senator ALLISON—You have provided us with a set of the conditions that give rise to that, so it makes a lot of sense, but it would be interesting to see it.

Mr Gogorosis—It really is a critical issue. Again, it is an example of where we are not addressing a very important matter for a substantial number of elderly people who just do not have the language and the cultural background.

Senator ALLISON—Are there any equal opportunity legislation barriers to attracting staff or to establishing an ethnic-specific facility? Are there any problems associated with advertising, for instance, for people from particular backgrounds?

Mr Gogorosis—We have not come across them. No-one has questioned it. We probably breach some legislation—I am sure of it—but no-one has ever queried it because it is such a logical sort of thing to do.

Miss Lau—The legislation does state that, to comply, all applicants for work in aged care facilities now have to be qualified in any of the categories—including your personal care workers, who all have to have a certificate III. Given that, I do not think any proprietor would have the courage to not accept someone with a certificate III because, in the past, they have been employing unqualified personal care workers in place of the division II and also in many instances division I registered nurses as well.

Senator ALLISON—I think there is still a period by which time you comply.

Miss Lau—Yes, we still have that but, given the unfair dismissal laws, people are now starting to not employ unqualified workers. Again, that is with the rationale that, although we do have a qualifying period, we want to make sure that the people we employ are qualified, and we say to unqualified applicants, ‘We’ll take you on when you’ve obtained your qualifications.’

Senator ALLISON—Miss Lau, what sort of tasks do volunteers at the Chinese 31-bed facility you referred to do within the unit?

Miss Lau—They are involved in a lot of diversionary social activities, assisting me with outings and providing companionship support for those who do not have visitors. They do that as well. Mostly, they are involved in diversionary activities and therapies. Of course, we have a lot of festivals. There is a festival every other day, so that keeps the seniors very much occupied. We could not have those activities without our volunteers and our lifestyle coordinator. You cannot put on a full-time lifestyle coordinator in a 31-bed facility, and a part-time person would have great difficulty fulfilling these requirements and providing these activities.

Senator ALLISON—And keeping up with all the festivals.

Miss Lau—Yes.

Mr Nguyen—In addition, like the Vietnamese volunteers at the hostel, they also bring in religions services like Buddhism, Cao Dai and Hoa Hao that would otherwise not be available in other places. There are volunteers coming in from the community from special branches of Buddhism in Vietnam that are very meaningful and very important to the residents at that stage of their lives. We even have some of the Buddhist people going to see the Catholic priest while the monks are not there, just to have somebody to talk to! That level of volunteering from the community is vital to and really helpful in lightening up the place quite a bit.

ACTING CHAIR—Thank you all very much for your contributions to our committee inquiry.

Proceedings suspended from 12.28 p.m. to 1.19 p.m.

BROWNRIGG, Ms Jan, Assistant Secretary, Australian Nursing Federation

CLUTTERBUCK, Miss Jill, Senior Professional Officer, Australian Nursing Federation

JACKSON, Ms Kate, Industrial Relations Organiser, Australian Nursing Federation

KELLY, Ms Leonie, Industrial Officer, Australian Nursing Federation

NALL, Ms Catherine Marjorie, National President, Australian Physiotherapy Association

JAFFIT, Mrs Carol Heather, Clinical Nurse Consultant, Aged Care, Royal District Nursing Service

ROMANIS, Mr Daniel, Chief Executive Officer, Royal District Nursing Service

CHAIR—Welcome. Information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. In particular, I draw your attention to paragraph 8 concerning the giving of evidence in private session and indicate that it would not be the intention of the committee to publish this evidence. I now invite you to make a statement to the committee.

Ms Brownrigg—Thank you very much. I have one document here for tabling and I will talk to that in a moment. Over the last 13 years that I have worked at the Australian Nursing Federation—first as an industrial relations organiser, then as a professional officer and now as the assistant secretary—it has been my unhappy experience to see a deterioration of staffing levels and the skills mix especially. Over the years I have observed the removal of the regulations which addressed those two issues—that is, the staffing levels and the skills mix, which were removed in 1995, plus the simplification of the awards and the removal of acquittal of CAM funding—care aggregate model funding—in 1978. Since that time it does appear to have made it easier for business, because it allows proprietors to reduce levels of care if they so wish by reducing staffing levels, and that is a common occurrence when things are tough.

None of the previous budget initiatives by the federal government have been effective in stemming the deteriorating staffing levels or skills mix, because the moneys received—and I am sure you have heard this before—have not been tied to anything, nor have proprietors been required to maintain staffing levels. Any further deregulation, we believe, will only exacerbate the problems that have been raised in our submission, and the new model of care has not even addressed these two very important issues.

I want to table a document which is an example of why this system has not remedied any of the problems. The letter I am tabling was sent to me recently—Friday night last week. It is from a director of nursing who has resigned from a nursing home because of the frustration caused by being unable to provide the level of care that she believes the residents are entitled to. She also tells me that in her area alone five directors of nursing have resigned from the private aged care sector, all for the same reason: frustration at this mind-set of profit over care. She came to us because she has not received any of the entitlements she is owed, like her annual leave, since she left. This is not an uncommon occurrence in this facility. No-one at the facility has been paid superannuation for nearly a year, and that is the subject of a legal investigation at the moment. Even more importantly, she came to us not only for help to get her entitlements but also for help to expose what she considers to be malpractice by the proprietor.

The content of this letter is the reason I originally asked for this session to be in camera. For a start, there is no evidence attached to it; it is full of ‘I believe’. But this director of nursing is so upset by what she has seen and what she considers to be malpractice by this proprietor that she does wish to take this further, and she claims to have evidence. She fears, though, that if too much pressure is put on this proprietor he is just as likely to move on, change to another name and the staff will all lose out—and believe me it has been done before, by this proprietor too.

As you can see from the document, the first page is basically about her entitlements. The second page and the bottom half of the first page contain a litany of events that have occurred during her time there, including various facilities such as the baker and the butcher—I will not say the candlestick maker—and no doubt lots of other people who were simply not paid for the bread et cetera. The director of nursing and the nursing staff employed there tell me that they often buy food for the residents out of their own pocket. This is done out of desperation. Because these facilities would not deliver food to this nursing home, the director of nursing paid for it herself out of petty cash. The petty cash has run out now, and she does not know where she will get the money because the proprietor refuses to replenish the petty cash in case she uses it again. She was in quite a bind as to what to do, and hence the desperation of this letter.

She tells me a whole lot of stories of how grim things are in this nursing home. One is that for a long time the beds have been totally inadequate, and the patients were falling out of them all the time. A stack of incident reports written by the nurses describe bruises, cuts and in some cases even worse accidents and injuries that required acute hospitalisation. After many years of complaining about the beds, patching up the residents and bringing in WorkCover, which eventually forced the issue, electric beds were ordered. They arrived two weeks ago, and they were promptly sent back to the manufacturer because the owner would not pay for them.

The residents in this nursing home have gone back to being cared for on mattresses on the floor because the beds are too unsafe for them to sleep in and the safest way to care for them is on the floor. I do not need to tell you what that entails in terms of occupational health and safety for the nurses caring for the residents, let alone the indignity to an elderly resident having to sleep on the floor.

As you can imagine, places like this get a reputation and people do not want to work in them. Consequently, agency staff are relied on to fill the majority of the shifts in this place. In fact, no agency will send staff to this nursing home, because none of them have been paid for the nurses that they had sent previously. Of course that means staff have to work short, the problems are exacerbated yet again and the downward spiral continues.

Although the financial aspects might be worse in this place than in others, the point is that, through not having accountability or any mechanism whatsoever to tie the money that is received by the proprietors to adequate staffing, food et cetera, there is no compunction on the proprietors to tie that money to anything. Whilst this situation continues, I believe that examples such as this one will not be uncommon. Accreditation does not work, and my colleagues will raise further issues on that. Thank you.

Senator KNOWLES—I am interested to know why you would prefer this evidence to be given in camera rather than in open session whereby, if the allegations are correct, these people could be held accountable and so would everybody else involved.

Ms Brownrigg—It was a case of timing. As I said, this letter was faxed to me last Friday night, and then there was a long weekend. I am protecting my member, this director of nursing. I did run the letter past our solicitors to see whether tabling it could present any problems. They said, ‘It depends; it could be seen as defamatory.’

Senator KNOWLES—But this is protected by parliamentary privilege.

Ms Brownrigg—Outside the closed—

Senator KNOWLES—The whole hearing is protected by parliamentary privilege, whether it is in camera or not.

Ms Brownrigg—That was the sole reason—to protect.

Senator KNOWLES—Legal action cannot be taken against evidence that is given to a parliamentary committee. I am fascinated to know why, if the allegations are as serious as you claim them to be, you would prefer to have this in camera rather than have these people held accountable.

Ms Brownrigg—I can only say it was for the protection of my member because this letter could be perceived as defamatory. I have given it to the solicitors so they can act on the entitlement aspect of it, and I fully intend to expose this letter to the accreditation board et cetera—although the nurses already have. It was solely to protect my member. I do not mind if this is exposed. I would like to see this proprietor exposed. The director of nursing tells me that she can provide evidence but, until that evidence is provided, I guess I thought presenting a document such as this without evidence could expose her. That is all I can say. I would like it be exposed.

Senator KNOWLES—If that same letter were presented in an open session, she would be covered.

Ms Brownrigg—What can I do about that now?

Senator KNOWLES—You can present it in open session.

Ms Brownrigg—Again?

Senator FORSHAW—Can I suggest that you confirm with your member if she is prepared to have this and the evidence made public. Then the committee can deal with that in due course. I understand the cautionary nature of the way you have presented it. That may be a way we can deal with it. You said the agency has been informed. Is there any history of difficulties? Has the agency done anything about this nursing home?

Ms Brownrigg—As I said, time has gotten away from us, but certainly we know this nursing home. We have been called out for various breaches of award conditions over the years. The problem that occurs when we do make complaints is when they are acted on and how much notice, if any, is given—and there is usually notice given. There are ways and means to cover up these sorts of things. In answer to your first statement, I have checked with our member and she is more than happy for this letter to be a public document.

Senator FORSHAW—There is the answer.

CHAIR—We were just discussing the best way to deal with this. The committee has the ability to simply turn the session we have just had into a public session, but we would probably prefer that you consult with your member and then formally write to the committee requesting that, and then we will do it.

Senator HUTCHINS—She already said that.

CHAIR—I missed that because we were discussing the strategy.

Ms Brownrigg—I did check with the member after I spoke to the solicitors. I checked with the member last night and asked her if this situation become public would she happy with that. She is more than happy for this document to be public.

CHAIR—Would you like this session we have just had to now be a public session?

Ms Brownrigg—Yes, if what you are saying is correct—and I believe it is.

Senator KNOWLES—It needs to be understood very clearly that everyone—you and this lady, Mrs Payne—is protected under parliamentary privilege. So you are not subjecting her to the possibility of legal action based on the evidence you have given to this committee. All right?

Ms Brownrigg—Yes.

Senator KNOWLES—So do not feel as though you are doing something lightly in this regard.

Ms Brownrigg—Thank you very much for that assurance.

Senator HUMPHRIES—I move:

That this in camera session now be made public session.

CHAIR—There being no objection, it is so ordered. We can now open the doors and the document may now be published.

Senator HUMPHRIES—If this is in the public arena and you are asked to comment on it by the media, you may want to get legal advice about how you do that. It is only the words that have been spoken here and what is in the document which is privileged, not other things that might be said about this subject. So before you or Ms Payne speak to the media, should you be asked, you should probably take advice on that subject.

Ms Brownrigg—Okay.

Senator KNOWLES—Do not, whatever you do, go and just hand them the *Hansard* from today’s meeting either because, unless they have the whole *Hansard* instead of just the excerpt then you could subject yourself. You need to do what Senator Humphries is doing and get very good legal advice from someone who knows and understands parliamentary privilege, because clearly the advice that you got before was from someone who did not understand parliamentary privilege.

Senator McLUCAS—To that effect, the Department of the Senate is also an available resource for you, and I am sure they would welcome queries from you to assist you to ensure that you are protecting your member.

Senator KNOWLES—The Deputy Clerk of the Senate, Ms Anne Lynch, is the Secretary of the Senate Privileges Committee and she would probably be only too pleased to be of assistance to you in providing guidance.

Senator FORSHAW—The nature of the evidence in this document is very much hearsay. It would be of great assistance to the committee if there was some specific evidence that could be provided. You can take that on board. I am not talking about the entitlements issue—that is direct evidence—but the other issues relating to potential misappropriation.

Ms Jackson—I have been employed as the industrial relations organiser for about 8½ years. Prior to this I was employed as a charge nurse for nine years in a large aged care facility and have probably spent most of my nursing career working in extended care. Part of my portfolio involves looking after the interests of our members employed in 60 aged care facilities, and they include a mixture of high-care beds and low-care beds. Part of my role also is to, on a regular basis, approximately every six months, visit all our facilities. It has been my experience as an organiser that a number of facilities have reduced registered nurse numbers, and particularly division 1 staffing levels, for two reasons. The first reason that proprietors have stated to me is that, because there is no requirement to have minimum or regulated staffing levels, they are now able to reduce registered nurse numbers.

The second reason that has been given to me is that, because of wage increases through enterprise bargaining here in Victoria and the belief that there has been no subsequent funding from the Commonwealth, they have had to reduce staffing levels in order to pay the wages increase. The most expensive staff member in any aged care facility is undoubtedly a division 1 registered nurse. In the last 12 months I have dealt with two large high care facilities that have reduced the number of division 1 registered nurses, particularly on night duty. One of these facilities has 100 beds. It is divided into four ward areas and is spread over a number of floors. In the past, each ward area had a division 1 registered nurse employed in the unit. This organisation restructured and declared three of those positions redundant and now has one registered nurse for 100 beds on night duty. The proprietor openly stated to me that they did not believe that division 1 registered nurses were required on night duty and that it was now industry practice to have only one division 1 registered nurse on night duty, regardless of the numbers, as there was now no requirement to have minimum RN levels or, I suppose, a skills mix.

Other restructurings that I have dealt with over the last 12 to 18 months have involved reductions in rostered hours. For example, there has been a cutting of half an hour from each shift, which leads to the nursing staff having no overlap time with the next shift. They usually use that overlap time to give a handover regarding the resident care to the oncoming nursing and personal care staff. Many staff, however, still feel that it is their duty to stay on after their rostered shift because they want to give handover to the next shift. They do not receive payment for overtime and I have been told that, when they request that payment for overtime, they are basically told, ‘Don’t bother applying, because it won’t be paid.’

As recently as last week I dealt with the issue of a high care facility restructuring and creating a position for a division 2 nurse, which is an enrolled nurse, who had a quality coordinator position three days a week and, I think, six hours a day. That position was made redundant on the basis that the budget could not afford that position plus a full-time director of nursing position. This facility is part of a not-for-profit organisation that has approximately 760 beds. That is not counting the independent living units that they have as well. So it is a very large organisation. My belief, as a division 1 registered nurse, is that nurses cannot continue to work under these conditions. Nurses are constantly stating to me that they feel they cannot meet their duty of care, they do not have the time to supervise unregistered or unlicensed staff and they feel that clinical care issues are being missed because there are inadequate numbers of registered nurses on the floor providing direct care.

Mr Romanis—I will briefly outline the Royal District Nursing Service position on four elements of the committee’s areas of interest. You have received our submission. I will not go back over the items that we have raised in that submission, but, in relation to the adequacy of current proposals involving aged care work force shortages and training, we remain concerned at the continuing prospect of staff and skills shortages for the aged care sector generally. Australia faces a critical chronic nursing work force shortage. Universities in Australia are producing 50 per cent less graduate nurses than 10 years ago, and I have a fear that the division of responsibilities for nursing undergraduate training between the federal and state governments and the universities themselves is allowing responsibilities and accountabilities to fall between the cracks. Significantly greater numbers of university places are needed to make any impact on general nursing work force numbers, let alone the less popular areas of practice in aged care.

For students themselves, the cost of undergraduate and postgraduate studies acts as a deterrent to study. Nursing study curricula need review and we need to reduce the drop-out rates both during the undergraduate training years and in the first two years after graduation. By and large, general practitioners do not make home visits any more. Carers themselves are ageing and their health is declining. District and community nurses are increasingly the only professionally trained health care workers who can routinely undertake home visits. Yet funding streams do not reflect this. Increasingly, community nurses are seen as expensive.

Our submission to your inquiry goes into some detail about the appropriateness of young people with disabilities being accommodated in residential aged care facilities. We have a concern that younger disabled people need to be part of a peer group of bright, younger people whose days consist of activities, of discussions, of thinking, of growing and of idle chatter. Instead, too many them spend their days alongside older people, most of whom spend much of the day sleeping and most of the rest reminiscing. For too many of these young individuals there is a feeling of being caged, of despair and of lack of hope. I respectfully suggest that these people really do deserve better of us.

Our submission also addressed the adequacy of home and community care programs in meeting the current and projected needs of the elderly. The majority of older people no doubt prefer to remain in their homes with the support of a range of community services rather than being placed in residential aged care. But as a society we all too often seem to ignore this fact and consider nursing homes to be the places to which people go when they get old. In other words, we simply do not give sufficient recognition to the concept of ageing at home, within our communities, and we certainly do not resource this area sufficiently. We need to carefully consider the impact of reduced length of stay in hospitals, the levels of knowledge expected of nurses working across the community and the potential which effectively trained district nurses offer for reducing hospital admissions and then look at whether we are seriously and adequately resourcing HACC programs.

But even now what do we find? Whatever we fund, we fragment. We put together packages such as CACPs, EACH and Linkages, for those with perceived higher levels of need, but we do not pay sufficient attention to the needs of those who are coping at home but only just. We let them struggle. We create systems, structures and environments which are extremely difficult for the average person to navigate, then we create a dependency focus rather than promoting independence at home. We establish brokerage arrangements for services and funds and additional layers of management rather than funding additional on-ground services themselves. Quite simply, the growth in the aged population needs to be matched by a growth in HACC funding for aged care.

Overall, aged care is an area of health and community care which we believe deserves far greater focus and attention from government. It is an area in which service providers such as RDNS can do more with appropriate resourcing and can save funds within the overall cost of health care. But to see aged care and community as in some ways an extension of acute care is fraught with problems and pitfalls.

Ms Nall—As National President of the APA, I represent some 10,500 physiotherapists throughout Australia, which is about 80 per cent of the total registered physiotherapy population. My background is that I am the director of physio at Austin Health, which has, among other things, 60 aged care beds and a 60-bed residential aged care facility. I have with me this afternoon Melanie Farlie, who is the chair of the National Gerontology Special Group of the APA, representing some 550 physiotherapists working in the aged care sector across Australia. We also have with us Kerren Clark, our manager of policy and external relations, who has been closely involved in the preparation of our submission and related papers.

Thank you very much for the opportunity to present to this hearing this afternoon. Aged care is an area of great importance to physiotherapists and their patients. Given our widespread involvement in the sector, our association has an important perspective on some of the shortcomings of the current system and the recommendations for strategies to overcome them.

As identified in our submission, there are a number of areas that we wish to highlight. Maintenance and improvement of mobility, falls prevention through accurate assessment and balance retraining, maintenance of cardiovascular and respiratory fitness, and general rehabilitation are all areas in which physiotherapists have a major role. Continence management is another area of expertise of great relevance to this sector.

In the residential aged care sector, our problems in providing this care are twofold. Firstly, there is insufficient funding to support the employment of physiotherapists for more than just the required documentation and very minimal treatment time. There are already major problems with work force, and these problems are projected to increase. These two issues are interrelated.

Physiotherapists have a large role to play in the prevention of physical decline in the elderly. Good preventative care has the potential to save the aged care sector significant sums of money which could be better spent on ongoing rehabilitation and other much-needed services. It could also reduce the need for many hospital admissions. The APA has developed a standard for the amount of physiotherapy required for residential aged care in order to meet these needs. It has been developed by our expert gerontology physiotherapists and is contained in our statement. I would also like to table of this standard separately.

This standard states that, at a minimum, a high care resident should receive 30 minutes of physiotherapy and 25 minutes of assistant time per week. Best practice is 30 per cent more than this. So if, in the clinical judgment of the physiotherapist, the best practice amount of care time is required, this is the amount that should be provided. This compares with the current situation where a good allocation is eight minutes per week in total and a poor allocation is none. An example was given to me today where, in our own nursing home, Darley House at the Austin, two residents were discharged from an acute hospital—one with a fractured ankle and one with a fractured hip—after 48 hours in acute care. Our physiotherapist has five hours for 60 residents. That is all she is funded for. If she were to give the appropriate time to managing these two new patients, there would be no time left for any of the other 58 residents. Some residential aged care facilities have no physiotherapy time at all. It is essential that this standard is recognised and that funding is allocated so it can be implemented. I am sure you have got many questions, and we would be very happy to answer them.

Senator KNOWLES—Could I seek comments from Ms Jackson and Mr Romanis on the document that was released last week, the *National Aged Care Workforce Strategy*?

Ms Jackson—I am sorry; I have not seen that document.

Mr Romanis—We have yet to analyse it, so we are not in a position to comment on it at this point.

Senator KNOWLES—Okay. Mr Romanis, you mentioned the difficulty—and I am sure we all agree—about having young people in nursing homes. What has your communication been with the state government in this regard: to get young people out of nursing homes and into appropriate care?

Mr Romanis—I suppose it is an ongoing dialogue, but the options appear to be very limited. It seems that we identify pockets of activity, but my concern is that we need a holistic approach to it, and we just do not seem to achieve that. Could I invite comment from Carol, who is one of our clinical nurse specialists.

Mrs Jaffit—I have not personally had any contact with the state government, but I certainly recognise, as Mr Romanis has said, that we do regularly see clients within residential care facilities where they are just unable to reach their potential and their life span and their quality of life are reduced.

Senator KNOWLES—No-one is denying that. What I am asking is: what is your organisation doing about getting the state government to provide facilities for such people under the Commonwealth-State/Territory Disability Agreement?

Mr Romanis—Our focus with the state government is primarily around aged and community care, rather than the disability sector of the Department of Human Services, so our dialogue with the disability sector of DHS is not there.

Senator KNOWLES—Is there any reason for that, considering that it is an expressed concern of yours that young people are continuing to be inappropriately placed in nursing homes?

Mr Romanis—It is a continuing concern but it is not something over which we feel we have potential to influence government policy.

Senator McLUCAS—Mr Romanis, can you explain how your service interrelates with the other community care providers in Victoria? Am I right to think that you are the only provider of community nursing in this state?

Mr Romanis—We are not the only provider; we are the largest provider of district and community nursing. We employ about 1,000 division 1 registered nurses. That equates to about 600-650 effective full-time division 1 nurses. Victoria has a difference, as I understand it, from most other states in that in Victoria local government is the major provider of HACC personal care services, so we have longstanding interface with local governments throughout Melbourne. Our service is very much the greater Melbourne area only. We have continuing arrangements with local government right across the Melbourne area to enable shared care in personal care as against nursing services. We also have arrangements with a raft of other providers. There are a small number of other providers who are involved in HACC district nursing, but the largest of those would employ probably no more than 10 registered nurses, compared with our 1,000. So there are ongoing arrangements and understandings right across the greater Melbourne area. From a client’s point of view that works reasonably well, but it is quite different from my understanding of the way that it works in many other states.

Senator McLUCAS—It is very different to have one major provider. Is it simply for historical reasons that you are essentially metropolitan based and do not work in rural areas?

Mr Romanis—Yes, it is. What has occurred in country Victoria is that district nursing has by and large been established as an adjunct to base hospitals, as an extension. In many ways, from a client’s perspective, that has worked and continues to work pretty well. Across Victoria generally, district nursing being a function of the local hospital is probably the best way of doing it from a client's point of view—rather than having a service based in Melbourne trying to relate to a service being delivered 600 kilometres away.

Senator McLUCAS—I come from Queensland and it is a lot bigger there.

Mr Romanis—I can understand that very well with Blue Care.

Senator McLUCAS—Do you have any relationship with ACAT—we call it ACAS here—as an organisation?

Mr Romanis—We do. In fact, we were just talking about ACAT relationships on the way in. I will ask Mrs Jaffit to comment on that.

Mrs Jaffit—We have a very close relationship with the ACAS teams, but it is very area dependent. I work in the area which north-west ACAS operates and I attend their case conference every fortnight, so there is a lot of collaboration in the provision of care for clients within the community as a result of our association with the ACAS team. There is a lot of cross-referral as well, so we have very close links with ACAS.

Senator McLUCAS—To the ANF, thanks for your submission. I think every representative organisation of care workers and of nurses has talked to us about a benchmark of care and minimum staffing levels. The Health Services Union, who appeared before us yesterday, essentially agreed that a formulaic approach to minimum staffing levels was probably not flexible enough to deal with the changing needs of a group of people in a residential aged care facility. They suggested, and I think I am paraphrasing them correctly, that in the development of a care plan you would make an assessment at that time about the amount and type of care that is required. So you could develop a staffing level out of the assessment of the need of the residents and then bring it all together to work out what you in fact would require. Has the ANF got a view about how you could ensure that appropriate levels of staffing are maintained and how you would do that technically?

Ms Jackson—Miss Clutterbuck might want to comment on that.

Miss Clutterbuck—There have been a number of approaches taken to this problem over the years. In our original submission we attached some material from research and recommendations that were made in the USA at the beginning of last year. I do not know whether or not any of the American states have taken up that issue. That is one way of looking at it, in that you have a minimum baseline of hours of care per resident per day and built within that is a skills mix of registered nurse, licensed practical nurse—that is over there; here that would translate to enrolled nurse—and care worker or assistant in nursing. I think you do need to have some baseline indicator such as that. You would build up from that depending on the assessed need of the resident according to the care plan. Unless you have a baseline, you have a system like we have now where there is no bottom. I think, human beings being what they are, you need to have some guiding line. I think that approach of hours of care per day with a relative skills mix built in is probably the best indicator that research has come up with.

Senator McLUCAS—You are referring to the document *Keeping patients safe*?

Miss Clutterbuck—Yes.

Senator McLUCAS—I have to say that I did find it hard to understand. I did not realise it was from the United States—that explains it.

Miss Clutterbuck—I have the book if you would like to have a look at it. It is very thick. It is a difficult area. Unless you are familiar with it, it does become a bit confusing. In our Victorian public sector hospitals we now have a nurse to patient ratio, which is very simple but nobody likes it. In some of the other states there is in the public system enterprise agreed hours of care per patient. I know South Australia has a system like that in its public sector which is by agreement with its state government. So there is a lot of nursing research around which would inform such a formula.

Senator McLUCAS—My assessment, though, would be that it is pretty hard to extrapolate the acute care formula to a residential aged care situation.

Miss Clutterbuck—While you have an instrument such as the RCS funding our residential aged care, yes, that would be hard to extrapolate. But I think you could develop one. The original nursing research which informed the development of the original RCI in aged care was based on a nurse dependency tool called BenEx. There are a number of such tools around used in nursing and some of them have been adapted quite well to residential aged care. So there is the beginnings of work there that could be used.

CHAIR—It occurs to me that the ANF is probably one of the groups regularly entering nursing homes, looking at what is happening from a professional, knowledgeable point of view about standards and standards of care and has an understanding of what is actually going on there. Also, the ANF is in a unique position where direct communication with the nursing staff about what is going on in aged care facilities is fed back. In the example earlier about the Hastings Regional Nursing Home it was mentioned that it would be pursued through the accreditation authority. My question is about the relationship you have with the accreditation agency—how they respond to complaints that the federation has raised or information that the federation has given them and whether you think that is satisfactory and timely and whether you think appropriate action is taken by them.

Miss Clutterbuck—I am happy to comment on that. I represent the Australian Nursing Federation on the Victorian Standards Agency Liaison Group which meets every three months. I have been a representative on that group since the agency was first set up—and I think that was in 1998 or 1999. My comments are not to be taken as laying the blame at the accreditation agency’s feet. When the legislation was first discussed and propounded in 1996-97 I asked the then manager of the Commonwealth Department of Health and Ageing in Melbourne how the legislation would resolve the nexus between the department and the agency—that is, how they relayed information to each other—and how the legislation would operate. There are always issues around privacy and confidential information; they are dealing with businesses effectively. I do not believe that that was resolved terribly well. When a complaint is made it is made to the Complaints Resolution Scheme. I think there are questions around the efficacy of the Complaints Resolution Scheme dealing with issues such as the one that has been presented to you this morning. That needs to be addressed in a very timely fashion—

CHAIR—If you referred this complaint off in the form that it is in, would there be a hearing or would it result in a spot check being done of the facility, or does it go through a bureaucratic process?

Miss Clutterbuck—From our perspective we have never been called in, although we have put forward lots of complaints to the Complaints Resolution Scheme. We have never had any follow-up from the department. We have not been called in and questioned about our evidence or information that has been given to us.

CHAIR—But you would know if the accreditation agency then went and did a spot check, wouldn't you?

Miss Clutterbuck—Not necessarily. There is no feedback mechanism like that. You can ask the complaints resolution people to get back to you—and I have done that a number of times—but it does not always happen. A decision is made within the Complaints Resolution Unit to either pursue the matter further and investigate it or hand it to the accreditation agency for them to look at. There is no link back from the accreditation agency in relation to complaints to us the complainant. I have no qualms about the fact that on the many occasions we have put forward information it has in most instances been followed up, but I only learn that from talking to someone in the facility.

CHAIR—What happens if it is followed up? Do we see nursing homes closed down? Do they get their act together?

Miss Clutterbuck—Yes, in some cases they are closed down. I think that the last time we had an issue—and the facility was Emerald Lodge—there were agency people out there within about 48 hours. That was some months ago and something was done about it.

CHAIR—I think the HSU referred to that in their submission too.

Miss Clutterbuck—The administrators came in.

CHAIR—There has been some general criticism that you get accreditation, which then lasts for three years, if you meet all the requirements. But, really, the chance of having a spot check in the three years is virtually zero. So you get extra agency staff, things are painted up, rented facilities come in, extra activities are planned and everyone is quite happy. Then, after the accreditation period, you go back to what is considered normal. So what they are actually judging accreditation on is abnormal. It is important that, if we are going to have three years between accreditation and stick with that standard if it is appropriate, there is a fairly quick response when complaints are raised from legitimate sources. I would have thought—and, again, that is why I made my opening comments—that the federation, with its experience, the type of people that it employs in an industrial sense and the communication it has with its members in these sites, would be a very legitimate source for complaints, hence your relationship with them and how they act. In your view, are they acting appropriately?

Miss Clutterbuck—They do act appropriately, I believe, when they receive substantiated information. With reference to your point about getting all of the equipment and the nurses on board for accreditation and going back to what we really are when they leave, during the first round of accreditation, through the work of our organisation I supplied quite a substantial amount of information about that sort of behaviour to the agency in writing. Everything we give to the Victorian agency they pass on to their national organisation. By chance that board was in Melbourne some months later and I asked the CEO of the national organisation what had happened and what had been done about the complaints that we had lodged—for instance, the one where truckloads of equipment and staff arrived the day before the auditors came and then left a few days after the auditors had left. I was told that they had investigated all of those complaints and they were merely malicious and litigious.

CHAIR—So they never got back to you until you actually asked?

Miss Clutterbuck—No, and they never have. We wrote numerous letters to the agency in relation to concerns we had over staffing levels that would obviously lead, and were leading, to poor care. I have copies of letters in my file. I have pursued these letters and have been told that it was being referred to the national board. Eventually I got a letter back stating that the issue related to staffing levels was an industrial issue and not one relating to care. When I pursued that even further I was told that the Commonwealth reserved their right to set staffing levels. But they never have.

Senator McLUCAS—But there is a standard that says that there has to be a staffing level appropriate to deliver the level of care. I forget the actual words. They were seemingly saying that that standard gave them no indication to deal with the concern that you are raising.

Miss Clutterbuck—I am not too sure that I understand.

Senator McLUCAS—There is a standard that talks about an appropriate level of staffing?

Miss Clutterbuck—Yes. What is an appropriate level?

Senator McLUCAS—That is the question.

Miss Clutterbuck—We have put the issue to the agency and said, as a professional organisation, what we believe is a baseline or appropriate level. The response was that the Commonwealth reserve the right to set staffing levels. My comment is that they never have. It is still anyone’s guess as to what an appropriate level of care is. It just seems to be as long as a piece of string.

Senator McLUCAS—In your view, does it vary?

Miss Clutterbuck—Would the need vary?

Senator McLUCAS—Does it vary—that is, the application of that standard? Some residential aged care facilities that are approved as complying with that standard and with an appropriate level of staffing may be different to another facility which has a very similar client base.

Miss Clutterbuck—It does seem to vary. In the years I have been involved in the area I have not seen a report from the accreditation agency which states that the agency is not meeting appropriate levels of staff. They will say they are not meeting certain standards but they, so far as I am aware, never criticise them in terms of staff levels or the skills mix.

Senator FORSHAW—Would you provide the committee with copies of the correspondence that you have had with the department that you have just been referring to?

Miss Clutterbuck—With the agency.

Senator FORSHAW—Sorry: with the agency. And could you also provide their response?

Miss Clutterbuck—Yes.

Senator FORSHAW—I note that your submission states:

> We have made written inquiries of the Federal Department and been told 'the Government reserves the right to determine appropriate staffing levels' ...

Was that the Department of Health and Ageing or was that the agency, which is effectively part of the department—in a sense, anyway?

Miss Clutterbuck—My letter went to the state agency. They referred it to the national agency group and they, from their letter of response, sought the opinion of the Department of Health and Ageing.

Senator FORSHAW—If you could provide that material to the committee it would be very useful. You are being told that issues of staffing, whether we are talking about appropriate minimum staffing levels or whatever, are industrial. Is there anywhere else you can pursue that issue, such as the Industrial Relations Commission? As I understand it, staffing levels or manning levels would not be regarded as an issue that could be arbitrated upon in an award, for instance.

Miss Clutterbuck—The history in Victoria is that in the old common nurses award we had nurse to patient ratios. We also had state regulation which stated nurse to patient ratios and the skills mix. The state regulations were withdrawn by the state government in 1995 on the basis that the Commonwealth regulated this area. We ran a case in the federal Industrial Relations Commission, which we were in at that time, to have those ratios put into our federal award. We were successful. They sat there from 1997 until 2000 because by 1997 they were unable to be enforced. They were stripped out of our award with the stripping of awards in 2000.

Ms Kelly—Before then.

Miss Clutterbuck—It was 1999.

Senator FORSHAW—They were not an allowable matter under the act.

Miss Clutterbuck—No, they are not an allowable matter.

Senator FORSHAW—You had so many years for them to be removed from an award.

Miss Clutterbuck—That is correct.

Senator FORSHAW—This is probably more of a comment but there is a question attached: you have said that there is research and evidence out there, and you have referred us to the US recommendations, that you can develop an appropriate numerical standard of minimum staff to resident ratios. We have here in this system an accreditation system which is the basis of funding being provided—to get the funding you have to be accredited as a facility—and that in turn is based upon a resident classification system, where residents are classified into various levels of care and there is funding attached to each of those levels.

As I understand it, the funding amounts must involve some consideration of the costs of labour, of staffing. I would have thought it was a matter of logic that the funding has to include that. Whether it is enough is another question, but it must include some consideration of what the staffing component is of providing care. From that it seems to me—it is a good argument and it is an opinion, I know—that it is arguable that the resident classification system, and a funding system based upon that, must go hand-in-hand with a minimum staffing ratio as well. Do you understand where I am coming from? I am interested in your view.

Miss Clutterbuck—Yes, I do. You would believe that that would be logical. The original funding classification tool for residential aged care in the high care area, or the nursing home sector, was based on the costs of wages to provide a minimum skill mix.

Senator FORSHAW—Was that a fairly substantial part of that overall funding?

Miss Clutterbuck—The original formula was determined by analysing rosters from a range of nursing homes across Victoria and New South Wales and other states. It formed the basis for funding for that state. That is why CAM funding was different in Victoria to what it was in New South Wales and Tasmania; it was based on the cost of that baseline staffing mix and level. But since the single classification instrument came in during 1997 that formula disappeared because of the melding of high and low care and a range of other classifications.

Senator FORSHAW—You make a comment in your submission that, to paraphrase it, you do not think it works terribly well. It is hard to judge whether the agency, as a training provider, is adequate. Can you expand on that? It has been put to the committee that the agency really should not have a dual role or a multiplicity of roles—namely, accreditation and training development. I am interested in your view, or the organisation’s view, as to whether or not they should actually be involved in training at all.

Miss Clutterbuck—The opinion I put forward in the submission is that the agency should be focusing on accrediting facilities. Once it gets involved in best practice or education of staff or what is the best way to address delivery of care, then it will have an inherent conflict. Our concern then is that it is not going to get any better, that there will be an inherent conflict of interest. They are not going to say that this way of doing things and training your staff in this way is what we believe is right, and then come in and say, ‘You’re doing something wrong.’ They are not going to criticise that part of the industry if they are following the advice or the training or the education that is being provided by the agency.

Senator FORSHAW—I found your comment that the training is, as it were, geared towards meeting the accreditation standards rather than training and development of staff for the object of providing care—rather than for bean counting and meeting 45 different services—very interesting.

Miss Clutterbuck—I think they are doing both. For the best practice forums that the agency are currently running—there is one, I think, later on this year in Victoria—they call for papers from people, and those papers are presented. What they are calling for is facilities that have done something really good. It is called best practice. It is done under the aegis of the accreditation agency. People will pick up on that and say, ‘Well, that’s the right way to do it, because the agency obviously thinks that’s a good idea.’ It becomes a bit of a self-fulfilling prophecy.

Senator MOORE—Ms Nall, I am sorry that we do not have more time to talk to your team, because your submission states that, despite your best efforts, the role of physiotherapy was not taken up in the National Aged Care Workforce Strategy. I would like to get on the record some more comments from you briefly about why you think that happened and what you think we can do about the fact that the area of allied health was not picked up in this process. And, Ms Farlie, in the same kind of process, I would like to get a little bit more on the record about allied health and in particular physiotherapy. Your submission talks about the degree of specialisation and the need for specialist gerontologist physiotherapists; I would like a little bit more about why that is so important but undervalued in effective aged care—and for acquired brain injury victims; that has come out quite a lot, the need for therapy there. I just wanted a little bit more on the record about your very specialised area.

Ms Nall—From the work force strategy point of view, it was despite our best efforts and representations. We struggled to get the very important role of physiotherapy in the aged care sector recognised in the way that it should be. We continue to make representations about the need for work force studies for physiotherapy generally and within specific sectors.

Ms Clark—I actually attended one of the consultation forums for the work force strategy. The consultants at that forum said to us quite clearly, when I stated that we believed that the study was deficient because physiotherapy was excluded, that that point had been made over and over at every consultation they had attended, but the remit that they had been given by the government or by the department did not allow them to include those comments. During those meetings I had terrific support from the other health professionals who were there as to the importance of physiotherapy in the sector, but we faced this blank refusal to acknowledge that physiotherapists are a core component of the aged care work force. There seemed to be no logic, and there was no reason or rationale offered; it was simply stated that this was the limit of the study and that was all that would be examined.

Senator MOORE—Ms Farlie, what about your specialist part of the profession?

Ms Farlie—The primary reason why physiotherapists with special interests and special skills in the area of gerontology are required in the residential aged care sector is purely around some of those work force issues, in that they are usually working alone and in isolation and working with some of the frailest clients, clients who have some of the most complex co-morbidities in our community. Given that level of responsibility, you want to know that the people who are working with these clients are adequately and suitably experienced to manage that case load.

In other sectors we have a hierarchy of grade 1, 2 or 3 physiotherapists that go through, but the level of experience required to work with the more complex clients is higher up that hierarchical tree. Unfortunately, the way that the aged care sector is set up at the moment means there is very little recognition of the need for the specialist experience of physiotherapists. It is a free market—anyone can go work in a residential aged care facility—but we would argue that for best practice you want physiotherapists with those skills. Unfortunately, it then goes back to the issue of remuneration. A physiotherapist with great experience and expertise can be remunerated at a much higher level in other sectors than in the aged care sector. When there is no requirement to remunerate in accordance with experience and skills, unfortunately what you get are physiotherapists who are happy to work for those lower rates of pay.

Senator HUMPHRIES—I want to ask the ANF a question about the burden of meeting the accreditation agency requirements. In your submission you state:

> Unless the government decided to move away from accreditation of facilities, it is hard to see how the current accreditation .paperwork burden could be reduced. ANF (Vic. Branch) would not believe it is overly burdensome compared to other such systems.

I am just a bit intrigued by that because I think the weight of evidence we have had from other people within the system is that it is overly burdensome and it should be reduced. I assume those comments reflect what your members are telling you about the paperwork burden and I assume it is the nurses themselves who are in fact shouldering most of that burden within the nursing homes.

Miss Clutterbuck—I think what we are referring to there is that the greatest paperwork burden is the accountability requirement for funding of RCI.

Senator HUMPHRIES—I see. So you are not referring to the general burden related to the accreditation agency requirements?

Miss Clutterbuck—No. What we go on to say is that, unless the government decided to move away from accreditation, it is hard to see how the accreditation paperwork burden could be reduced. The accreditation paperwork burden is quite great—it is quite marked—because they are small organisations. So the amount of work that is dedicated to accreditation is quite high. For instance, our public hospitals are required to be accredited under another accreditation system. The paperwork burden in both areas is about the same. Probably the work that is being done in accreditation in residential aged care has much improved the management of those organisations, but unless you remove accreditation you are not going to reduce that paperwork burden in relation to accreditation. The biggest burden that our members complain about is the RCI documentation—that is, documenting the classification of the residents.

Senator HUMPHRIES—But as far as accreditation is concerned, you are saying that your members do not consider that there is any likelihood of a reduction of that burden by virtue of some reorganisation of the requirements for accreditation.

Miss Clutterbuck—I am sorry; I do not quite understand.

Senator HUMPHRIES—I assume that the RCI requirements and the accreditation requirements are simultaneously falling on the desks of the nurse managers in the homes and they have to fill in both sets of paperwork. Putting the RCI stuff to one side, as far as the accreditation paperwork is concerned are you saying that your members consider that that is not likely to be susceptible to some reduction in volume if we were to recommend, and the government were to act on that recommendation, a reduction in the amount of paperwork required to satisfy those requirement?

Miss Clutterbuck—We would find it hard to believe that you could reduce that paperwork burden for accreditation because similar systems in other sectors of health generate just as much paperwork. If it is going to be an effective system, there is a certain level of paperwork that is needed. I do not see how you avoid that.

Senator HUMPHRIES—Evidence before the committee has suggested that there is too much of it and it certainly could be cut back significantly.

Miss Clutterbuck—If there is, that is good. I guess I am a simple nurse who has seen two different accreditation systems and they are both equally burdensome.

Senator FORSHAW—The issue is the requirement to be constantly doing it. For instance, if somebody is receiving HACC services and then moves into a nursing home, why do it all again if there is already a lot of information on record? If the GP has got a lot of information on record, why reinvent the wheel by having another whole set of documentation done? That is one of the arguments for how you could reduce it.

Senator HUMPHRIES—I suppose another way of putting the question is this. As your members fill in these accreditation documents, do they say to themselves: ‘What the hell am I doing answering this question? What does this have to do with anything that happens that affects the quality of care to patients?’ Do you get the sense that many of the questions are repetitive or unnecessary or do not contribute to anything that is important in the operation of the home?

Miss Clutterbuck—I have not actually had that raised with me as an issue. Have you had that, Kate?

Ms Jackson—No, not that example as such.

Senator HUMPHRIES—I turn to one other thing. You make a comment about the DRG Casemix funding within the hospital system and how this is forcing nursing home type patients out of the acute care beds. They are not getting appropriate rehabilitation to return to their homes or to be able to look after themselves. You say:

> But there is no provision in Federal funding to ensure that these elderly citizens can benefit from appropriate rehabilitation to ensure their quality of life is maximised.

I was surprised to read that, given the transition care program that was announced in the last budget, which, as I understand it, is designed specifically to create places for elderly people to experience some transition and rehabilitation—the context of that—to help them make that transition more effective.

Miss Clutterbuck—That is what was announced in the budget this year.

Senator HUMPHRIES—No, it was in last year’s budget.

Miss Clutterbuck—I have since become familiar with it. I wrote this in about May or June last year, which was around the time that initiative came out. I have since learnt more about it. It is very much in its infancy as yet, but it is to be applauded. I do not know enough about it yet to make comment on it, although I have had some comment back to me from members who are involved in areas that will be touched on by transition care. But I guess we wait to see how it goes. It seems to be a similar initiative to that which was instituted by our state government some two or three years ago, called interim care, although I think transition care would be a better approach than that which we had from the state. Their approach was really trying to cope with a deficit that existed in the system at the time. The transition care seems to be a little more thought out. I do hope it does achieve its aims. Leonie, I think you had some papers you wanted to present.

CHAIR—Just quickly, because we are in fact out of time. Do you want to finish off on that?

Ms Kelly—I had a couple of documents that I wished to table, but it is a bit pointless without speaking to them first. Would you like me to put in writing what I was going to speak to?

CHAIR—That would be good, because we have gone over time on this. If you would like to put in a supplementary submission with those documents, we would be happy to receive that. Thank you all for your submissions and your presentation today.

[2.40 p.m.]

DONALDSON, Ms Pauline, Past Chairperson, Aged Care Assessment Services Victoria

SMITH, Ms Maureen Patricia, Chairperson, Victoria Branch, and Manager, Caulfield, Aged Care Assessment Services Victoria

CHAIR—Welcome. Information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. The committee prefers evidence to be heard in public, but evidence may also be taken in camera if you consider such evidence to be of a confidential nature. 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 Donaldson—Thank you for the opportunity to speak this afternoon. I am going to go over a few of the points that we have in our submission and offer a few possible solutions. The first issue that we want to address is the ageing in place issue. We would like to express concerns regarding the recent legislative changes which remove the need for ACAS assessment in low-care facilities except under certain circumstances. Anecdotal evidence suggests that there are a number of residents whose restorative and rehabilitative potential are not being addressed as a result of these changes. This is in part due to the lack of available RNs in these low-care facilities. These residents may be in low care, have their condition deteriorate, become high care and not have that change picked up in the facility because the appropriate assessment processes are not in place.

The residents can then go on to remain as high care or potentially be moved to the emergency department of the public hospital when their hostel or low-care facility cannot manage them anymore. They may be admitted and, in many circumstances, they do come out as high care and remain as high care. One of the solutions could be the requirement for adequately trained RN access in these low-care facilities to assess for reversible changes. We have also heard about the need for allied health assessment in those facilities. The other solution is that ACASs be resourced to continue to provide the in-depth clinical assessment and management of these clients where they are moving from low care to high care within the same facility.

The next issue we would like to address relates to younger people with disabilities. I understand that you have heard much comment about this. Increasingly, ACASs are reluctantly approving entry for aged residential care for younger people with disabilities due to the lack of appropriate accommodation suitable for their age requirements. Increasing numbers of these clients have complex medical and clinical situations that really do require a skilled assessment and in-depth clinical management. Whilst their physical needs may be provided for, their emotional and social needs are often not provided for in an aged care environment. The solution could be to develop clinical assessment teams to provide the same type of service that ACASs do, possibly integrating with ACASs so that there is a specialised team that can provide the same sort of assessment and management that ACASs provide.

CHAIR—Why do you provide an aged care assessment of people who do not meet the criterion of being aged?

Ms Donaldson—Under our guidelines we are able to assess those people. In the circumstances where there is no other alternative in terms of a residential environment for them—it is usually in a crisis situation—

CHAIR—Who developed the guidelines?

Ms Donaldson—They are Commonwealth guidelines.

Senator MOORE—I think the original guidelines for setting you up were departmental guidelines.

Ms Smith—The guidelines for aged care assessment services were developed by the Department of Health and Ageing. That is what they are actually in at the moment. But there is just one line that states that a person has to have an age related type of disability to qualify, so you could have someone who is 40 years of age with an early ageing type of illness.

CHAIR—What about someone who is 12 years of age?

Ms Donaldson—There is someone in Victoria who is nine years of age and who was admitted to an aged care facility in the country. To try to work with this situation—because, understandably, we do not want younger people admitted to aged care facilities—ACAS Victoria and the Victorian department of health have developed some protocols and guidelines. We have worked with disability services to look at the responsibilities of ACASs and the responsibilities of disability services so that these clients do not fall in the gap in between, which is where they fall at the moment. We have developed these protocols over a 12-month period. The exercise has been very positive in that it is probably the first time we have sat together with disability services and tried to work through what the differences are in our two areas and how we can collaborate to work with the situation, rather than having the client fall into either area or in between. I think that has been a movement in a positive direction.

The other solution, potentially, is high-care beds for younger disabled people. Currently the community residential units are structurally not suitable for a lot of residents who have very complex medical conditions—residents who need hoist transfers in the bathroom, for example. In a lot of the residential units you cannot get a wheelchair through the door of some of the facilities, because they were not built to manage that. I guess we would be recommending facilities that are able to manage their care in a suitable age environment. The innovative pools have provided some funding for an ageing in place, for example, in our MS Society. We went in and our team assessed 22 younger people for them to be able to access this funding so that they in fact could have high care in the MS Society units. I think that model of care has worked very well.

The other area we want to address is the lack of dementia care facilities which provide therapeutic environments to manage behaviours related to dementia. It has been our observation that many facilities provide a secure environment without it necessarily being a therapeutic environment. Those facilities that do provide high-quality care are limited due to the associated financial restraints of providing that type of care. There are obviously some dementia-specific facilities in Victoria, but many of them are just locked units without the support of training and care.

The solution could be to develop guidelines relating to the specialised care provision, the staffing skill and the qualifications required. Also, there is need for the development of a monitoring process to enforce some type of standard in those facilities, which we do not have at the moment. The other solution would be the community based dementia support models. Our team have a behavioural support service attached to our ACAS where we provide a rapid response to people with dementia, either in residential care or in the community, who are having a crisis situation. We go in, assess and develop care strategies and see them over their crisis so that they do not have to go to hospital. That has been a very successful program. The main concern with extra service beds is their location in low socioeconomic areas. If they are replacing other aged care stock, we would prefer that those beds be located in appropriate areas.

One of the last points is the tensions between the level of HACC services, admission to package care and the flow in the community care sector. There is a variability of hours of HACC services available in some areas. There are periods when some local governments close referrals for up to three months at a time. This obviously has an impact on the acute sector—in terms of discharging people—and on the community care programs being able to support people to remain in the home rather than go into residential care. The shortened length of stay in hospital has obviously increased the demand for those services. There is pressure on ACASs to refer clients to packages, because there are limitations on the availability of the HACC services. One example is older clients requiring an escort to assist them to attend appointments when often they are living in family situations where both people are working. Those clients are potentially being referred to a CACP package, which would seem a rather expensive way of working with the system.

With the packages, the waitlists do not provide an authentic picture of the client groups due to the multilisting that occurs. CACP and EACH are not able to meet the service needs of their high-cost clients due to the full cost recovery. One of the solutions could be reassessment of the clients with packages to see if they could be discharged back to lower level HACC services, which could allow for the high-needs HACC clients to move into the packages, thus allowing for some flow in the system. Providers will tell you that they have got people on their books who could go back to HACC services.

The other issue is maintenance of the effort in accessing HACC services and the aids and equipment program funding to which our Linkages clients in Victoria have access. Not having access to funding for aids and having to pay for full cost recovery within the packages mean that they are a group of people that cannot be cared for. It seems incongruous that people on an EACH package, who are high care and who could be in a residential facility with access to RNs, are not picked up by EACH packages because it costs too much to have an RN coming in. The other solution is funding to develop regionalised electronic waitlist systems for packages, which could improve infrastructure inefficiencies and potentially target those in greatest need of packages. There are some pilots happening in Victoria at the moment associated with Aged Care Assessment Services which are looking at developing these electronic waitlist systems, as we did with waiting lists for residential care many years ago.

The last point is convalescent care—the need to provide for older persons who are convalescing. We mentioned transitional care previously. One particular group of clients where there are problems in locating them post acute care are those clients that are non-weight bearing. They are not suitable to take up a respite bed in residential care. They are not suitable for transitional care, according to the guidelines. If they require 24-hour care—that is, care overnight—to be at home, the funding is not available to provide that type of care. So they sort of fall in a gap, and they either sit in an acute bed or take up a respite bed, which is probably where they go now. A possible solution would be to expand the eligibility criteria for admission to transitional care for this particular group of clients.

CHAIR—It was put to us yesterday or this morning—it gets a bit blurry after a while—that if young people with disabilities stopped getting ACAS assessments and therefore could not get into aged care facilities that would be a good thing, that it would actually force those who are ultimately responsible for providing the care for people in that situation to do so. It is another argument as to whether they have the money or not. I do not want to take a political position about whether there is enough money being provided and where it comes from to actually do that. On the one hand it does seem that the Commonwealth's guidelines allowing it to happen and then their willingness to fund it seem like complying with the problem and contributing to the problem. On the other hand there is an acceptance and I notice the Victorian government in their submission accepted that they are ultimately responsible for providing services for young people with disabilities. We also heard in the same submission that there are regions where young people with disabilities are being refused ACAS assessments anyway. So can you explain why you keep doing them, and how a nine-year-old could get an ACAS assessment, when there is a policy position of not doing them for young people with disabilities? What would be the consequences, in your view?

Ms Donaldson—It is true that some ACASs may not accept that referral. I come from an ACAS where we like to look at the situation. We take the view that if we think this person may potentially need a residential care bed we will go and assess them. But we have to be fairly clear about it. We would not just assess any younger person who is referred.

CHAIR—I am just thinking about the language there. How can you say that someone who is not aged can potentially need an aged care bed? They do not need an aged care bed; they need a bed that is going to look after their medical needs.

Ms Donaldson—Exactly—they do.

CHAIR—And aged care beds do not do that.

Ms Donaldson—What we do is go out to certain clients, do the assessment and document what we think they need and provide that to Disability Services. We have found that when we have done that and gone through that process a bed has been able to be found for that person in the system.

CHAIR—In the aged care system?

Ms Donaldson—No, in the disability services system. We have also found that when we go there and specify what they require in terms of additional services in their residential unit there has in fact been movement.

CHAIR—Not in 2,588 cases. There are 2,588 young people with disabilities in aged care facilities in Victoria.

Ms Smith—There are certainly not enough residential care for Disability Services clients. Taking your point, it is totally correct that a large number of those people should not be in nursing homes and aged care hostels. That is why this new protocol has been helpful, because it has helped us clarify a few things with Disability Services, which is quite a complicated system in Victoria—and, I am sure, in other states. There are something like 30-odd types of disabilities that fall under that service provider.

Technically, the clause in our aged care assessment guidelines is the one that actually creates the problem in the sense that it is a vague line. It has no particular specifics about it. It gets very subjective. It just says, ‘You may assess somebody under 65 years of age with a frail age type illness or an early ageing type disease.’ Someone with multiple sclerosis may suddenly have an early onset of dementia due to their multiple sclerosis. Can somebody tell me whether multiple sclerosis is a disability or early ageing because of the fact that it is a degenerative neurological problem? It is a really difficult task to make that one line into something quite specific.

We would be much better off if we were like aged psychiatric services. They have a cut-off point where they assess no-one under 65. It does not matter what their criteria are; it is simply no-one under 65. We have been given this clause. On a humane level, I believe it helps in some situations where people do fall in the gaps and there is no other alternative. I also take the point—and I think ACAS Victoria has certainly pushed this point—that it was only when we started agitating a little with Disability Services and when some ACASs stopped making assessments, period, that the state-level Disability Services were forced to actually take some.

I agree with you that it is not just political, but the whole thing is that we have to look at a macro picture. The macro picture for us is that we get lots of people in the community who do not fit into little boxes. We have got that one clause that leaves us with a bit of a generalised persuasion, I suppose, where we can choose which way we go. I would say that, of those 2000-odd people, about half of them—I am estimating based on anecdotes—could have gone into a disability type service and did not require an aged care service.

CHAIR—I think it would be easy for me to conclude that none of them should be in an aged care facility if they are not aged. If we are making the distinction that, yes, an aged care facility is able to provide them with their medical needs then that is one thing, but it is still not a proper environment for a young person in terms of social development and the rest of it. I want to ask you specifically about the 9-year-old. How does that happen? Bring the person who is responsible for that here!

Ms Smith—It was in a country area, wasn’t it?

Ms Donaldson—I believe it is in a country area. I cannot comment anymore.

Ms Smith—We have referrals of teens at times, and we obviously try to deflect them. All I understood was that it was a very small regional town that had nothing else but a nursing home in it. That is my understanding.

Ms Donaldson—There was nothing else.

Ms Smith—It was either that or separate the child from the family.

Senator HUMPHRIES—The ACAT system, as I understand it, was an initiative of the present federal government. What was done before then? How did people get into nursing homes before that?

Ms Donaldson—There was a form that could be signed by a general practitioner which would allow admission to a residential facility.

Senator HUMPHRIES—What was the stated reason in the last budget for the reform that you are complaining about here that allows the homes themselves to make assessments of their residents?

Ms Donaldson—There were issues around waiting times for responses from ACASs to facilities, which of course had funding implications for them. I think that that was probably a driver.

Ms Smith—The other thing is that if someone can be aged in place, which is a proliferating phenomenon out there, then hostels realise that if they are going to stay in the one residence there is security of tenure and their care needs are already being met, although they are obviously going to increase their needs, and so there is no real need to have a reassessment because it is not a relocation. In a certain number of cases ACAS Victoria—and certainly other ACASs around the country—agreed with that during the Hogan review. The only problem is that it is a sort of twofold thing. Aged Care Assessment Services was around before the initiative of an aged care assessment team being involved with the gatekeeper role for aged care facilities and they were seen as a multidisciplinary team that could look at aged care issues for people in all settings. So that element of our role is a bit duplicated, where we still have a role of giving opinions and advising on restorative issues for people with aged care issues—and certainly in the public hospitals that is what we go in and do most of the time.

I do not believe that we have a position of wanting to go back to the previous system. I think the changes on one level were very good—to not involve us with a link to a funding change, which is all that it is between a level 4 and a level 5. We are just raising the issue that, in some cases, the facilities that have a lot of ageing in place people now are perhaps at times not picking up some of those restorative issues. We are not necessarily saying we have to go back to the old system to make that happen; we are just raising the issue of how else we could make sure that some of those people's restorative needs are met.

Ms Donaldson—An example is that we had a rapid response service attached to our team and so we have an 'in' with facilities when residents are having a crisis—we can move in there, provide assessment and broker some private services. This is through state funding attached to our service. We have had occasions when we have gone in there and, on taking the history of the client, have been able to see where changes have taken place and where restorative care perhaps needed to be brought in but had not been brought in because the carers in that situation were non-nursing staff. They may have been administrators, with no health background whatsoever, in a low-care facility. That is a potential issue for older people.

Senator HUMPHRIES—What happens when a decision is made in respect of a resident and they or their family disagree with that assessment? Is there some sort of appeal mechanism?

Ms Donaldson—There is an appeal process.

Senator HUMPHRIES—Is it to an ACAT?

Ms Smith—My understanding is that it can be to an ACAT or to medical practitioners.

Senator HUMPHRIES—Obviously the reform is designed to make the assessments happen quicker and possibly for more resources for the pointy end of home care. Do you think it is fair to say, ‘We should see how these things pan out and in the longer term maybe reassess whether or not it has been a worthwhile reform?’

Ms Smith—I think aspects of that reform are good. I do not think we ever saw it as helpful just to have us attached to that change in the facility from one level of funding to another. Certainly we would like to see how that pans out. Interestingly, in certain facilities—and I am only noticing it now—there are times when we still do go in obviously for relocation and sometimes some of those standards are not always maintained by the facilities, and we advise families when they have changed their classification. But that is in their guidelines, so it is really up to them. We have no reason to intervene in those issues, but sometimes I have had to advise families: ‘Your mother is receiving high care and did you know that she is now eligible for X.’ So there are times when I think there is a certain amount of quite harmful ignorance on the part of some of the facilities in that they do not realise that that is what they are meant to do.

Senator HUMPHRIES—Do you think there is a danger that some less reputable operators might say, ‘We get more subsidy for a high-classification patient than for a low one, so we will push them up into that higher classification.’ Is that the sort of fear that you have?

Ms Donaldson—We have examples of facility providers going into acute hospitals and talking to social work departments and so forth, saying: ‘We’ve got this particular bed in the facility. We can admit them at this level of care.’ Pressures are being brought to bear on that issue.

Ms Smith—Also, on the other point you made, I think most providers are very reputable in terms of their intent. The other built-in part of the changes to the legislation, the changes to the guidelines, was to build up the RCS auditing so that there would be, to my understanding, a larger number of visits from the RCS. That is what we thought would happen, because that is who would do those checks and balances—that is, somebody from the RCS accreditation system would go in and say, ‘Your RCSs are now going to be audited every three months instead of every six months.’ I understand that some of the facilities have been advised that they will be getting more visits, but they have not actually eventuated. I still think there needs to be a check, but I do not think it needs to be ACAS who does that.

Senator McLUCAS—Ms Donaldson, going back to the point you just made about owners of residential aged care going into acute hospitals and essentially touting for business, can you explain that a little more and explain to me where you fit into that process?

Ms Donaldson—There are different practices in hospitals and amongst ACASs in terms of the ACAS assessment in the acute area. Allied health staff who are agents of ACAS, if you like, provide the assessment information which contributes to the assessment and then it is delegated by an ACAS at the other end of the process.

Some ACASs go in and do the whole process themselves, which is quite time consuming if they do it according to the guidelines. That involves including the carer in the decision making, looking at the history, looking at the client and speaking to all the people who have direct care of that client. In some hospitals that takes place; in other hospitals it is reliant on the staff in the hospital who are treating that client to provide the information on their functional level. It is then up to the ACAS person who is delegating to question and make sure that the information recorded on the documentation is how it really is.

The provider may enter the hospital when the hospital is looking at placement, particularly when they are wanting to move a person out of a bed. The hospital may ask the provider of a facility that a patient has come from to assess the functional level of that patient to see whether the provider can still provide care et cetera; or the hospital may know that a bed is available in a particular facility and invite the provider in. Pressure can be brought to bear then. For instance, the client may look like they are high care in the hospital setting but the provider may have a low-care bed available, and the provider may say, ‘We can admit somebody as low care and then, if they really are high care, further down the track we can have them made high care.’ That may be picked up, but sometimes it may not be picked up by the ACAS.

Senator McLUCAS—Why wouldn’t it be picked up by the ACAS?

Ms Donaldson—It will not be picked up unless an ACAS person is involved in the assessment from the beginning, right through, and knows that situation intimately.

Senator MOORE—Once they are in the facility, it is ageing in place.

Ms Donaldson—Yes.

Senator McLUCAS—But the RCS assessment would surely pick that up?

Ms Smith—It does pick it up. Your point about it was the way that certain providers are using a commercial exercise to try and gain people to fill their beds—

CHAIR—You are not proposing just a hypothetical to us. You have obviously seen this happen or experienced it.

Senator McLUCAS—Is it also your experience that people are more likely to be assessed at a lower level of care, which would put them into the situation where a bond would be required?

Ms Smith—There is nothing in the guidelines stopping a low-care facility admitting someone who is high care, knowing that they are probably going to be at the low end of the four upper categories. So there are plenty of times when facilities have suggested, ‘We’ll take them in as long as they have the low-care paperwork, then we’ll put them into high care later,’ because of the fact that it does raise a bond. That raises the issue that the bond is, in many cases, the only way we can keep our hostels viable financially. I have to be frank and say that I am not sure whether the hostels would remain viable if they did not have the option of the bond money coming in.

Senator McLUCAS—The other thing that concerned me about your opening statement, Ms Donaldson, was your comment that pressure was brought to bear to refer people to packages. My understanding is that the assessment should be done completely on the medical and social needs of that individual, not relative to what is available or happening in the community. This is a clinical assessment of need. What you have just said today supports what I heard at estimates the other day when the department acknowledged that assessments were done to link people to vacancies. Is that your on the ground experience?

Ms Donaldson—That has been reported from ACASs, and it was fed into this submission.

Ms Smith—That is quite true. We could say that they are our criteria for assessments. I have been working in the health system for 25 years, and I have never been one to eliminate the person at the other end. The trouble we have is that in some cases we are not getting services for anyone at all. This is a dilemma we are facing with the EACH packages, for example, that have only recently been rolled out. We immediately got 80 on a waiting list in most of the regions with EACH packages.

Senator KNOWLES—What did those people do before an EACH package was around?

Ms Smith—They probably had a CACP that was struggling to maintain that high level of care or they were put into residential care. There is a snowball effect when you put an EACH package out there. All of a sudden there are 80 on the waiting list and people are saying, ‘Gosh, it is shocking that nobody has got an EACH package.’ Twelve months ago they did not have them. It is a terrible irony that once you have something everybody says, ‘We need it; we’ve got it.’ Now we have CACP providers, for example, who are saying, ‘Because we have EACH packages, we now go back to our original guidelines,’ which we had shifted slightly because there was nothing else in the community. Those providers say, ‘Unless they are low care, we won’t take them back.’ So now we have people in hospitals, who, people are saying, could go into the community with an EACH package. They cannot get a CACP and they cannot get HACC services because they are too high care, so they will go into residential care. I am not quite sure exactly what this phenomenon is and why it happens.

Then we get pressure from people who say, ‘You need to assess this person for a package or an EACH.’ When we say pressure is brought to bear, it is the fact that the service system gets that sort of constraint put on it. Immediately it is a matter of asking whether we should look at that individual and say, ‘That person will stay at a residential facility if we approve them for a package purely and simply because there are no HACC services.’ Or do we just go hard line and say, ‘You’re not actually eligible for a CACP; you could manage with HACC services but there are none so we’ll put you into a residential facility’? So I take your point. It is quite valid that if we go down that pure line, it would not be a difficult task at all. It would be quite an easy job, actually, to just say, ‘No, you don’t meet the criteria so we won’t assess you,’ but, in the real world, I am not quite sure about that. We also have to balance our responsibility for the residential side of aged care, too. With the way it is targeted, we have only a certain number of beds available for the population aged over 70. On the other side, if we do not assess people for a package and keep them at home, do we really want the proliferation of the entry of people into aged care beds? It is probably not our job to decide those things, necessarily, but at times we have to balance it. But I take your point. Purely and simply we could just say, 'No, you don't meet the criteria.'

Senator McLUCAS—What about the assessment for whether a person is a low-care residential aged care resident or high care? Is pressure brought to bear there as well?

Ms Smith—I think there is always pressure in the sense that the system obviously has that one grey area in the middle, especially with the borderline people between high and low, which is very difficult. I know that a new tool is being looked at. But we assess using one tool and the RCS is a totally different tool. We do not use an RCS to determine somebody's entry into an aged care facility, and that is where a lot of the conflict has arisen between residential care and ACASs, because we are making a judgment based on a home situation; they are making a judgment based on a residential facility. So the pressure to bear is twofold. Firstly, with hostels, certainly if someone is borderline and eligible for low care, the bond issue is sometimes there. Secondly, families and facilities have pushed the issue the other way, where families have said, 'No, please make them high care, because we won't pay a bond.' So that comes to bear, too. There is that grey area with a borderline situation of high and low care where you could see the person probably managing in either a high-care or a low-care facility, especially with ageing in place. A lot of the facilities are now moving in on that, and, as I say, it has proliferated quite a bit. They will say, 'We'll manage these people but, initially, they have to come in on a low-care basis for the bond.' That is where that pressure comes to bear.

The other thing of interest which came up yesterday was the fact that a nursing home rang me because they had admitted somebody who we assessed as being high care and who came up as a level 4 on their RCS—and, of course, that is acceptable, that is high care and they are a high-care facility. But there has been anecdotal information that tells us that most nursing homes survive best on one and two classifications on an RCS, again, for funding. So they also tend to bring pressure to bear in terms of saying, 'Should this person really be in a nursing home?' Technically, under the guidelines, they should be. It is just that awkwardness, I suppose, when you are looking at anything, in that you have got a category where 50 per cent changes to 51 per cent and all of a sudden there is not much difference for a person between those two levels. So it is bringing pressure to bear with all those factors.

Senator McLUCAS—On another issue, this morning the Ethnic Communities Council talked about the difficulties experienced in the ACAS process by a lot of their constituents who did not speak English or who did not speak English very well. For the record, can you provide us with some information about what you do?

Ms Donaldson—The ACAS that I manage is in the northern region of Melbourne. We have about a 45 per cent non-English-speaking catchment. I am surprised to hear that. Our policy is that we always take an interpreter with us. We would not go on an assessment. We employ staff who have a second language. We work very closely with the various ethnic organisations in training ACAS clinicians in cultural differences. The main issue for us is really that many of our ethnic groups do want to maintain and care for their family members at home. It is about trying to access culturally appropriate services, within perhaps the HACC service system, for them to be able to maintain that care at home. People who speak the language understand the cultural differences. That can be very difficult. I think it is problematic to send an English-speaking carer into a non-English-speaking household in the community.

Senator MOORE—My question relates to something that has been raised at a couple of the residential facilities that I have visited, which is to do with clients who have special needs, to which your submission referred, but who do not have dementia. They are people who have psychiatric issues—and episodic, very serious psychiatric issues. My understanding is that in Queensland very few places offer that kind of service, and it becomes almost a ping-pong effect. The residential home to which the person has been referred and is living in would prefer not to have them back because of the problems they cause for other residents and staff. There is nowhere really appropriate for them to go and they are talking to ACAT teams in Queensland about what they should do. I am sure you have similar things in Victoria.

For the record, because we have not really had too much evidence on this issue, but it is always there, what should be happening to people like that? What kinds of facilities should be available? There is definitely a focus now, in all the documentation, on everything being dementia based, and all facilities are going to have to have dementia places. You have already said that they are not always meeting the need, but, for the record, could you say something about that kind of situation? Sorry to do it to you, but it is very real.

Ms Donaldson—Certainly we need more access to respite types of situations to give families a break so that they can continue to maintain those people in the community. We do have a lack of suitable residential beds that will be able to manage. There is always a long waiting list. It is hard to get into.

Ms Smith—Are you talking about aged psychiatric or under-age psychiatric issues?

Senator MOORE—The aged psychiatric issues are the ones that have been raised with me by residents. For the under age, particularly 50 and below—which is getting into the issues Senator Marshall raised—the really serious issue is facilities. When you say ‘appropriate residential beds’, what are appropriate residential beds for people who have a mental illness, as much as anything else?

Ms Smith—I think the anomaly in Victoria is that we still have SRSs, supported residential services, which no other state in Australia has. That has skewed our system slightly. I work in the St Kilda inner city area and certainly we have a large number of pension-only SRSs. We tend to quite regularly review people’s care needs, and those SRSs are full of younger people—and I mean under 65—with long-term psychiatric problems. We know some of the long-term psychiatric medications cause symptoms such as Parkinsonism, frontal dementia et cetera. So they are a very difficult category of people to deal with. I have had mental health care workers tell me—

CHAIR—I interrupt you there because the tape has to be changed. The tape has now been changed, so we can continue.

Ms Smith—I was making the point that people feel it is not appropriate to build more bricks and mortar facilities for people with psychiatric illnesses. Unfortunately, we now have a pseudo type system with the SRSs. I think we had 17 in our area and most of them are now closing. We only have three left in the St Kilda area—I am referring to pension-only facilities—where a lot of people have moved out from psychiatric facilities. I do not know whether residential care is the best option for them. In psychogeriatric facilities, which is supposedly the mental health area for people over 64, it appears that there is a long wait and very limited access. There is also a two-way system which is quite complicated. We do the assessments to approve someone for an aged psychiatric service. However, access to the beds is determined by Mental Health under another umbrella. We might determine that someone should go to a psychogeriatric facility, which limits them to that type of facility only, under our guidelines, but the psychogeriatric facility might say, ‘We don’t think they are appropriate.’ So it is a very convoluted path.

CHAIR—I thank you both very much for the frank and forthright way in which you answered our questions today. For me, it has certainly filled in some of the rather glaring holes in our inquiry so far.

[3.32 p.m.]

SYKES, Dr David Raymond, Manager, Policy and Education, Office of the Public Advocate

CHAIR—Welcome. Information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. The committee prefers evidence to be heard in public, but evidence may also be taken in camera if you consider such evidence to be of a confidential nature. I remind you that you shall not be asked to give opinions on matters of policy. The committee has before it your submission. I now invite you to make an opening statement, to be followed by questions from the committee.

Dr Sykes—Thank you for the opportunity to address the committee today on this very important issue of significant concern to the Office of the Public Advocate. As you would have seen from the submission, the office is a statutory body that is charged with the responsibility of protecting and promoting the rights of people with a disability. What I have to say specifically relates to older people with dementia. I say that up front because that is the particular lens through which we look at and interface with the aged care system.

Having said that, the other area we have obviously highlighted in our submission is that of younger people—in this case, anyone under the age of 65—who find themselves in the situation of being involved with the aged care system. From our point of view, this is a failing of the aged care system and the disability services systems that are designed to support people in those contexts. Where people have significant care needs that ultimately place them in the context of the aged care system, that system has almost become a default system to fill the void of not having many other alternatives, besides perhaps the more recent options that are around. We heard reference in the previous submission to the EACH package and to the increasing focus within government policy on trying to provide a high level of care at home.

A comment I would like to make in opening up discussion on this whole area—in addition to that issue of younger people finding themselves in the aged care facility context—is the requirement, by default more than anything else through a whole range of policy decisions, that aged care facilities are getting larger to survive. From our point of view, as we fight to close the last remaining large institutions for people with disabilities in Victoria—we have one currently being closed—it is ironic that we seem to be having a reverse trend in aged care, which raises some significant questions about how that fits with current thinking about meeting individual client need, certainly in disability and, I suspect, increasingly in aged care. There seems to be a real dissonance there, with one going in one direction and the other going in quite the opposite direction. I merely raise that as something that, more broadly, the system needs to confront and consider, particularly with in-home support, which I will come to.

The inadequacy of home and community care services is something that we are continually confronted by in our role as advocate or guardian for someone with a disability. There is a low level of service due to either limited funding or, as we are increasingly finding, risk-averse practices by local council services, the Royal District Nursing Service and others. They interpret their obligations to staff in some instances or their fear of litigation in other instances to an extreme point, whereby it either severely limits the service that is provided to clients in their own homes or, indeed, precludes it completely. To illustrate that, we had a case not that long ago where someone who was a smoker was discharged from hospital and assessed as requiring in-home support. The local council determined that it was an occupational health and safety risk for workers to go into a smoke filled environment to support this elderly gentleman in his home. As a consequence, an application was made for a guardian to make a decision about this gentleman going into an aged care facility. To me that highlights how extreme some of that risk-averse practice out there has become and how it is affecting people's lives to the point where they are going into much higher and more expensive levels of care, at times well before they need that.

The poor level of servicing at that community based level also increases the potential for greater instances of elder abuse. Indeed, the lack of adequate access to respite for families can be a contributing factor, at times, to instances of elder abuse. Indeed, the absence of a national strategy to deal with that issue, though not within the terms of reference for this inquiry, is something that certainly needs to be considered at some point at a federal level whilst individual states and territories are taking various initiatives in that area.

Poor discharge planning is another area we have highlighted in our submission. Of concern to us is the sometimes poor discharge planning process to aged care facilities from hospitals, though there seems to be quite a body of work around how you do it. In the Victorian context, there are some clear standards and, indeed, penalties for hospitals failing to do that adequately—although there are probably questions about how that is ultimately recorded if someone has a readmission due to poor discharge planning on the part of a hospital.

It is interesting to note that recently we had a case in Mildura where a person was placed in an aged care facility in, of all places, Morwell. That was partly a response to the pressure on the whole bed blocker factor. It is such a pressure on hospitals to do appropriate discharge planning and link people in appropriately to services that are in their local area. If there is a bed that comes up sooner in Morwell it is a case of, 'Well, let's just do that because that will take pressure off the system.' Again, it is a symptom of a system in crisis.

CHAIR—Are you saying that the guardian makes that decision?

Dr Sykes—In that context, yes. We were appointed as a guardian to make a decision for that gentleman because he lacked the ability to make that decision himself.

CHAIR—But the guardian is supposed to be acting in their best interests. Why would they make that decision?

Dr Sykes—In that case it was interesting because the hospital made the decision without consulting the guardian. Again, this is something we experience when we are appointed as guardian for someone in the hospital context. It is not an uncommon thing. Whilst we obviously take that up with the hospital at the time, it seems to repeat itself.

CHAIR—I am sorry to have interrupted. I have had a lot of bad experiences with guardians and I am tempted to spend all afternoon speaking with you about guardians. But I had better not.

Dr Sykes—I have mentioned the engaging of support services. I notice that the previous submission touched on the associated problems around people who might have a mental illness. Wherever the issues become more than, for want of a better term, one-dimensional for the service system, it has problems. If someone has complex care needs and is younger, it has problems. If they are older and have a mental illness or some other problems in addition to problems associated with the ageing process, the system has problems. We are frequently involved in issues around the boundary fights between disability in aged care, mental health and aged care and home and community care services and where they see the lines being drawn around what they see as being the services that they should provide. That inflexibility in the system ultimately means that people fall through the gaps.

There is a limited capacity for interim case management by agencies when ACAS have done an assessment or there has been a determination that someone needs a level of care. ACAS have already mentioned the long waiting lists for community care packages. We find the limited capacity of ACAS problematic. They are essentially an assessment service. Although they have some limited case coordination capacity, often people are left hanging whilst they await a placement and, indeed, someone who can make sure home services are being monitored and that they are picked up and do not fall through the gaps. Ultimately that waiting list plays out in the form of people potentially needing to go into higher care much sooner than they should otherwise have to if there is more timely support, particularly in the community context.

The other issue for us is primary care and whether GPs, community health centres and other first ports of call are adequately resourced and knowledgeable about the service system. We take just over 11,000 calls on our advice service every year. The vast majority of those are from families who are struggling to understand a service system that is enormously complex and very difficult to penetrate. Even once you do penetrate it, you have those associated resource problems. Interestingly, we developed a guide for our own guardians and advocates to help them understand the complexities of that system, just around home care packages. We decided to put that on our web site. We found that it was actually a useful resource for families as well as for us. If we are having those difficulties, certainly families are experiencing them as well.

In closing, those are probably the main comments I want to make about the broad issues that we see across the system and the unfortunate tendency, I think, to not consider how we can fund better the lower end of care. There is a preponderance to resource the far more expensive end—at a cost, I think. Whilst the recent review of that area and how community care can be structured in a more streamlined way is encouraging, we still have a long way to go.

CHAIR—Once a guardian has been appointed, does the guardian report back to your office or have any accountability to the appointing body, which is yourself?

Dr Sykes—There are a few points to that. There are national standards relating to the processes that guardians need to use in arriving at a decision. They cover such issues as seeking the views of the person for whom they are guardians and consulting key people involved in that person’s life to make sure they are as adequately informed as possible in arriving at a decision that ultimately has to be in the best interests of that person. So there are those guardianship standards that we are obliged to adhere to. In Victoria, and it operates similarly in other states and territories, we have a clear complaints process for people who are dissatisfied or concerned in some way about how a guardian is making a decision for an individual they know. We invite people to use that process if they have any concerns—in any way, shape or form—about how our guardians are going about their role. So that would be our first point.

The other aspect is that obviously in the Victorian context people can request the tribunal to review an existing guardianship order, through VCAT. The other thing we do is support private individuals who are appointed guardians. Where it is a family member, we also offer support to them, through our Private Guardian Support Program, to enable them to take on what is, I think, one of the most difficult tasks you can do, given our experience with that. That is done in a way to try to encourage the tribunal to, as much as possible, appoint family members to that role, because that is our preference.

Senator KNOWLES—I notice it says in your submission, and you have said today:

> Careful consideration needs to be given to developing appropriate alternatives based upon the needs of the individuals concerned.

We are talking here about young people being placed in appropriate accommodation. Is it the role of your office to negotiate or express concerns or opinions to the state government about the lack of places which has ultimately created a lot of the bed blockers that you are talking about?

Dr Sykes—We do have that role. We do have a very clear role, as an independent statutory entity, to raise concerns on a whole manner of issues, including those.

Senator KNOWLES—How often have you raised concerns about this in relation to the Commonwealth-states disability agreement? What response have you had to the expression of those concerns?

Dr Sykes—Unfortunately, those responses tend to be around the state-federal divide and who is responsible for providing what, particularly where it involves disability as distinct from aged care. That is certainly an issue around young people in nursing homes. There has been that problem about whose responsibility that is perceived to be. Whilst they have a responsibility to respond to that need, I think we are yet to see how in fact they intend to meet that responsibility.

Senator KNOWLES—I do not quite understand your answer about where there is debate as to whose responsibility it is, because clearly there is no question under the CSTDA as to whether the responsibility for providing appropriate accommodation for people with disabilities is state or federal: it is state. I do not quite understand why you would be giving the answer, ‘This is part of an argy-bargy with the Commonwealth.’ Do I understand correctly your answer to my question?

Dr Sykes—That is right. I think that when you push on that some of it is around the level of funding. So if you say, ‘It is your responsibility to provide support in a disability context around young people in nursing homes,’ then it is a question of the level of funding that is made available when you are talking about people who have higher care needs. But you are absolutely right in terms of an argument that really does not hold water.

Senator KNOWLES—Have you pressured the state government for increased funding to try and fill the gaps that we are talking about?

Dr Sykes—We have through our support of the YPINH consortium and that has most notably been around how the state government is supporting our work in the supported residential services area—and there was mention of that in the previous submission. I am referring to pension only supported residential services and the extent to which those services become a default for a lot of the individuals we become involved with. We have certainly pushed government very hard. We are starting to see some response around how government can support those entities to support people with quite complex needs.

Senator KNOWLES—Have you raised it with the state government in the context that every person for whom they do not provide accommodation in accordance with their responsibility under the CSTDA is blocking an older person getting into a nursing home? Have you said that you need those places in the nursing homes vacated for legitimate nursing home places for older people?

Dr Sykes—Absolutely. That has certainly been a consequence.

Senator KNOWLES—And what has been the response in that context? Do they care?

Dr Sykes—I have to be careful here, because I think the state government is sitting behind me.

CHAIR—I do not think we are quite there yet, but we should not be asking this witness to give opinions on matters of policy.

Senator KNOWLES—I am not asking —

CHAIR—I did not say we were there yet; I think we are getting close, though.

Senator KNOWLES—I am fully familiar with where I can go and where I cannot on these questions. But I am very familiar with the fact that I need to know where your office is dealing with it.

Dr Sykes—That particular issue is certainly one where it is a cost-shifting exercise.

Senator McLUCAS—You said a lot of families contact your office seeking advice as to how to negotiate the myriad services. Do you provide advice to those people who are obviously not your responsibility? If you do not, who do you refer them to?

Dr Sykes—Often it is really entry point stuff, where there is a concern that someone’s health has gone down quite significantly—a mother or father—and the family is really not sure where to go. Very often it has reached the point of needing to get some sort of assessment, so we will often refer to our colleagues in the Aged Care Assessment Service. The family are often totally unaware that that is where they go for that. So we will often try and direct them to some entry points into the system so they can get that information.

Senator McLUCAS—Do you use Care Link?

Dr Sykes—Our experiences with Care Link have been mixed. Depending upon the area, they often do not seem to always have as good a knowledge as ACAS about services on the ground. I am not entirely sure what that is about, but there seems to be a certain dissonance between the knowledge that ACAS and Care Link have.

Senator McLUCAS—That is interesting. The other evidence we had today was from the Brotherhood of St Laurence, who identified homeless people as a particular group of people who fall through the cracks, who we have been talking about for the last two days. I do not think you heard their evidence, but I will try to paraphrase it. They talked about the eligibility criteria for younger homeless people who are 40 to 60 and who are exhibiting the symptoms of ageing because of the lifestyle they have led. Because of their age they just do not get into the HACC program or a Community Aged Care Package and are not assessed for residential aged care. Do you have experience along those lines as well?

Dr Sykes—I will say up front that our experience with the homeless is fairly limited, but the cases we have had have been more about the capacity of services to be flexible enough to engage with someone who is living on the street and who is older. With the exception of certain programs, like the RDNS Homeless Persons Program and a few others, there are not a lot of services that are flexible enough to do that. Presuming someone has not reached that point where they have significant care needs, but perhaps they have early stage dementia that may be complicated through some alcohol related brain injury, again you get back to that same scenario that I was talking about before—that is, as soon as you get beyond the one-dimensional in our service system it becomes problematic. Certainly our experience is that it is difficult to get services to engage with that group. Sometimes it is because they are unpleasant and difficult to deal with in their behaviour, and their approach to services is to tell them to take a long jump. They can be a difficult group to work with, and there is no denying that, but I think the extent to which the system and services which we have in place are flexible enough to do that and have some proactive outreach is quite limited.

Senator McLUCAS—That concurs with the evidence we had this morning from the brotherhood. Thanks very much.

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

Dr Sykes—Thanks very much.

[3.58 p.m.]

JACOBSON, Ms Jeannine Alexandra, Manager, Coordinated and Home Care, Aged Care Branch, Department of Human Services

PUCKEY, Mr Christopher John, Manager, Policy and Analysis, Aged Care Branch, Department of Human Services

CHAIR—Welcome. Can you clarify what your department is?

Mr Puckey—The Department of Human Services is a Victorian department that encompasses health, community care, aged care, housing and all aspects of human services.

CHAIR—Does that cover more than one ministry?

Mr Puckey—There are four ministers, including the Minister for Aged Care, to whom we have responded.

CHAIR—Information on the protection of witnesses and evidence has been provided to you. The committee prefers evidence to be heard in public, but evidence may also be taken in camera if you consider such evidence to be of a confidential nature. I remind the officers that they shall not be asked to give opinions on matters of policy. The committee has before it your submission. I now invite you to make an opening statement, to be followed by questions from the committee.

Mr Puckey—My presentation will briefly summarise Victoria's submission, which addressed the five terms of reference from the committee. In respect of the aged care work force, Victoria welcomed the announcement in the 2004 Commonwealth budget of funding for work force initiatives. We also welcomed the release last Thursday of the national aged care work force strategy by the Commonwealth minister, but more needs to be done to assist in meeting aged care work force shortages and training.

In particular, Victoria looks to the Australian government to provide significant additional tertiary places for nurse training. Victoria believes strategies are required to highlight aged care nursing and to encourage nurses to enter aged care. Retention strategies to address current and predicted work force shortages are required as well as strategies to minimise workplace injuries, including additional funding by the Australian government for training and equipment, and the development of the aged care work force to complement newly emerging care needs and client preferences for both residential and community based care.

In respect of the reference on the performance and effectiveness of the Aged Care Standards and Accreditation Agency, Victoria supports the ongoing commitment to the continuous improvement approach underpinning the Aged Care Act quality accreditation framework, but believes there remains room for further development of quality arrangements. In particular, there seems to be a lack of consistency in the interpretation of the standards and a lack of consistency in the provision of education and advice, both in accreditation assessments and in support visits. There is a need for adequate resources for the standards agency and a need for more definition in the minimum requirements in the standards arrangements. Victoria’s experience is that the continuous quality improvement approach, with its focus on outcomes, is supporting the delivery of quality care in a way in which a focus on inputs may not.

In respect of the reference on young people in residential aged care and meeting the needs of residents with special needs, the Victorian government recognises that younger people with disabilities with nursing care needs require a range of care and accommodation options. While services provided through residential aged care provide an option for some, more appropriate care alternatives are required for others. Victoria strongly favours the joint development of sustainable and long-term solutions with the Australian government.

In respect of meeting the care needs of residents with special needs, the current funding arrangements are not at an adequate level to meet the care needs of older people with special needs. We welcome the recent recognition by the Australian government of the specific costs of dementia care with the creation of a dementia care supplement. Victoria has been actively engaged in the work that is proceeding towards the development of a new care classification system.

There is an immense demand on the Home and Community Care program and additional resources from the Australian government are required to enable more older people to receive care in their own homes for as long as possible. The Australian government also need to address the way community care for older people is best organised and targeted.

The final reference, on the effectiveness of current arrangements for the transition of the elderly from acute hospital settings to aged care settings or back to the community, we believe to be fundamentally important. The lack of available residential aged care beds, especially high-care places, puts extreme pressure on available hospital beds. The effectiveness of transition arrangements of the elderly from acute hospital settings to aged care settings will depend on the provision of more high-care places. Victoria continues to suffer an underprovision of high-care places on the Commonwealth’s own benchmark of 40 places per 1,000 people aged over 70. Our ratio of high-care places has fallen again this year to 38 places per 1,000—the lowest of any state. Victoria’s provision of total places is also the lowest of any state.

The Commonwealth has allocated additional places to aged care providers, but they need to be made operational. That means they need to be allocated sufficiently in advance of the need in order to be available when needed and they need to be sustainable. High-care places are difficult for the sector to provide economically. Insufficient capital is available to providers through the present arrangements, and the indexation arrangements are inadequate to provide sufficient recurrent funding in the longer term.

The effect of the inadequate provision of residential aged care is that significant numbers of Victorians are waiting for placement. The average number of people awaiting residential care placement in health services in the year ending June 2004 was 626. Those are people who have actually completed their health care episode and have been assessed by an Aged Care Assessment Team as requiring residential care. Nearly all of them require residential care at a high-care level. We estimate that that is a cost to the Victorian health system of $115.7 million.

Senator KNOWLES—What ages are those people?

Mr Puckey—Of those 626, 589 or 94 per cent are aged 65 years and over and 86.3 per cent had an ACAS recommendation for high care. The Victorian government has led the way in the development of services to support older people moving from hospital to the community, including into residential care, through the introduction of the Interim Care Program in 2001-02, through participation in the innovative care rehabilitation service pilots in the Commonwealth's Aged Care Innovation Pool and generally through our very well developed subacute system, to which $247.8 million was committed in the current financial year, 2004-05. But, ultimately, the effective transition from the health system to aged care requires the adequate and sustainable provision of both residential and community aged care.

CHAIR—Thank you, Mr Puckey. In your submission you have given us some figures from November 2003 about the number of people less than 69 years old with disabilities who reside in aged care residential units. At that time it was 2,588. Has it increased or decreased since then?

Mr Puckey—There has been a decrease. In June 2004 there were 1,528 people aged less than 65 years.

CHAIR—In high care?

Mr Puckey—Residential aged care generally.

CHAIR—That is a substantial reduction.

Mr Puckey—I am not sure that I have a separate number for high care.

CHAIR—I have taken both your figures. In 2003 you had 1,574 in high care and 1,014 in low care. It is down to 1,500-odd; it is a very substantial reduction.

Mr Puckey—It is certainly something that the department has been giving attention to. The figures for people in residential aged care actually come from the Commonwealth's data. The state does not collect that data itself—it is within the Commonwealth system. The data that I have here extends, I believe, to aged care generally. I note that of those some 14 per cent or 218 people were under the age of 50.

Senator MOORE—I am questioning why you would not have those figures at the state level, seeing that they are people for whom you have responsibility. I know other senators will be pressing you on that more closely. We know they are in the Commonwealth system because they are in an aged care facility, but they are actually your responsibility because they are under 65. Is there not a regular way of getting that data transferred across? Those people are actually yours.

Mr Puckey—I understand your inference that the state government has a responsibility for people with a disability under the disability agreement, but the Aged Care Act does not have any explicit age at which people are entitled to enter the aged care system. It depends on the nature of their disability and on whether they are acknowledged as being suitable for aged care through the Aged Care Assessment System, in which case they are indeed a Commonwealth responsibility.

But the primary reason for us not having the data as a regular aspect of the system is that they are effectively the Commonwealth's clients. The Commonwealth are paying subsidies to them and they are subject to all the Commonwealth privacy requirements. In recent times, when there has been an intention for the Commonwealth and the states to work together, the Commonwealth have been kind enough to provide us with that data, but effectively it is their data.

Senator McLUCAS—Yesterday we heard evidence from the National Alliance of Young People in Nursing Homes. They talked about the numbers of people in various age cohorts who are in residential aged care. What we cannot seem to find out is the nature of the disabilities of those people, and we have previously been advised that the Commonwealth does not collect that data. Is that your understanding as well? Is there any way at all that we could try and peel back the raw age based data to find out the levels of disabilities of those people?

Mr Puckey—That would be my understanding too, that the Commonwealth does not keep data on the nature of the disabilities. The level of the disabilities with respect to the Commonwealth's dependency level scheme would be known, but that is only numbers on a scale. I do not have those numbers but it would certainly be possible for them to be derived.

Senator McLUCAS—That would simply tell us the level of dependency that individual has, not the nature of the disability.

Mr Puckey—Yes.

Senator McLUCAS—That is a start.

Mr Puckey—It is.

CHAIR—You indicated there were 626 people on the waiting list to get into an aged care facility, of which 86 per cent require high care. Those are the figures, and that would cost the state $115.7 million annually. But isn't there a larger number of people in aged care facilities who are not aged but are being looked after because they are young people with disabilities? If they were looked after in an appropriate accommodation facility for young people with disabilities, wouldn't there be more than enough beds to cover the waiting list?

Mr Puckey—On the statistics we have looked at, there certainly are more people under the age of 65 in residential care than there are waiting in the Victorian health system, but I think we would acknowledge that the care for many of those people is appropriate. Whilst other care options should be explored for a number of those people, for some significant unknown number the care in the aged care system would be the most appropriate that is available.

CHAIR—Can you explain that to me, because I think this is probably the first submission that has indicated that it is appropriate at any level to have young people in aged care facilities? I want to be clear about what you are saying. Your submission says that it is generally not an appropriate place for young people to be but that it does provide suitable options for some people. It might provide suitable medical care at a level, but it is more than that, isn't it? There are people as young as nine years old in Victorian aged care facilities. Are they really expected to have any fulfilling social development by living in an aged care facility for the rest of their lives?

Mr Puckey—Clearly that is limiting. The positive issues regarding people being in aged care facilities are the critical mass that is required to have a facility for the general care of people with functional disabilities in a particular area and the importance of maintaining the family and other social links for that person. The detrimental aspect is people having to move out of that environment to be in an area where there would be a sufficient number of people with disabilities to make an effective service.

It is a similar issue with the provision of aged care generally. Ideally, aged care facilities would be provided in close proximity to people's own original communities, but, because of the need to provide larger facilities in order to provide both economic viability and an effective care model, people often need to move further away from their own homes. For younger people with disabilities, whose incidence in the community is so much smaller than older people with functional disabilities and frailty, it is a similar issue writ large.

Senator KNOWLES—I do not quite understand that. I think I have just missed a beat somewhere. Were you talking about providing larger facilities for younger people with disabilities?

Mr Puckey—No. The general issue for providing aged care services, both for economic reasons and in order to provide good quality care, is that aged care facilities themselves are growing larger. The average size of a facility in Victoria is under 50 places. That is considered to be too small to be an effective service these days. The industry is talking about a viable service of around 120 places.

Senator KNOWLES—I am talking about younger people with disabilities getting into facilities. Did you say that to make it viable there needs to be a relatively large number?

Mr Puckey—That is right. To have a service that is both economically viable and able to provide effective care, you would need a fair critical mass, and in many cases that would mean drawing people away from their own original homes and communities.

Senator KNOWLES—That is not really what we are talking about in this day and age. In this day and age we are talking about smaller being bigger. Last night we visited the most wonderful MS facility at Carnegie where three people who had been consigned to nursing homes were now living as normal people in a normal house, where any one of us would love to live. It is a very good model. What is the position in Victoria on trying to expand that model to create a more homely environment for people with disabilities?

Mr Puckey—As I stated, we presently have a project operating between the state department and the Commonwealth, working jointly on looking at a range of options for younger people with disabilities, but presently there is not a particular preferred option.

Senator KNOWLES—Could you provide to the committee the number of extra places for younger people with disabilities that have been provided under the current CSTDA?

Mr Puckey—I am afraid I do not have that data, but I would be happy to provide it on notice.

Senator KNOWLES—So you can get that for us?

Mr Puckey—I would be happy to go back to the department and provide that.

Senator KNOWLES—Thank you. That would be excellent. How many places have been provided under the innovative pool? If you were able to get that information, that would also be a useful statistic. On what basis—where and when—are more places made available for younger people with disabilities?

Mr Puckey—I am afraid I do not have that information either. As I said at the beginning of our presentation, I am from the Aged Care Branch of the department and the information that I have with me today on disability issues is limited to the briefing material that I have.

Senator KNOWLES—So neither of you can respond to that?

Ms Jacobson—No. I am sorry.

Senator KNOWLES—Is Disabilities another part of the same department?

Ms Jacobson—Yes, it is.

Senator MOORE—So you have a matching stream somewhere, with people at the same level, with the title ‘Disabilities’?

Ms Jacobson—Yes, that is right.

Senator KNOWLES—Do you know why, given that it is a major part of our terms of reference, someone did not come along who could answer those sorts of questions about that term of reference?

Mr Puckey—We did not brief the disability division to attend today. I have the information supporting our submission and I am only in a position to speak to that.

Ms Jacobson—But we are happy to take whatever questions you have on notice and provide you with the data that you would like.

Senator KNOWLES—Thank you. I would appreciate that. In your submission and in your oral evidence you have said about home and community care programs, for example, that you are seeking an additional resource from the Australian government. What resources has the Victorian government put into that in the last five years? What level of increase has there been for home and community care?

Ms Jacobson—The Victorian government has fully matched the Commonwealth’s contribution every year and is currently contributing an additional $46.9 million over and above the matching requirement in the agreement.

Senator KNOWLES—I want to get crystal clear the figures that were being thrown around earlier. Senator Marshall referred to the figures on page 7 of your submission. The most up-to-date, or most recent, figure that you have is a combined figure of 1,528. Is that correct?

Mr Puckey—That is right.

Senator KNOWLES—So there are 160 fewer people than at November 2003?

Mr Puckey—That appears to be so. The figure I had of 1,528 people is for those aged less than 65 years.

Senator KNOWLES—Hold on—the others are under 69.

Mr Puckey—I think that would account for the difference.

Senator KNOWLES—Yes. We are not comparing apples with apples, are we?

Mr Puckey—No. That is right. There is a slight disjunction between the disabilities and aged care programs inasmuch as the disability program is aimed at people under 65 and the aged care program is principally aimed at people over 70; although, as I said, there is no specific age requirement for the aged care program.

Senator KNOWLES—You have second-guessed me, because my next question is: why have you included people under 69 there when, in fact, you are now quoting under 65, which is more appropriate to the inquiry about younger people? It thrills me no end that I will be considered young when I reach 64.

Mr Puckey—To be honest—and this probably reflects my aged care bias—our usual examination of aged care issues has been for people over the age of 70.

Senator KNOWLES—This probably needs to be taken on notice. I would be interested to know exactly how many people there are under 65—who are considered young people—who are placed in nursing home facilities and who should not be there. Could you check that 1,528 figure?

Mr Puckey—Yes.

Senator KNOWLES—I would like to know how many extra places have been created for people with disabilities in the current CSTDA and where they have been placed. I would like to know the types of facilities: whether they have been group homes or more like institutions, if I dare use that word. I would also like to know what their level of care is and what the perceived level of unmet need is, because clearly the level of unmet need would be something that would come into negotiations on any disability agreement between the Commonwealth and the states and territories. And the 626 people who were awaiting aged care beds—were they over 65 or over 69?

Mr Puckey—There is an average of 626 in total and, if I remember rightly, 84 per cent of those were over the age of 65. So 589 of 626 people were aged 65 and over.

Senator KNOWLES—Given that 37 of those people are under 65, they should be classified as not going into a nursing home at all. They should be waiting for some other form of accommodation.

Mr Puckey—It would depend on the nature of their disability. If those people are suffering from general functional disabilities rather than specific disabilities, and if they are disabilities that are similar to those experienced by aged people, then they would appropriately be awaiting placement in a residential aged care facility.

Senator KNOWLES—That is true. Is there a way in which we can get the ages of those 37 people? Can we find out whether or not they are young people who have had some catastrophic accident or whatever, and whether they should quite legitimately be on a nursing home list or whether they should be on a list awaiting some other form of accommodation?

Mr Puckey—It is not 37 particular people. Those figures are an annual average, based on four quarterly censuses of the hospital system.

Senator KNOWLES—So it is not a current figure.

Mr Puckey—No. It was the average for the year ending 30 June 2004.

Senator McLUCAS—I think that is the point: we do not have the data that would tell us what the levels of disability of those individuals are, and to use the figures in a raw form can actually be quite misleading.

Senator KNOWLES—Yes, I realise that. We have been trying every avenue to get this information, and that is the difficulty. We cannot actually get a yardstick by which we can accurately measure a level of unmet need—that is part of the problem.

Senator McLUCAS—We heard earlier today about homeless people. By the nature of the lives they have led, they exhibit classic ageing symptoms at around 45 years of age. They would fall into that group that we are trying to identify and, legitimately, they should be on the aged care waiting list. It is fairly fraught trying to look at raw data and make some real assessment of what the unmet need is. I recognise that you, as the state government, just do not have the data to answer those questions.

Senator KNOWLES—I want to come to a statement that is on page 1 of your submission:

> Victoria strongly favours the joint development of sustainable and long-term solutions with the Australian government.

And we are talking here about young people in residential aged care. You referred to that in your oral submission as well. I ask you, having given that evidence today: what are you seeking that is not already there in the CSTDA?

Mr Puckey—I do not have information on the particular aspects that may be sought in the CSTDA. At present there is a joint project—the details of which I am not aware of—between the Commonwealth and the state. It involves people from an aged care perspective as well as from a disability perspective, and it is looking at the range of options. They are not limited to CSTDA services and Commonwealth residential care; importantly, the HACC program is involved as well. There are a couple of pilot projects that are presently proceeding. One of those may well be the one that you referred to—in the facility that you visited yesterday.

Senator KNOWLES—Would you be kind enough to take on notice that question as to the specifics of what is being sought in that joint development of sustainable long-term solutions?

Mr Puckey—Certainly.

Senator MOORE—Seeing that your submission and evidence, as well as general community discussion, is focusing on this issue of young people with disabilities, aged care and how the systems overlap, is there any structure within the department that has any kind of joint working party, regular meetings or an internal focus on this issue which would mean that sharing of information that we have been discussing? It would seem to me that the issue has been out there for a while. It is acknowledged in the departmental submission. I know that you are here with the aged care hat, but I am just wondering whether it has been reflected within your bureaucratic structure. The term at the federal level is a whole-of-government approach—that is, joint committees and all of that kind of stuff. Is there anything of that nature on this issue in the Victorian state government?

Ms Jacobson—There is a joint working party between Disability Services and the aged care branch which is looking specifically at the overlap in the client population between Disability Services, the HACC program and residential aged care. It is looking at options for better care for people across the continuum. There is no question about the fact that the populations bleed into each other. It is not really possible, as we discussed earlier, to have strict age demarcations such as the age of 65—for example, Disability Services in Victoria has a surprising number of people over the age of 65 living in supported residential units. They are ageing in place. There are Disability Services clients who are up to the age of 80 and who live in those accommodation units.

The HACC program provides services across the aged spectrum. There is no age limit or demarcation for people receiving HACC services. A substantial number of people receiving HACC services, particularly at the high end, are what you would call younger people with disabilities. As we have been discussing, there are younger people with disabilities in residential aged care.

Senator MOORE—Who heads up that working party?

Ms Jacobson—It is actually chaired by the undersecretary in charge of policy and strategic projects in the department.

Senator MOORE—In the Department of Human Services?

Ms Jacobson—Yes. The representatives on it are the Director of Aged Care and the Executive Director of Disability Services.

Senator MOORE—It just seems to me that that group should have all of the data that we have been asking for. It would seem that that would just make sense.

Ms Jacobson—Our source of data for people in residential aged care is the Commonwealth—the Department of Health and Ageing. There is some data that Disability Services has on its own clients, but the people we are talking about are not necessarily Disability Services clients. From discussions with our colleagues in other states, the only way that people have been able to get a handle on, for example, the condition of people in residential aged care who are under the age of 65 is by doing a census of those people.

Senator McLUCAS—I will go to Home and Community Care, which is always left to last. I am going to turn that around. In your submission you talk about the equalisation formula. For the benefit of the committee, could you explain the history behind the situation that Victoria is in and what you are suggesting should happen for equity?

Ms Jacobson—There are a number of different dimensions to this. The first is that, when the HACC agreements were first struck between the Commonwealth government and the state governments, varying levels of contribution were required. For example, Queensland contributes a bit over 35 per cent compared with the Australian government’s 65 per cent; Victoria contributes 40 per cent compared with the Australian government’s 60 per cent; and the ACT has a 50-50 ratio of contributions. When the HACC program first started, various states and territories did not fully match the offer of Commonwealth funds. Victoria at that time, because it was significantly underprovided for in residential aged care, took up the residue that was not taken up by those states and territories that had the offer. Over time Victoria has attracted a higher level of Commonwealth funding—and matched it, I might add—than other states and territories if you just look at the HACC program and per capita expenditure.

In 1995 the Commonwealth government decided that it wanted to equalise per capita expenditure of HACC dollars across Australia, which is not a valid policy objective. Our concern is that the Australian government does not look at the totality of aged care funding; it only looks at HACC. That means that Victoria actually has fewer residential aged care places and we get a lower rate of growth in HACC services than other states and territories—for example, while the program grows at a real rate of six per cent nationally, which is great, Victoria receives less than four per cent growth each year. Queensland receives 10 per cent growth each year. New South Wales receives over six per cent growth each year. The availability of residential aged care places is not taken into account when that distribution is made.

Senator McLUCAS—In the process of equalisation, Victoria’s historical low number of residential aged care beds is not being added in. You are not the first witness to talk to us about the importance of looking at the whole continuum of care options in making planning decisions. In some respects you might be at an advantage, given the move away from residential aged care and into community care—as long as you can get through equalisation.

The other question I have is to do with Victoria’s involvement in the innovative pool process. Mr Puckey, are you able to talk to us about that? It was through the innovative pool that $124,000 was allocated to Carnegie House. It was put to us yesterday that the way the innovative pool is structured means that the Commonwealth’s commitment is for only two years, so it is risky to say the least, for any community based organisation or the state government to enter a partnership from which one of those partners is going to expire in two years. That was put to us by one of our witnesses yesterday. It is that your experience of working within the innovative pool process?

Mr Puckey—I have not been directly involved in the innovative pool but I am aware that that has been a concern of those working through those issues. There is an underlying contention that if only you can assist people to make the transition then things will work through. But that lack of certainty of the future would have to be a limiting factor. Nonetheless, Victoria is committed to working on an ongoing basis with the Commonwealth to reach agreement on projects of that nature.

Senator McLUCAS—That is through this bilateral arrangement that you currently have?

Ms Jacobson—I have the information that Senator Knowles asked for about Victoria’s innovative pool projects, if that would be helpful. There are three innovative care rehabilitation service pilots that have been funded through the innovative pool. One is in Eastern Health, which has 15 places; one is in Northern Health, which has 15 places; and one is in the Doutta Galla Aged Care Service, which originally 90 had places but it was felt to be too large and has been scaled back to 50 places. The Victorian government is contributing approximately $1.2 million over the two years of the pilots at Eastern and Northern Health, in addition to approximately $2 million contributed by the Australian government. The government’s maximum commitment to Doutta Galla is approximately $4.8 million over two years.

Senator MOORE—Can we get the specifications of those pilots?

Ms Jacobson—A description of them?

Senator MOORE—Yes.

Ms Jacobson—I can provide those to you.

Senator MOORE—That would be really useful. Senator Marshall expressed earlier an aversion to guardians. I have much the same feeling about pilots. I am interested in the planning for the end of the two years and whether that is in the specification at the front. It sounds like it is an exciting project and we will see that for 15, 15 and 50. They are the numbers of places?

Ms Jacobson—Yes.

Senator MOORE—I want to see what the hope is for what will happen at the end of the two years. I am interested to see whether there is anything in the specification documents that looks at that. We will see.

Senator HUMPHRIES—I will start by commending you for appearing today. Despite what you might think to be the enormous significance of the issues that this committee has been looking at across Australia, yours is the first state department of health or equivalent that has chosen to appear before this committee. I commend you for having that amount of courage—unlike your colleagues in other states. I want to go first of all to the question of the CSTDA. I refer you to page 7 of your submission, where you say:

> The Victorian Government has consistently argued that while it accepts its responsibilities under the Commonwealth States and Territories Disability Agreement (CSTDA) ...

It goes on to say other things. What are the state government’s responsibilities under the CSTDA?

Ms Jacobson—The state government’s responsibilities under the CSTDA are to provide accommodation and support services for younger people with disabilities.

Senator HUMPHRIES—Isn’t that the answer to the concern that was just raised by Senator McLucas about the innovative pool projects having only two years of Commonwealth funding? It really is not an ongoing Commonwealth responsibility to fund the recurrent costs of these projects, because they are not Commonwealth responsibilities. Under the CSTDA, these are state government responsibilities and a contribution by the Commonwealth merely assists the state government to go down a path that it should be going down anyway with respect to young disabled people.

Ms Jacobson—I will disaggregate the innovative pool projects here. The ones that I referred to are specifically aimed at older people who are transitioning out of hospital and need a longer period of rehabilitation. The innovative pool project that you visited in Carnegie is one small project that specifically recognises the needs of those people. I do not have the data on that project with me. The significant issue is that it is a group of people who span an age range—from people who are very young to people in the 40 to 70 age group. You need to look at those groups of people differently. People in the 40 to 70 age group can have a variety of conditions that require 24-hour nursing care, which is basically what residential aged care places offer, and particularly high care places. The question is: is it a sensible use of resources to replicate that infrastructure for very young people with severe disabilities who also need 24-hour nursing care? That is a policy question that needs to be resolved, and I am not in a position to comment on that.

Senator HUMPHRIES—Mr Puckey referred to the economic efficiency of providing costly facilities for small numbers of young disabled people.

Mr Puckey—As a feature of aged care generally, the sector has held—and the Hogan review seemed to confirm—that very small facilities are not economically viable within the sorts of frameworks envisaged by the Commonwealth’s arrangements.

Senator HUMPHRIES—Yes, but there is a policy question, isn’t there, behind what is an acceptable trade-off between poor economies of scale and suitable outcomes for young disabled people. Could you take on notice the question of what the Victorian government considers to be in general a reasonable level of commitment to young disabled people, bearing in mind that the overwhelming weight of evidence—I think it is true to say the unanimous evidence before this committee—is that for almost all young disabled people nursing homes are inappropriate settings. They should be in other settings, so the question is: what level of state government support is appropriate and to what extent should funding be made available for those sorts of people to have alternatives other than nursing homes?

Mr Puckey—I will be happy to take that on notice. I wish to clarify that the state’s position is not one that sees it as appropriate generally that younger people with disabilities should be in aged care facilities; indeed to the contrary, we believe that should only be the option where there are no other facilities available. The joint project we have operating at present is examining those options and we will report to the minister later this year on options.

Senator HUMPHRIES—I think you were also saying that the government policy is that there is a maximum price for provision of that—a maximum price above which it is not economic to provide individual or tailored services for young disabled people.

Mr Puckey—I think I was referring generally to aged care and trying to draw a parallel between having a critical mass of people which will enable you to deliver a service which not only is economically viable but also is of a size to have the base of skills to provide effective care outcomes. I think in aged care and through examination through the accreditation arrangements it has been shown that very small services find it difficult to have the skills sets within their staff to provide the acceptable outcomes and that a somewhat larger facility will enable you to develop those skills, develop continuity of skills and provide good outcomes, including for social aspects of care that are difficult to provide in a very small facility. I was trying to strike the parallel that, if you are to develop facilities of a larger size than has been the average for aged care facilities in Victoria, which is averaging something under 50 beds, you would need to draw younger people with disabilities from a large area and necessarily draw them away from their own communities in many cases.

Ms Jacobson—The Victorian government invests significant amounts of money in providing residential aged care services in rural Victoria for exactly those reasons. The Victorian government is the dominant provider of residential aged care services in rural Victoria.

Senator HUMPHRIES—Sorry, do you mean services for young disabled people or for aged people?

Ms Jacobson—Primarily for aged people, but there are some younger people with disabilities in those residential aged care facilities, the reasons being that they need 24-hour nursing care and they need to be close to their families, and there is no alternative for them.

Senator HUMPHRIES—I think we would accept that, but the question is whether that is appropriate for the majority of young disabled people. That is a policy question which, therefore, I will not put to you, but can I clarify—

Mr Puckey—I can reiterate the minister’s attitude, which is that generally it is not appropriate for younger people with disabilities to be in aged care facilities and they should only be there where there are no suitable alternatives available.

Senator HUMPHRIES—Okay. How many young disabled people in Victoria are accommodated in facilities funded by the state government?

Mr Puckey—I would have to take that question on notice; I do not have that briefing material with me.

Senator HUMPHRIES—We have a rough figure—it does not give us the full picture—for how many young people are in nursing homes in Victoria. I would like to know how many of them are outside nursing homes but in other facilities run by the state government.

Mr Puckey—I am happy to provide that information.

Senator HUMPHRIES—It has been put to me that the Victorian government has made it clear that it will not apply for any more innovation fund packages from the Commonwealth for young disabled people, beyond the Carnegie home project that has already happened. Is that the case or not?

Mr Puckey—I am afraid I do not have that information.

Senator HUMPHRIES—Could you take that on notice as well, please. You make reference in your submission to the need for funding of additional tertiary places for nurse training. Is the Victorian government contributing anything to the cost of additional tertiary places for nurses?

Mr Puckey—Not within the university sector, which is a Commonwealth responsibility. However, the state government contributes to the training of nurses through the provision of clinical placements within the health system which is—

Senator HUMPHRIES—I am talking about places within universities.

Mr Puckey—No, the Victorian government does not contribute directly.

Senator HUMPHRIES—Because it is a Commonwealth responsibility?

Mr Puckey—Yes.

Senator HUMPHRIES—I am just intrigued as to why the position of the Victorian government is that it would not contribute to the tertiary training of nurses because it is a Commonwealth responsibility, when the submission calls for the Commonwealth government to contribute jointly in some way to the Victorian government meeting its obligations with respect to young disabled people.

Mr Puckey—I think, as Ms Jacobson outlined, it is not an issue of a particular division at a particular age. There are many people of an age who could be accommodated within residential aged care facilities who are living in community residential units within the CSTDA funded system. It is a matter of working in a spirit of partnership to try and find the best options for the individuals concerned.

Senator McLUCAS—It also recognises the fact that, when research has been done and there is public understanding of the inappropriateness of this situation, historically the Commonwealth has been funding those places. I think the overwhelming evidence from the sector is that they are so sick and tired of hearing, ‘It’s not our fault; put it onto someone else,’ that they are actually looking for the language that you are using—they are looking for a partnership approach to solving the issues around the disability of these people and appropriate housing for them and their health needs, which move across all boundaries. They want us to actually get onto solving the problem rather than pointing the finger at whomever else may or may not be responsible, which would mean that we would not get on with the job. So I think the sector would agree with your language, which is, ‘Let’s get on with doing something with a partnership type approach.’

Senator HUMPHRIES—We understand that the Commonwealth will start talking about a joint approach towards the funding of tertiary education places for nurses given that there is a need to fill more of those places. We can all contribute to that exercise, I am sure.

Senator McLUCAS—You take over the universities.

Senator HUMPHRIES—We could.

Mr Puckey—There is a clearly understood division between the higher education sector, as it is generally known these days, and what used to be known as the ‘VET sector’ and which now seems to be called the ‘tertiary sector’.

CHAIR—We are probably digressing a bit too far, given the lateness of the hour. Along with Senator Humphries, who thanked you earlier, I do want to again thank you as a state government representative for appearing before the inquiry. I do have to slightly correct Senator Humphries—though I thought that he was correct initially. It was brought to my attention that New South Wales did in fact appear as a government department, too, in the very first hearing, which was prior to the last election. I thought I had better just correct that. I think that they were very lucky that they appeared prior to us really understanding the full extent of the problems this committee is facing in its inquiry. Of course you are at the other end. Thank you again for appearing.

Committee adjourned at 4.56 p.m.