AUSCRIPT AUSTRALASIA PTY LIMITED
ACN 110 028 825

T: 1800 AUSCRIPT (1800 287 274)
E: clientservices@auscript.com.au
W: www.auscript.com.au

TRANSCRIPT OF PROCEEDINGS

O/N H-985228

THE HONOURABLE R.R.S. TRACEY AM RFD QC, Commissioner
MS L.J. BRIGGS AO, Commissioner

IN THE MATTER OF THE ROYAL COMMISSION INTO AGED CARE QUALITY AND SAFETY

ADELAIDE

10.00 AM, MONDAY, 11 FEBRUARY 2019

Continued from 18.1.19

DAY 2

MR P. GRAY QC, Counsel Assisting, appears with DR T. McEVOY QC, MR P. BOLSTER, MS E. BERGIN, MS B. HUTCHINS and MS E. HILL

COMMISSIONER TRACEY: Please open the Commission. Yes, Mr Gray.

MR GRAY: Thank you. Commissioners, I appear with the same members of counsel whose appearances I announced on 18 January with the addition of Ms Erin Hill. At the opening of the inquiry on 18 January we identified matters within the terms of reference and we also outlined our proposed approach for the conduct of the inquiry over the months ahead. As we said then, an important part of the Commission's work will be a program of public hearings at which testimony will be heard and other evidence will be received. Where possible, this will include the voices of those who have directly experienced the system. This is the first of those hearings.

It is scheduled to run for eight days from 11 February to Wednesday, 13 February and then on each day next week, 18 to 22 February. During that time we hope to call as many as 26 witnesses. I will speak about those witnesses in more detail towards the end of these opening remarks. At the opening in January, we also said that most of the public hearings will have a focus on particular themes relevant to your terms of reference. For example, the next public hearing commencing on 18 March in Adelaide will focus on home care, that is aged care provided to people in their own homes. The next in May will be on certain aspects of residential care with a focus on dementia.

This hearing in February is different. Its focus is not limited to any particular aspect of the terms of reference. It has a special purpose which is to provide background information for what is to come and to identify in advance the issues that are going to require attention as widely and as generally as possible. I will briefly mention the reasons for that. First, it is necessary to describe and understand the aged care system as it currently exists. This includes the services that are meant to be included, the ways access is supposed to be given to them and the framework for regulating them. All of this is supposed to safeguard quality and safety.

It is also important to understand how the aged care system is supposed to link to other services, such as health or disability services. This is no simple matter. The system is overly complex. Many changes have been made over more than 30 years, perhaps the frequency of these changes has led to unintended complexity. There have been many inquiries and reviews. Many have addressed particular aspects of the aged care system. Where the reviews have been limited in their scope they have not been able to address the bigger picture. Too often, the reforms made to aged care have been addressing a problem in isolation, rather than the system as a whole.

The sheer number and frequency of reviews shows that there are many issues in aged care which have not been resolved to the community's satisfaction. The Commission has prepared a background paper describing the aged care system. This will shortly be available for download from the Commission's website. I will return to this subject later in these opening remarks. Secondly, it is necessary to identify the issues

of concern about the way the system currently functions. This should provide many potential insights as to what the inquiry should address over the months ahead.

There are many valid perspectives about how the system is operating. Acting within the constraints of this scheduled hearing in February, we will lead evidence of this kind from witnesses on behalf of some of the principal representative organisations that have deep interest and involvement in the aged care system. Thirdly, it is necessary to obtain the best factual data we can about the issues that currently face the aged care system and how these issues are likely to look in the future, particularly when consideration turns later in the year to the options for improving the system. It will be important to consider the sustainability of the system, including its economic sustainability. At the very least, there are demographic, fiscal, investment and workforce related matters to consider.

There are many other issues of concern including ones which cannot be quantified and are hard even to define. One of these is cultural. Our older Australians are valuable members of the community. We should have a society where all Australians are valued over their entire life spans but that message is not being heard clearly enough. We, the Australian community, have a lot of work to do to improve our attitudes to older Australians and the way we think about and plan for ageing. Age-based discrimination is prevalent in our society in many forms. Neglect is an ever present risk. Many nursing home residents do not receive any visits from year to year. Their only connection may be with their nursing home staff and a GP if they are able to find one willing to visit them.

The dominant narrative in current Australian culture seems to be that older Australians are a burden. We reject that narrative. A culture of appreciation and respect for older people is needed. This is not a matter of bearing a burden, but of becoming the nation we know we should be. And for the thousands upon thousands of informal and unpaid carers of elderly parents, partners, relatives and friends, they must be given the supports they need. The work of this Royal Commission will challenge all Australians to reflect on our attitudes to caring for loved ones as they age. It will challenge us more generally to reflect on our responsibilities to older Australians whom we've never met but whose contribution has given us so much.

Before addressing further the matters to be covered by this hearing, let me say something about the submissions that have been received by the Royal Commission so far. Many people who have received care, family members and workers in aged care have approached the Royal Commission to tell their stories. Some have had harrowing experiences. We are grateful to them for their courage in being willing to bear witness to the effects that the aged care system has had on them and we thank them. There have also been positive experiences related to us. This is also very important information. We thank all those who have come forward so far. We invite others to come forward.

The website details for those who are interested in contacting us are go to the Royal Commission website, click "submissions" on the black tool bar and on the

submissions page under the heading "Making A Submission" click on the words "online submission form". Alternatively, you can send an email or letter using the details on that page or phone 1800960711. The email address is acrcinquiries@royalcommission.gov.au. The postal address is GPO Box 1151, Adelaide, South Australia, 5001.

Many of the accounts the Royal Commission has received so far are critical of specific aged care providers and give accounts of the role of the regulator. This hearing in February is not the occasion to hear those sorts of accounts but those accounts are being considered for inclusion in future hearings. In later hearings we will lead evidence from people who are expected to make specific allegations about a particular provider, regulator or some other person. In such cases, advance notice will be given where possible and the affected provider or person will be given an opportunity to respond. It is possible that there may be case studies at hearings later in the year at which critical evidence will be led directed to particular practices or providers.

We consider that case studies may be an effective means of enabling you, the Commissioners, to consider paragraph A of your terms of reference and in particular the causes of any systemic failures which have led to substandard care, including mistreatment or any form of abuse. Again, in advance of any such case studies, affected providers, regulators or other persons will be given notice if they are likely to be criticised by the evidence which will be led. However, before leading that evidence in those later hearings and in order to assess it properly when it is led, in this hearing we wish to lead background evidence about the system and the key issues of concern. That will assist you in making sense of the evidence that will be heard in the hearings that will follow.

Soon after it was called, the Royal Commission sought voluntary responses to information requests from the top 100 approved providers by size of aged care by a deadline in January and from all other approved providers by a deadline in February. There are nearly 2000 approved providers in all. More than 900 responses are now in. As to the largest 100 providers, 79 of them have responded in respect of most of their services. We are considering those responses. We will follow up the providers who have not responded to the request to ensure it has been received and has been receiving proper attention. As Commissioner Briggs noted previously, providers who do not engage with our requests draw attention to themselves and to their practices. They will be subject to careful scrutiny.

We have received over 800 submissions from the public to date. Many of these accounts relate to substandard or unsafe aged care services. A similar proportion raised concerns about staffing levels, including the ratio of staff to care recipients in aged care. In addition, the Department of Health has provided to the Royal Commission the submissions which were received by the department when public comments were sought on the Royal Commission's terms of reference. Let me now say something about the evidence you can expect to receive during this hearing in

February. We propose to lead evidence of or about, firstly, the concerns of some advocacy bodies regarding the current state of the aged care system.

Secondly, the clinical issues affecting elderly people and general challenges that arise in meeting clinical needs. Next, the concerns and views of some medical and nursing professional bodies relating to the current state of the aged care system. Next, demographic information relevant to the provision of aged care services. Next, the perspectives of government and the principal regulator as to the state of the aged care system. And finally, the perspectives of some workforce representative bodies as to the state of the aged care system, and Commissioners, you will also hear evidence from people about their experiences in the aged care system and their opinions on issues that need to be addressed.

There are several key topics which we considered. There will be evidence describing the system of Commonwealth subsidised aged care in Australia and how it is operated, monitored and regulated. As I mentioned at the outset there will also be a background paper on these matters available in the near future. Much of what I will now say will be available in that paper in due course. What is aged care? In 2011, the Productivity Commission described aged care as covering, and I quote:

> *The services available to older people who, because of frailty and other age-related conditions are unable to live independently without assistance.*

Those services can include one or more of the following: firstly, assistance with everyday living activities such as cleaning, laundry, shopping, meals and social participation; secondly, help with personal care such as help with dressing, eating and toileting; next, health care such as medical, nursing, physiotherapy, dietetics and dentistry; and accommodation. As people age, the amount of support and care they require changes, both in intensity and in type. Often people begin by needing assistance with household tasks such as cleaning and transport. This is the case regardless of whether or not the person also has a form of disability. These services can supplement support provided by a carer or are a substitute for carer support for a person living alone. Over time, this may increase to more supported services such as service-integrated housing, complex community care and residential care.

Who accesses aged care? Aged care services directly affect a significant proportion of the Australian population. In order to access subsidised aged care under the Aged Care Act four criteria must be met. First, the recipient must be assessed as eligible. Second, the care must be provided by a government-approved provider. Thirdly, the care must be provided through a government-allocated place or package. And fourthly, the care must be of a specified quality. According to the Department of Health, over 1.3 million Australians access aged care services. Millions more are indirectly affected through informal care and support arrangements, social networks, and community groups. Many people know someone, family friends, colleagues, who receive aged care services.

The vast majority of people who access aged care services require home-based care and support. And around 20 per cent live in residential aged care. Those entering permanent residential aged care tend to be frail and have an average age of 82 years for men and 84.5 years for women. One of the drivers of the need for aged care is the increasing number of people with dementia. Current estimates are that there are 376,000 Australians living with dementia, with almost half of these being people over 85 years of age. The Australian Institute of Health and Welfare, from whom you will hear tomorrow, anticipates that there will be around 900,000 Australians living with dementia by 2050. A hearing of this Royal Commission in May will focus on this issue.

This Royal Commission will also consider the issue of young people with disabilities living in aged care. We will address the issue of young people with disabilities living in aged care at a hearing later this year currently planned for September. How do people engage with the aged care system? In 2013, the Australian Government established the My Aged Care portal. My Aged Care is intended to be a single entry point for and a gateway to access to Australian Government subsidised aged care services. The My Aged Care portal is a website and a call centre. It provides information on aged care, refers people for needs-based assessments and attempts to assist in finding appropriate services in their local area.

We expect to lead evidence from people of their experiences of using the portal during this hearing. There are strong views amongst some of the witnesses about the current effectiveness of the My Aged Care portal in enabling elderly people to gain access to their services. There have currently been external reviews of aged care, including of the My Aged Care portal. There's a recent review that concluded that the portal was an important step forward for service delivery. However, the review also noted low levels of community awareness about the portal, along with implementation challenges and concerns about accessibility. We will examine the issues around access and engagement with the aged care system in more detail at a later hearing.

What kinds of care are available? The kinds of care available depends on the needs of the person seeking care. There is care that is received in the home and residential care. For care received in the home there are two mainstream programs. Firstly, the Commonwealth Home Support Program – CHSP – and home care packages. The Commonwealth Home Support Program generally provides entry level support services, whereas a higher level of funding is available through a home care package. Residents of home care packages are currently assessed at one of four levels of need. The Australian Government rations or caps the supply of both home care packages and of funded residential care places.

There are also forms of flexible care available, including transition care, short-term restorative care, multipurpose services and innovative care. There are also special flexible programs available for Aboriginal and Torres Strait Islander people. For veterans, there is Veterans' Home Care as well as the veterans' community nursing program. Residential care is designed for people who have been assessed as needing

higher levels of care than can be provided in their homes. Residential care can either be long term or for shorter periods of respite care.

How much do people pay? The aged care system relies on funding from the Australian Government as well as contributions from the person receiving care where they are able to do so. The Australian Government pays for the bulk of aged care in Australia. A person accessing residential care or a home care package is means tested to determine the amount they can afford to contribute for their care and for their accommodation, if they require residential aged care. The fees vary, depending upon the means of the person and the type of care they are receiving and can be significant. People are protected by hardship provisions and by annual and lifetime caps on the care fees they can be asked to pay. The care fees paid by people living in residential care can be as much as $27,000 per year.

The maximum care fee for home care packages is almost $11,000. Depending on the type of care a person is receiving, there are additional fees beyond this for daily services or accommodation and there may be fees for extra and additional services. Fees are generally much lower in the CHSP, the Commonwealth Home Support Program, where there is no formal means testing. What does aged care mean to the economy? A number of advisory bodies have been established by the Australian Government to provide government with advice on various aged care related issues after consultation with the industry, consumers and other sectors. One of these is the Aged Care Financing Authority which provides advice on funding and financial issues. The Authority estimates that annual revenues derived from aged care services providers total around $22 billion. In 2017/18 total Australian Government expenditure on aged care was around $18.2 billion and this is projected to increase by some $4 billion by 2021/22.

There are nearly 2000 aged care providers approved under the Aged Care Act ranging from complex corporate entries providing a full array of services to small businesses which provide a single service or operate a single facility. In addition, another 1456 providers deliver services under the CHSP. The sector employs over 366,000 workers with another 68,000 volunteers and is part of the health care and social assistance sector which has been the largest growing part of the economy since 2015. Another important advice body is the Aged Care Sector Committee. In 2016, that committee produced a document advising on a road map towards a consumer-driven more market-based aged care system.

How is the quality and safety of aged care regulated? The terms of reference give specific attention to quality and safety. The evidence in the hearing will shed light on the meaning of quality and safety in the context of aged care from a variety of national perspectives. The starting point must be to understand the framework for safeguarding quality and safety including the complaints processes that are supposed to be available when something has gone wrong. A system for safeguarding safety and quality needs to be effective through having an avenue for complaints, including a system for following up and improving as well as effective protections for complainants.

The quality and safety of care provided within the aged care system is subject to a complex raft of legislation and subordinate legislation which is administered by different Australian Government agencies. The principal piece of legislation in the framework is the Aged Care Act, 1997. Medical care provided within the aged care system is also subject to Commonwealth and State legislative requirements. It is unnecessary to refer in detail to much of the aged care legislation in this opening. However, the objects of the aged care Act articulate what individuals and the community can and should expect of aged care laws in Australia under the current Act. The objects are set out in section 2(1) which is now being displayed. The objects include:

(a) to provide for funding of aged care that takes account of –

five factors that are listed in that paragraph –

(b) to promote a high quality of care and accommodation for the recipients of aged care services that meets the needs of individuals;

(c) to protect the health and wellbeing of the recipients of aged care services;

(d) to ensure that aged care services are targeted towards the people with the greatest needs for those services;

(e) to facilitate access to aged care services by those who need them, regardless of race, culture, language, gender, economic circumstance or geographic location;

(f) to provide respite for families and others who care for older people;

(g) to encourage diverse, flexible and responsive aged care services that, (i), are appropriate to meet the needs of the recipients of those services and the carers of those recipients and (ii), facilitate the independence of and choice available to those recipients and carers;

(h) to help those recipients to enjoy the same rights as all other people in Australia;

(i) to plan effectively for the delivery of aged care services that meet –

three outcomes that are listed in that paragraph; and –

(j) to promote ageing in place through the linking of care and support services to the places where older people prefer to live.

Commissioners, you may consider that many of the above objects are appropriate statements of purpose. However, there are likely to be views expressed in this hearing that the objects place inappropriate emphasis on funding constraints at the

expense of safety, quality and consumer interests. It is also necessary to say something of the minimum standards for quality established under the legislation. The Aged Care Act establishes a framework for setting the minimum standards for aged care service delivery through a program of quality standards, compliance activities and enforcement. The Act sets out the framework for residential care services, home care services and flexible care services.

An entity that wishes to supply aged care services must apply in writing to the secretary of the Department of Health. Whether or not that application is granted is determined by reference to a number of considerations. Under the Aged Care Act, approved providers are responsible for the quality of care and services that they provide. The quality of care and services must meet standards established by the Australian Government. The Act authorises the Minister to make quality of care principles for providers of residential and home care services in division 54 of the Act. For residential care, under the current Quality of Care Principles 2014, in order for an approved provider to obtain and retain accreditation, there are at present 44 expected outcomes that must be met under four accreditation standards and there are 18 expected outcomes under the home care standards.

The Quality of Care Principles currently establish minimum requirements and are expressed in general terms. They have been criticised in various independent reports for their focus on process rather than the actual experience of people receiving aged care. Importantly for people wanting to access aged care, the current Quality of Care Principles lack clear and measurable indicators of quality of service or of clinical outcomes. The current standards will be replaced from 1 July 2019 by a single set of redrafted quality standards set out in the Quality of Care Amendment (Single Quality Framework) Principles 2018. There are eight new standards, each expressed in terms of a consumer outcome from the perspective of the aged care resident and an organisational statement from the perspective of the provider and the requirements that the provider must meet.

I will ask the operator to please display document CTH.1000. Thank you. 1012.2385. That's now on the screen. As can be seen from this page, standard 1 is consumer dignity and choice. Without asking the operator to turn through the entire document, it should be noted that standard 2 is ongoing assessment and planning with consumers. 3 is personal care and clinical care. 4 is services and supports for daily living. 5 is the service environment. 6 is feedback and complaints. 7 is human resources. And 8 is organisational governance.

Operator, please go to page 8, standard 3. Thank you. Personal care and clinical care. The detail under requirements, clause 3(a) to (g) is more detailed than the current expected outcomes in certain respects. Until the end of last year, the Australian aged care quality agency was responsible for accrediting, reviewing and monitoring providers against the accreditation standards and for reviewing providers against home care standards and for the provision of education and training. Those responsibilities have, since 1 January 2019, been transferred to the new Aged Care Quality and Safety Commission. Likewise, until the end of last year, the Aged Care

Complaints Commissioner provided a free service for anyone to raise concerns about the quality of care or services delivered by Australian Government subsidised aged care services. That function has now also moved to the new Aged Care Quality and Safety Commission.

Care recipients, family, friends and staff can raise any concerns regarding the quality of care and services in an aged care home with the Aged Care Quality and Safety Commission. Complaints can be made openly, confidentially or anonymously. In 2017/18, the Aged Care Complaints Commissioner received 5779 complaints. The majority, 75 per cent, related to residential aged care.

The independence, accessibility and effectiveness of complaints handling within the aged care system has been raised in submissions to the Royal Commission and in independent inquiries and reports beforehand. The issues of fear and intimidation and reprisals by people – well, with respect to people making complaints about the quality of aged care have also been raised in Commissions (sic) – in submissions to the Commission. These matters are of great concern to the Royal Commission and they will be examined in future hearings.

As I have mentioned, accreditation and quality monitoring and the handling of complaints were transferred to the new Aged Care Quality and Safety Commission from 1 January. Further functions relating to provider approval and compliance are planned to move across to the Quality and Safety Commission from 1 January 2020. The efficacy of this new body and its ability to ensure the quality and safety of care for the elderly, now and for future generations, will be a subject of consideration in the hearings of this Royal Commission.

I want to turn to the topic of demographic context and sustainability. The sustainability of the system is specifically raised by the terms of reference. As I have already noted, the inquiry will need the best available data on a range of topics. Demographic information is critical. Our population is becoming older and advances in medicine create an expectation of more years of healthy life after retirement. That is something to be celebrated. Its implications for sustainability of the aged care system also need to be considered.

The ageing of our population does present real challenges for our country, including to the aged care system. We will lead evidence from witnesses employed by the Australian Bureau of Statistics, the ABS; and the Australian Institute of health and welfare, the AIHW as to the data which is available on the changing demographic of our population and other relevant data. We will seek an overview from those witnesses about how those data have been analysed to date and raise the question of how they may be analysed further in ways that could assist the inquiry. In the near future, the Royal Commission intends to publish on its website a background paper on demographic information relating to aged care.

I will turn now to the witnesses. As I mentioned at the outset, across the eight days of this hearing, we anticipate that you will hear evidence from as many as 26

witnesses. Today, and immediately after my introductory remarks, the Royal Commission will hear evidence from Mrs Barbara Spriggs and then from her son, Mr Clive Spriggs. In 2016, Mr Spriggs' late husband Robert Spriggs, suffered mistreatment at the Oakden Older Persons Mental Health Service in Adelaide. The Spriggs family's action in seeking answers about what had happened to Mr Robert Spriggs led to a series of inquiries into what has been happening – rather, what had been happening at Oakden, and raised serious questions about failures in regulatory oversight.

The later report of Ms Kate Carnell AO and Professor Ron Paterson OZM on lessons highlighted by Oakden described Oakden as a sentinel case. The terrible treatment and abuse suffered by residents of that facility is well known and has been the subject of considerable attention and of reports of the South Australian Chief Psychiatrist and the Independent Commissioner Against Corruption. We do not propose to lead evidence of the experiences of the residents of Oakden. Instead, we will hear from Mrs Spriggs and Mr Clive Spriggs about their experiences and about the issues they identify as requiring urgent attention. As the Independent Commissioner Against Corruption said in his report:

Oakden is a shameful –

Pardon me. The report was titled Oakden, A Shameful Chapter in South Australia's history. And in that report he said:

It should not have happened. It must never happen again.

Following the Spriggs' evidence, the hearing will turn to the evidence of witnesses from advocacy groups, policy, regulatory and statistical agencies, health professionals, industry groups and unions. It will conclude with more evidence of the lived experience of people attempting to navigate the system.

There will be a number of important topics raised by this evidence over the next two weeks. Without meaning to be exhaustive, we anticipate that the evidence will raise the following themes. First, whether the current aged care system is failing to meet community expectations and in what ways. Next, issues relating to changing demographics and what that means for the aged care system. Next, the specific clinical issues that arise in caring for older people, including the skills required of doctors, nurses and personal care attendants. Next, creating and aged care sector which properly cares for Australians with dementia.

Next, the current aged care funding model and proposed different approaches to managing the funding of aged care. Next, the importance of the aged care system providing care which values the choices of those receiving care as individuals and which is person-centred. Next, issues regarding staffing, including the number of staff required to provide quality care in different settings, and the provision of those services to people with varying needs, the skills mix in the workforce required to achieve this, as well as the amounts that aged care workers are paid. We anticipate

that you will hear a wide variety of different suggestions for reforms to the aged care sector.

Weaknesses or failures of the current system. Commissioners, you will hear views about perceived weaknesses or failures. After you have heard from Mrs Barbara Spriggs and Mr Clive Spriggs, the witnesses that you will hear over the balance of today are Mr Ian Yates AM, the chief executive of COTA Australia; and Professor John McCallum, the chief executive officer and research director of National Seniors Australia. Both consider that there are significant problems in the current aged care system. Their concerns about the system are wide ranging and will provide an overview of issues that exist across the spectrum of care.

Testimony from advocacy groups will continue on Tuesday afternoon when we plan to call Mr Craig Gear, the chief executive officer of the Older Persons Advocacy Network, OPAN. We then intend to call Mr Paul Versteege, policy manager of the Combined Pensioners and Superannuants Association, CPSA. And then Ms Sue Elderton, national policy manager of Carers Australia.

The advocacy groups' evidence raise a number of concerns about safety and quality. For example, Mr Versteege's view is the inability to access aged care by reason of vast and shocking levels of undersupply of aged care places and packages is itself a safety issue. He also considers that recent increases in compliance action are not attributable to deterioration in providers' performance so much as a recent increase in regulatory action after a period of relative inaction. He says that compliance monitoring was broken prior to 2017/18. He also emphasises the need for better access to oral and dental care. We expect Mr Gear's evidence to be that the current system is confusing for consumers, including because costs are not made clear. Mr Gear is also of the view that substandard care is being provided in residential facilities.

Issues relating to the need for better integration of clinical care of elderly people will be raised by a number of witnesses. Dr Harry Nespolon, the President of the Royal Australian College of General Practitioners, will give evidence next week. Dr Anthony Bartoni, the President of the Australian Medical Association, will give evidence next week, also. Both these witnesses are concerned about the obstacles to the proper integration of clinical care and the poor interface between health and community services, on the one hand, and aged care services on the other. They are concerned about a lack of support within nursing homes for visiting GPs.

Mr Nicholas Mersiades, the director of aged care at aged care at Catholic Health Australia, expresses a range of concerns, including that access to health and allied health services within aged care settings is inconsistent and variable.

An emerging theme in the evidence more generally is the difficulty associated with people transitioning back and forth within the health care system and the aged care system. In future hearings, this will raise the prospect of close scrutiny being given to the administrative interfaces between health and community services, on the one

hand, and the aged care system on the other. It may be relevant to note that public health services are the responsibility of the relevant State or Territory, but the aged care system is not and is very largely Commonwealth funded and regulated.

This Wednesday, we will call evidence from Ms Annie Butler, a registered nurse and an official of the Australian Nurses and Midwifery Federation, the ANMF. We expect Ms Butler will explain the ways in which staff in the current aged care system are not put in the position to provide the standards of care that they would like. On the same day, we will hear from Ms Deborah Parker, who is the chair of the ageing policy chapter with the Australian College of Nursing. Ms Parker will give evidence on the challenges that nurses face in meeting the needs of older Australians, particularly those suffering from chronic conditions.

Some of the sector's peak bodies, such as Catholic health Australia, Aged Care Services Australia, leading aged services Australia and Uniting Care, have expressed concerns about the way that the system currently operates. You will hear from witnesses representing these bodies both this week and next.

The witnesses do not all speak with one voice. On the fifth sitting day, Tuesday next week, we intend to call Mr Matthew Richter, who is the chief executive officer of the Aged Care Guild, a peak body representing some of the country's largest care providers. The Guild is of the view that the system meets the current needs of most aging Australians who rely upon it, although unacceptable cases of failure have occurred and Australians are not well informed about the system and their choices. Mr Richter is concerned that the future sustainability of the system is under threat, and that there is a need for increasing the supply of places funded by the Australian Government.

On demographics, tomorrow morning we intend to call witnesses from the ABS and AIHW, who will explain the relevant data that is available and how it may be used. The ABS and the AIHW are both statutory bodies. The relevant function of the ABS includes the conduct of the census and other surveys of particular relevance, including the Survey of Disability, Ageing and Carers, SDAC. The focus of the AIHW is even more squarely directed to issues of particular concern to this inquiry. First, we are calling Ms Justine Boland, Health and Disability Branch of the ABS. Next, we will call Ms Louise York, who's group head Community Services Group of the AIHW, together with Mr Mark Cooper Stanbury of the AIHW.

I will turn now to accreditation standards. Many of the witnesses in this hearing will provide their view about the way in which residential aged care service providers are accredited. Mr Paul Versteege from the Combined Pensioners and Superannuants Association, CPSA, will give evidence that the current standards are formulated on a parc or fail basis and do not encourage improvements in quality over time. We expect that you will also receive evidence on this issue from the witnesses from OPAM, COTA Australia and the AMA.

We will have the opportunity to explore these concerns with Ms Janet Anderson, the commissioner of the new regulatory body the Aged Care Quality and Safety Commission at the beginning of next week. We will, of course, be interested more generally in Ms Anderson's views about the scope and purpose of this new body, as well as the challenges that it faces.

Representatives from peak provider bodies, including Mr Shaun Rooney, chief executive of Leading Aged Services Australia and Ms Patricia Sparrow, chief executive officer of Aged and Community Services Australia, appear to have a different perspective on the accreditation process. The Royal Commission will receive evidence from each of these witnesses expressing concern about the lack of clarity and consistency in the way that the accreditation standards have been applied. Mr Rooney and Ms Sparrow will both give evidence on Tuesday next week.

Turning to clinical issues, the medical professionals who will be giving evidence before the Royal Commission over the next two weeks will give you the opportunity to consider the interfaces between the health care system and the aged care system. Associate Professor Edward Strivens, President of the Australian and New Zealand Society for Geriatric Medicine, will give evidence on Wednesday this week. We expect his statement and evidence to be useful as a general reference tool for the kinds of clinical issues associated with ageing, as well as the need for integration of clinical care into the provision of aged care. Dr Nespolon of the RACTP, will give evidence about the challenges of managing relationships between clinicians, facilities and families of people receiving aged care, particularly in the context of residential aged care.

We have mentioned earlier the prevalence of dementia in older Australians. On Tuesday next week, Ms Maree McCabe, the chief executive officer of Dementia Australia, will give evidence about the need to integrate dementia care throughout the aged care system. On person centred care, respect and dignity, we will call Ms Claer Little to give evidence on Wednesday next week. Ms Claerwen Little is national director of UnitingCare. She's expected to give evidence on a range of issues that UnitingCare identifies as significant, including how respect for the aging and person-centred care needs to be a core practice of aged care service providers. We expected that she will be joined in this view by many witnesses, including Ms Sparrow from ACSA.

In his detailed statement, Mr Mersiades, of Catholic Health Australia, advocates for a realignment of focus on enablement, re-enablement and wellness and quality of life, goals which he says are less likely to be obtained while current revenue constraints and capped supply arrangements apply.

Staffing. Staffing in aged care facilities is a concern to many people who have made public submissions to the Royal Commission, as I mentioned earlier. And this will be a matter that we're keen to explore with a number of witnesses who will appear before you in this hearing. Ms Elderton, of Carers Australia, will explain how family, friends and carers are affected when aged care service providers do not have

adequate staff or have inadequately trained staff. She will also give evidence about how the negative community perceptions of aged care can make it difficult to find appropriate staff to provide care. Ms Sparrow, from Aged Care Services Australia, will also address this point, as will Mr Rooney from Leading Aged Services Australia.

Commissioners, many of the witnesses you will hear from will discuss the adequacy of funding that the Commonwealth provides. Many of those witnesses will tell you that the current funding arrangements are inadequate for the provision of care that meets community expectations. For example, the evidence of Mr Mersiades and of Mr Richter includes their views about the effects of supply caps and other revenue constraints. Mr Mersiades suggests that the application of the funding – mechanism – the Aged Care Funding Instrument, or the ACFI, is a central issue.

Mr Versteege points to the apparently inconsistent trends in residential care occupancy rates, which he says are falling, and significant waiting lists for both home care packages and residential care. He suggests that this may be occurring not only because of government restrictions on supply of funded places and packages, but because of the perception that residential care is unsafe or of poor quality.

The structure of funding and, indeed, the structure and operation of the entire aged care system, will be a focus of the evidence on Monday next week of Ms Glenys Beauchamp, PSM, the secretary of the Commonwealth Department of Health. One common theme in the evidence is the concern expressed about long waiting lists for allocation of home care packages to people after they have been assessed as needing care. Similar views are expressed about under supply by the government of allocations of funded residential home care places.

We note that just yesterday the media reported that the Minister for Aged Care and, indeed, the government, had announced new funding for more home care packages. We expect the evidence of Ms Beauchamp will be of particular interest and significance and should assist the Royal Commission to understand the full scope of the governmental perspective of the issues facing the aged care system.

As to solutions, Commissioners, most if not all of the witnesses giving evidence in this hearing will wish to outline their views on possible solutions to the challenges that the aged care system faces. While we will not be asking you to make findings about any of these solutions at the end of this current hearing, we hope that these ideas will assist your own consideration as the work of the Royal Commission progresses.

Toward the conclusion of this hearing on Thursday next week, the Royal Commission will hear further evidence from people who have experienced the aged care system. This will include evidence from carers who have engaged with the system for others, as well as those who are presently receiving care themselves.

We do not intend to lead examples at this hearing of substandard or unsafe treatment that some people have received. Rather, the testimony of lived experience in this hearing is to give the Royal Commission an impression of the diverse experiences and challenges that people have experienced in the system.

In conclusion, I wish to add that at the end of this hearing in February, Dr McEvoy QC will present a closing address will draw together the evidence that has been given to the Royal Commission in the hearing and will outline the implications that the evidence may have for the future work of the Commission. Future hearings of this Royal Commission from March to October will turn to a more detailed examination of home care and the community; residential care, including in particular quality and safety and dementia; person-centred care, choice and control; access, inclusion and diversity issues, including for indigenous Australians; navigating transitions between different forms of care and the interface with other related services; particular issues arising in rural, regional and remote locations; young people with a disability living in residential care; innovation and the use of technology; future challenges for the aged care system and how the aged care system can be sustainable.

This is a National Royal Commission. The Royal Commission will sit in cities and in regional areas throughout the country and particular local issues will be able to be raised in those settings. Commissioners, as I have said, we do not propose to ask you to make factual findings about the evidence in this first hearing. 11 applications for leave to appear have been granted in respect of witnesses who are giving evidence in this hearing. However, we do not anticipate seeking further submissions from any of the parties who have leave to appear. We encourage all Australians to engage with this Royal Commission, as we embark on this journey towards a national culture of respect for our elderly.

Commissioners, I now propose to proceed with calling the first witness. I call Barbara Spriggs. And I also call Clive Spriggs. Commissioners, I propose to call Mrs Spriggs and Mr Clive Spriggs concurrently.

COMMISSIONER TRACEY: Just make yourselves comfortable. Do you wish to take an oath or make an affirmation?

MS SPRIGGS: An oath.

<BARBARA ELIZABETH SPRIGGS, SWORN [10.56 am]

<CLIVE ROBERT SPRIGGS, AFFIRMED [10.56 am]

MR GRAY: Mrs Spriggs, is your full name Barbara Elizabeth Spriggs?

MS SPRIGGS: That's correct.

MR GRAY: And, Mr Spriggs, is your full name Clive Robert Spriggs?

MR SPRIGGS: Yes, that's correct.

MR GRAY: Mrs Spriggs, I will ask you to give your evidence first. And for that purpose I ask the operator to bring up document WIT.0025.0001.0001. Mrs Spriggs, do you have a paper copy of that document before you now?

MS SPRIGGS: Yes.

MR GRAY: Please take a moment to look through it. Mrs Spriggs, is that a copy of your statement?

MS SPRIGGS: Yes.

MR GRAY: Do you wish to make any amendments?

MS SPRIGGS: Yes. I've just got a couple of extra little things to put in.

MR GRAY: Please proceed with adding what you wish to say. I understand that before reading your statement you wish to say something about your experiences in general. And I invite you to do so.

MS SPRIGGS: My husband Bob was, unfortunately, one of the many people that needed to be in a government care home like Oakden. We had no choice. For Clive, Kerry and myself, it was heart breaking to leave Bob in such an uninvited, rundown, short of qualified staff facility. We need to make sure – we need to make sure each and every Australian, where through no choice of their own, and they are at their most vulnerable, that they are cared for with dignity and respect that they deserve.

MR GRAY: Thank you, Mrs Spriggs. Looking at the document that you have before you, are its contents true and correct to the best of your knowledge and belief?

MS SPRIGGS: Yes.

MR GRAY: Commissioners, I tender Mrs Spriggs' statement, document WIT.0025.0001.0001.

COMMISSIONER TRACEY: The witness statement of Barbara Elizabeth Spriggs, dated 8 February 2019, will be exhibit 1-1.

EXHIBIT #1-1 WITNESS STATEMENT OF BARBARA ELIZABETH SPRIGGS DATED 08/02/2019 (WIT.0025.0001.0001)

MR GRAY: Mrs Spriggs, I invite you, if you wish, to read from your statement. You can read the entirety of the statement, if you wish, or any parts of it that you wish.

MS SPRIGGS: This statement made by me accurately sets out the evidence that I'm prepared to give to the Royal Commission into Aged Care, Quality and Safety. This statement is true and correct to the best of my knowledge and belief. The views I express in this statement are my own based on my experience.

My full name is Barbara Elizabeth Spriggs. I am currently 66 years of age. I'm retired. My husband, Bob Spriggs, died at the repat hospice – hospital on 18 July 2016. He was 66 years old. We were married for 42 years. Everyone that knew my husband called him Bob. Bob was a patient at Oakden Older Persons Mental Health Service, Oakden, for two short periods in 2016. He was there in January 2016 and again in February 2016. On both occasions, he was sent there under a compulsory inpatient treatment order made by the South Australian Civil and Administrative Tribunal.

Bob was at Oakden because he had Parkinson's disease, Lewy body dementia and Capgras Syndrome. He was unable to go into private care. I was told that Oakden was the best and only place for Bob and that I was privileged that he was able to be accommodated there. Bob's treatment at Oakden has been publicly documented in the media. The Oakden facility has also been the subject of several reports. In April 2017, Dr Aaron Groves, the then chief psychiatrist at SA Health, provided a report to the then Minister for Mental Health and Substance Abuse, the Honourable Leesa Vlahos, MP.

Following this report in May 2017, the Federal Aged Care Minister, the Honourable Ken Wyatt, announced a review into aged care quality regulation processes. In February 2018, Oakden was also the subject of an Independent Commission Against Corruption, report by the Commissioner, Honourable Bruce Lander. There has been an inquiry by the Senate Community Affairs Reference Committee.

I do not wish to revisit all the details of the past. My family and I are looking forward to moving on when we know that action is being taken to address the abuse of the past. But I want to encourage others to tell their story about aged care in Australia. Based on my family's experience, I want to share my reflection on how the aged care system needs to change in the future. I want to make a few points about the importance and difficulties in speaking out. I know only too well that speaking out is not an easy thing to do. I'm not usually the sort of person who complains. I would rather compliment than criticise. I am an ordinary person without any formal education or qualifications. But when I knew things had been wrong with Bob's treatment, I had to keep pushing. I couldn't stay quiet knowing that others might face similar experiences to what he had been through.

But to this day I'm blown away by what the results of speaking out have been. There are a lot of positives. Oakden has been closed. Residents have been moved to a

much better facility called Northgate House. I have visited this facility and, for what I have observed, there is a huge difference between the facility and Oakden. Residents now receive better care. People are not physically restrained. Staff are given more guidance as to how to treat the elderly with the respect and dignity they deserve. Efforts are being made to improve staff training and staff ratios. I believe a new purpose-built facility has been planned. This was a direct result of Oakden's scandal.

We need to ensure that such standards are met across all care. Sorry. We need to ensure that such standards are met across all aged care facilities, not just those where concerns have been raised. Perhaps even more importantly, speaking out lifted the lid on a problem which was much wider than just the way Bob had been treated. It has lifted the lid for those who have had no one to speak for them or whose families felt unable to speak. I want to repeat that it has not always easy to speak out. I had to push hard and long to be heard. It took six months, from June to December 2016, before I was really listened to. It took all my courage, and will to keep going.

I would just like to add, I just came up against so many stumbling blocks to get – to be listened to. My speaking has – my speaking out has come at great personal cost to me and to my family. I'm still finding it hard even today. But I know that my speaking out made a difference and I'm glad that I did so. But it should not have – but it should have been much easier for me to be listened to and to get answers than it was. I know that it is too late to change Bob's experience, but I know that Bob would not want others to go through what he did. I also know that if the situation had been reversed, he would have spoken out. This is why I want to share my family's story and offer my views on what I think needs to change in the aged care system. I now want to move on to the need for accountability in the aged care system.

I now want to move on to the need for accountability in the ages care system. Firstly, I think there has been no accountability for wrongdoing in the system. I feel that this is illustrated in my family's experience. In early 2016, Bob was moved to Oakden from ward 18 at the repat hospital where, I must say, he was well cared for. It's worth noting that whenever Bob was at the repat, right from – right up to his death, he was content, generally calm and well cared for by a dedicated – by dedicated staff who came to understand Bob's problems and needs.

But, after only one week at Oakden, he was sent back to the repat hospital, ward 18, because Oakden, supposedly the only facility in the State which could care for him, found him too difficult to deal with. And, again, I cannot believe to this day that we had no choice to put Bob there. I can't believe that nobody else could pick up how bad that place was. Sorry. In February, Bob was readmitted to Oakden. After one week, we noticed a huge decline in his health. After our family expressed concerns at his deterioration, we left, but within an hour we were told he had been transferred to the Royal Adelaide Hospital.

He had been overmedicated by being given 10 times the dose, 500 milligrams instead of 50 milligrams, of his prescribed antipsychotic drug Seroquel. He was suffering severe bruising on several parts of his body, was dehydrated and suffering from pneumonia. To this day, I don't know what happened to Bob at Oakden. Was my questioning the only reason that his ill treatment eventually came to light? Did anyone at Oakden or at the Royal Adelaide Hospital or anywhere else report anything or raise any concerns to the authorities? I think about those who hurt Bob and I wonder whether they – and I wonder whether they are now employed somewhere else. I wonder if their employers know about their previous conduct.

I keep coming back to the fact that whenever I walked out of the repat, I was happy that Bob was in a facility where staff cared for him as a person, where they tried to understand him and meet his needs, where my visits were welcomed by the staff and where I knew Bob was as content as he could be given his condition. From the very first day, I never felt that about Oakden. Why was this the case? Why couldn't Oakden have offered the same level of staffing and care as he received at the repat? How come other professions didn't get the same gut feeling that I got each time I went out there?

My family and I tried to find out what had happened to Bob. I made a request under the freedom of information legislation. This was a confusing and frustrating process. The information that was returned to me was difficult to understand. It gave us no answers. Families should not need to jump through hoops, through the freedom of information system. I think that once a hospital sees bruises or signs of potential abuse, this should be triggered as a domestic violence-type alert. Can I add too, I'm sure if I had taken Bob to the Royal Adelaide Hospital, the state he was in, I would have been reported to the police.

As to why he was in such a bad state. To my knowledge, there's not even a system within the mental health service for reporting this level of incidents. I am worried that if this is a system-wide issue. I think there needs to be protection in the system. If there are red flags like bruising, there should be a procedure in place to alert the authorities. If the red flag goes up, then there needs to be an emergency and urgent process that can be triggered.

Complaints and inquiry system. I found it so difficult and frustrating and time consuming to get answers to my questions and to have my concerns taken seriously. I had no experience in working through bureaucratic processes. Also, it's difficult to describe the stress I was under. My very sick husband had been moved into an aged care facility and suddenly I had to deal with living without him. My lifestyle changed and I was dealing with things that he had once dealt with. I needed to juggle visits to the facility. I was feeling guilty that I was not able to take care of Bob myself.

When we saw signs that Bob had been physically abused and neglected, the stress and trauma only increased. I should not have had to battle so long and hard for months to be heard. Eventually, with the support of the community visitor scheme,

the media picked up my story and people started to listen. I could so easily have decided before that that it was not worth all the trouble I was coming up against. I was coming up against so many brick walls. There needs to be an easier to use, accessible and quick way for people to get information, particularly when they have serious concerns about what is going on in aged care facilities.

There needs to be a very clear pathway that an everyday person can follow if they or someone they are caring for experiences a problem. Preferably, the process should not be online. Not everyone is confident with online systems. This can put up barriers straightaway. There has to be a much easier, uncomplicated road to travel with personal contact to get information and get some answers and get some attention. It should be clearly advertised in a highly visible place. And this may deter – this may have a deterrent effect, as well.

There is now an 1800 number that people can call. This should be displayed on nursing home walls where families can see it. The number should be answered by a person 24 hours a day. It should have the capacity to trigger an urgent response.

Staffing. Another area that I think needs to be improved is staffing. Caring for the elderly is not a job that everyone can do. It's a special group of people that are good at doing this kind of work. They need to be passionate about their work and have empathy for the elderly. They need to be motivated to care for the aged as if they were caring for their own family. Processes need to be put into place to screen out those unsuitable for the work. Aged care workers need to be registered and highly trained with a clear set of qualifications required for registration. Staff also need to be appropriately paid, acknowledging the complexity of their work that they do.

Furthermore, in an aged care – furthermore, if an aged care worker does something wrong, this should be documented in a national database. Future employers should be able to see that there is a mark against their name in the system. Hopefully, this will stop unsuitable workers with bad traits moving to other facilities, including interstate. There needs to be more accountability when failings occur.

CCTV cameras. I believe that CCTV cameras should be installed in all common areas of aged care facilities. There should be an option to have them installed in private areas. This would mean that if anything goes wrong, there is a clear record of what has happened. CCTV is not just for the safety of patients. It also protects staff.

End of life care plan. Aged care and hospital staff also need to respect the wishes of family members, especially when it comes to end of life care plans. My family and I had previously made an end of life plan for Bob. We knew that he was – wasn't going to recover and that life for him would get progressively more distressing. We decided that he not be given resuscitation or antibiotics unless he was in pain. I remember we had spent so much time on all of that. There was a lot of paperwork involved and it was a very difficult decision to make. We made the decision as a family.

This plan was ignored by the system, or at least did not follow him from Oakden to the RAH, where he was given antibiotics for pneumonia. Although I questioned this at the hospital, the process went ahead. I was so distressed by Bob's condition and neglect that I felt helpless and numb and frightened and was in no state to insist that the documented end of life care plan be followed.

My conclusion. There is so much more that I could refer to which points to the fact that Bob and other residents at Oakden were not given the care, dignity and respect to which they were entitled. The accommodation at Oakden, for example, was like something from the 19th century. One time when I visited Bob I was let into his bare locked room where he was lying on a bed with just a sheet underneath him. There was no seat on the toilet in his bathroom. There were only paper towels in the bathroom. He was there on his own. It was like a prison.

While at Oakden, Bob was given medication to sedate him. And other patients at Oakden also appeared sedated. I felt strongly that this was done by staff to ease the management of residents, rather than for a true concern for their needs and welfare. We need to learn and move forward from our mistakes and develop an aged care system that Australia can be proud of. It needs to be one where we know that our loved ones are given the care and the dignity and the respect that they deserve. My family and I welcome the Royal Commission as an opportunity to have our say. My submission will not save Bob from the mistreatment that he experienced, but I hope and pray that this Commission will lead to recommendations and actions that will ensure no one else will suffer as my husband suffered, and no more families will have to go through the heartbreak which my family experienced.

MR GRAY: Thank you, Mrs Spriggs. I understand that you wish to add some additional matters to your account to the Royal Commission. Firstly, I understand that you wish to add something about the Community Visitors Scheme, and I invite you to do so now.

MS SPRIGGS: I strongly believe that the community scheme is a very good organisation, but just in the last few days I've given some thought to the naming of that service that is offered to the public. And I feel that maybe some time can be looked into maybe rewording the names Community Visitor Scheme. I don't feel it's a real inviting place for the public to go to to report things that have gone wrong in aged care facilities. I think it's worth looking at coming up with a more inviting name that is putting across to the public that this is an organisation that can help us work through a complaints system.

MR GRAY: Thank you. And the second matter is that I understand you have reflected on your experiences, and, in particular, an assumption you made that Oakden was a properly accredited facility. And I invite you to make any comment you wish about that matter.

MS SPRIGGS: Yeah. I question accreditation process that happens. To this day, I cannot believe that when accreditors or any professional people went out to Oakden,

how they did not pick up in their gut feeling that something was wrong. From the very first moment that my daughter and I went out to Oakden, I walked into the grounds of that place and my gut feeling said, this doesn't feel good. I don't think this is the right place. My gut was telling me this is not good. When we Googled it and found out that was the place that Bob needed to go to, I remember saying to my daughter, look, don't judge a book by the cover. We've been told that this is the best and only place for your Dad, so hopefully inside will be good.

The next day, we took Bob out there and went inside Oakden and, again, got a gut feeling that this doesn't feel really good. And so then I remember saying to Clive and Kerry, well, again, darling, don't judge the book by the cover, it's not all about the building. As long as the staffing is correct, that's the most important thing for your Dad. And just each day that we went out there, we kind of felt that the – he wasn't getting the care that he needed to get.

And it just concerns me that nobody else picked up on this. So – you know, when accredited people go – the accreditors go out to these places, it's not just about what things have been ticked off, what they've got, what they haven't got; people should be going with their gut feeling. And I think if the accreditors are trained correctly, maybe they would pick up on things that are not right, because my gut feeling told me right from the beginning that this is not a good place. And so I have concerns with how – how well our accreditors are and how accountable they are.

MR GRAY: Thank you, Mrs Spriggs. I want to turn now to you, Mr Clive Spriggs. Is your full name – well, I will ask you to state for the record your full name.

MR SPRIGGS: Clive, Robert Spriggs.

MR GRAY: Thank you. Do you have in front of you a paper copy of document WIT.0026.0001.0001?

MR SPRIGGS: Yes.

MR GRAY: Thank you. Is that a copy of your statement, Mr Spriggs?

MR SPRIGGS: Yes.

MR GRAY: And, to the best of your knowledge and belief, are the contents of that statement true and correct?

MR SPRIGGS: Yes.

MR GRAY: Mr Spriggs, I invite you to read from your statement as you wish.

MR SPRIGGS: Thank you. This statement made by me accurately sets out the evidence that I am prepared to give to the Royal Commission into Aged Care Quality

and Safety. This statement is true and correct to the best of my knowledge and belief. The views I express in this statement are based on my own experience.

My full name is Clive Robert Spriggs. I am currently 39 years of age. My father, Robert Spriggs, died on 18 July 2016. He was 66 years old. Before he died, my Dad was a patient at the Oakden Older Persons Mental Health Service. From my observation of Dad's treatment at Oakden, I think the aged care system needs to change. I think the big issues are CCTV footage, accountability, staff training and staff levels.

CCTV cameras. My mother, Barbara Spriggs, has given evidence to the Royal Commission about CCTV footage. I support what she has said. I would like to expand on the topic we both feel strongly about. Looking back at what happened with Dad, we do not know where the bruises he got came from. If there had been CCTV footage installed at Oakden, we would have been able to find out. To this day, we still don't have an answer. I think that CCTV cameras should be mandatory in all common areas of aged care facilities. There should also be an option to have them in private areas. This should be up to the discretion of the resident and their family.

I think the benefits of using CCTV footage come from all angles. It is not just about keeping residents safe and stopping and deterring mistreatment. There are also benefits for the carer and the provider. CCTV footage creates an objective record of what happened. If, for example, a resident were to have a fall, this could be picked up by the CCTV cameras and investigated. It could eliminate suspicion against staff. It could identify why the fall happened, so that it could be avoided in the future. CCTV footage could be used for training purposes on how to avoid certain scenarios occurring or being repeated.

Another possibility is that residents' behaviour might be a risk to staff or other residents. The record of an incident might be – might enable proof that a particular resident is a risk and what their behaviour has been. This could help keep staff and residents safe.

Accountability. There needs to be more accountability in the aged care system. Despite everything that my family has been through, nobody has been made accountable for what happened to my Dad. There were people running Oakden while it was deemed an unsafe, unfit environment. Staff and management of Oakden may have lost their jobs when it closed, but where are they now? Are they in another State? Are they going to be repeating what they did to someone else somewhere else?

There needs to be a mark on their name in the system. If they want to work in another State, the new employer needs to be able to access information about them. I think there should be a national database that an employer can check to see whether there is a red flag against their name. An employer providing aged care should have to go through the process of checking the database before employing new staff.

There should be a system of accountability similar to the system of – for the medical and health professions.

Staff and training. Staff training and staff levels. Another area that I think is really important is staff training. Every resident is different. Aged care workers need to be trained to understand how different illnesses work and to understand their different characteristics. All residents cannot be treated the same by aged care workers. Dad had Parkinson's disease, Lewy body dementia and Capgras syndrome. He had a complex combination of these conditions. He had different needs to other residents. Aged care workers need to have higher order training to understand how to care for residents with more complex needs. Training should cover characteristics of particular illnesses or combinations of conditions. I think there needs to be more specialisation in aged care – in the aged care industry and people should specialise in certain areas and care for residents with those specific needs.

Overall, there needs to be more numbers of staff caring for residents in facilities. My family and I welcome this Royal Commission to create a better level of care. And we urge anyone with a story to come forward and make a submission.

MR GRAY: Thank you, Mr Spriggs. Commissioners, I tender WIT.0026.0001.0001.

COMMISSIONER TRACEY: The witness statement of Clive Robert Spriggs, dated 8 February 2019, will be exhibit 1-2.

EXHIBIT #1-2 WITNESS STATEMENT OF CLIVE ROBERT SPRIGGS DATED 08/02/2019 (WIT.0026.0001.0001)

MR GRAY: That concludes the evidence of both Mrs Spriggs and Mr Clive Spriggs.

COMMISSIONER TRACEY: I thank you both for your evidence this morning. The Commission is very grateful to you for having gone to such great efforts to prepare the statement and to come this morning to give your evidence. We thank you.

MS SPRIGGS: Thank you.

MR SPRIGGS: Thank you.

<THE WITNESSES WITHDREW [11.35 am]

COMMISSIONER TRACEY: The Commission will adjourn until 10 minutes to 12.

ADJOURNED **[11.35 am]**

RESUMED **[11.55 am]**

COMMISSIONER TRACEY: Yes, Mr Gray.

MR GRAY: Commissioners, I call Mr Ian Yates AM.

<IAN GARTH YATES, AFFIRMED **[11.56 am]**

<EXAMINATION-IN-CHIEF BY MR GRAY

MR GRAY: Please take a seat, Mr Yates. What is your full name.

MR YATES: Ian Garth Yates.

MR GRAY: Do you have before you a paper copy of document WIT.0006.0001.0001?

MR YATES: Yes.

MR GRAY: Is that a copy of your statement?

MR YATES: It is.

MR GRAY: Do you wish to make an amendments to your statement?

MR YATES: No, there are some typos but no substantive amendments.

MR GRAY: Thank you. Are the contents of your statement true and correct to the best of your knowledge and belief?

MR YATES: They are.

MR GRAY: Thank you. Commissioners, I tender Mr Yates's statement, WIT.0006.0001.0001.

COMMISSIONER TRACEY: The witness statement of Ian Garth Yates dated 31 January 2019 will be exhibit 1-3.

EXHIBIT #1-3 STATEMENT OF IAN GARTH YATES DATED 31/01/2019 (WIT.0006.0001.0001)

MR GRAY: And Commissioners, might the exhibit also include Mr Yates' identified exhibits?

COMMISSIONER TRACEY: Yes. Is what you're proposing that they form part of the exhibit?

MR GRAY: Yes please.

COMMISSIONER TRACEY: Yes. That will be the case.

MR GRAY: Thank you. Mr Yates, you are the chief executive of COTA Australia.

MR YATES: Yes. Correct.

MR GRAY: In broad terms, Mr Yates, what is your experience in the aged care policy area?

MR YATES: Both in my current role as chief executive of COTA Australia or commonly called the Council on the Ageing, I sit on a number of federal government advisory bodies, I interact with aged care consumers, providers, families, carers. We interact with organisations that represent those people and have done for many years. I've been in roughly this national role – it has changed a little bit since 2002. Before that I was the chief executive of the COTA in South Australia and had similar experience of direct contact and also representation roles.

MR GRAY: Thank you. I will just ask you about COTA. What is the purpose of COTA and what is its organisational structure?

MR YATES: The purpose of COTA, really, is to project and promote the rights and interests of older Australians. It has been doing that in one form or another for 60 years. It's a federated body. There's a COTA Australia, there's a COTA in every State and Territory. It has boards that are elected from amongst its membership and it gets – it represents older Australians in a whole variety of areas, not just aged care.

MR GRAY: Broadly speaking, could you please describe what COTA does with regard to other bodies, including the body known as the National Aged Care Alliance.

MR YATES: The National Aged Care Alliance is a non-incorporated alliance of now over 50 organisations in the aged care field, comprising peak body representatives of provider organisations. The three principal unions active in the sector, a wide range of professional – health professional predominantly – organisations, social workers and so on, and consumer organisations like ourselves.

It exists to come together and to try and work out positions about improving aged care from – principally from a consumer perspective. And COTA Australia is both an active member, has been a member since very early in the alliance's period. It what's we call a sponsor member, those are the kind of nine or 10 organisations that organise most of the work of the alliance and we, since 2012, have hosted the alliance's aged care reform secretariat which is funded principally by the Federal Government.

MR GRAY: Thank you. Operator, please bring up document COT.9999.2222.0003. Thank you. Please go to the final page of that document. Mr Yates, is that, at least as at the date of that document, which is June 2015, a description of the member organisations of the National Aged Care Alliance, NACA.

MR YATES: Yes, that would be all of those organisations whose logos and names were represented there were members of the alliance at that time and subscribed to the document to which we're referring, which is what we colloquially know as blueprint number 2 which is the description of where we think reform ought to take place in the sector from there on.

MR GRAY: Thank you. Operator, please go to the first page of the document. Mr Yates, with reference to what you just said about this document being colloquially known as blueprint number 2, is that taken from the subheading, NACA, can I say NACA?

MR YATES: NACA, yes.

MR GRAY: NACA blueprint series.

MR YATES: Yes.

MR GRAY: Thank you. What is the significance of the blueprint series to NACA?

MR YATES: In 2012 when the then Federal Government was considering the report of the Productivity Commission into care of older Australians, the alliance, or NACA launched its first blueprint, a document signed on by the then members of the alliance, which advocated for predominantly the complete implementation of the recommendations of the Productivity Commission. And were engaged in consultations with the then government and department about various aspects of those recommendations, which eventually led to what was known as the Living Longer Living Better package of the Gillard Government. So the 2015 document is, if you like, an updating of that following the implementation of those reforms and where we thought things ought to go after that.

MR GRAY: And you said that that was known as blueprint number 2. I now just want to take you to what I understand to be a partial update of blueprint number 2. Operator, please go to document COT.0000.2222.0012. I will just restate the

number. COT.9999.2222.0012. Thank you. Mr Yates, is this the document in the blueprint series which partially updates blueprint 2?

MR YATES: This really derives from blueprint 2 and was prepared with specific reference to the 2016 federal election, as it says, where it put forward in some cases quite detailed proposals with regard to matters in 2015. In some cases they take those proposals a little further but they were essentially a more detailed drilling down into what we wanted government to do in the forthcoming period or what we wanted both parties to commit to in the election and which we would pursue after that.

MR GRAY: Thank you. Mr Yates, I want to ask you about your membership of other key advisory bodies and to ask you to give an explanation of the way each is organised and the function of each, if I may. Firstly, the Aged Care Financing Authority. What is that body and its organisation and purpose?

MR YATES: The Aged Care Financing Authority is set up as a statutory body under the Act. It was part of the Living Longer Living Better reforms and its purpose is to advise government on the funding and financing of aged care. Apart from a number of government statutory members from the department, pricing commissioner and so on, and Treasury, it's comprised of nominees of the Minister against the set of categories that are set out in the Act which in my case include an awareness and representation of consumer interests.

MR GRAY: Thank you. Next, the Aged Care Quality Advisory Council. Again, what's the organisation and purpose of that body?

MR YATES: That was originally set up as an advisory council to both the Minister and the chief executive of the former Aged Care Quality Agency that ceased on 31 December to provide advice on their business. It's not a board or anything like that. It's an advisory structure. It has been transitioned into providing the same kind of function to the chief executive of the new Aged Care Quality and Safety Council. Again, its representatives are appointed by the Minister and take into account a set of experiences which includes representation, knowledge of consumer interests.

MR GRAY: Thank you. And finally, the Aged Care Sector Committee, its organisation and purposes?

MR YATES: The Aged Care Sector Committee is established by the government. Day – it was created by the Coalition Government when it was elected. By – and the then Minister was Minister Mitch Fifield. It provides advice to the Minister and government. It has a chair appointed by the Minister but the members are selected again by the Minister but are more representative of their organisations than in the previous two bodies where we're there in our own right, rather than as representatives.

MR GRAY: Thank you. You also mention in your statement your position on an advisory board of the Centre of Excellence in Population Ageing Research. What's that body.

MR YATES: The Centre of Excellence in Population Ageing Research is a multi-university centre funded under a program for centres of excellence and this one is based at the University of New South Wales. It's a high quality academic body looking at a whole range of issues to do with population ageing, probably specialising in income security but other things, and it has an advisory board which I've been on for a number of years.

MR GRAY: Thank you. In your statement you express views on the meaning of safety in the context of providing aged care. What do you consider the meaning of safety should be in that context?

MR YATES: Safety should be in the context of providing people with appropriate clinical and other care, should be the avoidance to the highest possible degree of any harm to the person.

MR GRAY: And in respect of the meaning of quality, again in your statement you express some views about the potential meanings that can be attributed to quality in the aged care context. What are your views in that regard?

MR YATES: In the context, context of quality, quality takes different shapes, I suppose, for different individuals. But that kind of underlines its feature. A key aspect of quality is that what is happening to the person is respectful, that it takes into account their personal circumstances, that their experience of the care and support they're receiving is positive and constructive, those kind of things. So it includes, for example, as does to a degree safety, but it includes cultural sensitivities, for example, but also a recognition that people have different capacities and abilities and disabilities that need to be taken into account.

MR GRAY: Thank you. Operator, please go back to the blueprint 2 document which ended in the suffix numbers 0003. And please go to page 3. Under Vision on page 3, do you see there, Mr Yates, there are words adopted, are they, by NACA in the context of the blueprint series on the concept of quality; is that correct?

MR YATES: The – if you're referring to the italicised vision, under Vision?

MR GRAY: And the words that come under there:

> *This vision places aged care in the broader context of ageing and seeks quality aged care services* –

Etcetera.

MR YATES: Yes:

That are consumer driven, have a wellness and reablement focus, are affordable for the community and individuals, sustainably providing and inclusive of the diversity of older people according to their needs.

Which is a sweeter way of saying what I just – think I said a few minutes ago.

MR GRAY: Yes. Is that a NACA-adopted definition of quality in your view?

MR YATES: Well, it's certainly a description of quality by National Aged Care Alliance because it's in our document.

MR GRAY: Can I go now to another document. Operator, please bring up COT.1111.2222.0004. This is now a COTA document, Mr Yates.

MR YATES: Yes.

MR GRAY: You refer to this document in your statement. Was this the report of a survey into the measurement of quality and consumer choice which involved surveying a number of respondents receiving aged care?

MR YATES: Yes. This was a report of a project we undertook on behalf of the department looking at the future of quality indicators. And as part of that, we undertook both an online survey of consumers and families, but also a number of focus groups, and a more in-depth study that was undertaken by one of our State COTAs through a process that they've invented called the plug-in and it was exploring what consumers and families thought about quality and safety, yes.

MR GRAY: If we go, please, operator to page 7 under the heading Quality of Life Metrics. Is it one of the features of this report that a premium was placed on survey respondents on questions of quality of life? I refer you, Mr Yates, to the second bullet point.

MR YATES: Absolutely. Let me be clear that consumers and families place a very high priority on safety and care measures, but in terms of how important quality of life measures were to them, we see in this document that being treated with respect and dignity was seen as a very high priority by 98.7 per cent of the people which is pretty close to everybody. Staff friendliness also at 98 per cent, feeling safe and secure in rounded terms at 98 per cent. Being supported to encourage and raise concerns they have with the service and food satisfaction. Independence is another. And control of your daily life. All of these are in the mid-90s. Being supported to maintain social relationships and connections with the community. All of those are really high priority measures for people in terms of how they judge an aged care service. And if they have knowledge about that, how they would choose.

MR GRAY: If we just go to page 9, please, operator, under the Quality of Care Metrics, second bullet point, it seems that to pick up on what you said about quality

of care and safety, of course, also being important, the figures around quality of life actually rated higher; is that correct?

MR YATES: This is generally true and I – but I think we need to be careful how we interpret that. I don't think anybody would choose to go into an unsafe environment. The question is they expect – the illustration I used in my witness statement was as we get on a plane we assume in Australia that that plane is going to fly safely. Our choice of airline is probably determined by a range of other factors that go to how we're treated and price and so on. What I think is also interesting though about that second dot point is the very high priority that consumers give to getting more information than is available to them today about all of these things. You know, when I decide to book a hotel, which I often do travelling, I can go and read lots of comments on their website about people's experience of that. You can't do that – or very, very rarely with an aged care provider, except selected quotes used for promotional purposes, but to really have a mechanism of consumer feedback is very rare.

MR GRAY: I will ask you some questions about that topic soon. Just staying with the concept of safety, you do give some examples in your statement at around paragraph 25, subparagraphs (b), (c) and (e) of certain quality and safety concerns. You mention medication, food and, as you've just mentioned, information. Can you explain the concerns that you understand are expressed around medication?

MR YATES: It has been a concern of ours for a long time that research and anecdotal reports indicate what we would regard as too widespread and inappropriate use of medications, in residential aged care in particular, as patient management devices for the – for the organisation and staff, when it's not clinically indicated. There has been quite a bit of media attention on this recently and cases have been brought to attention. My understanding is, and you will undoubtedly pursue this with others, but my understanding is that the research that has been done on this including by the Quality and Safety in Health Care Commission indicates that the use of medications amongst older Australians is much higher than would be clinically expected. So we have a concern that this is not an isolated thing, that it's quite widespread.

Anecdotally, talking to providers in the sector, and talking to good providers who very rarely would use drugs in that way, they also are concerned that it's quite widespread to actually deal with issues that might be being created by behavioural issues, environmental issues and so on in the provider itself. It's an inappropriate response. It's not uncommon for us to hear reports – people to talk to us, families – about what they describe as the rapid deterioration of their family member in a residential care facility, and frequently that they are drugged and that they're non-responsive. Is it – it's not the majority of people but what we're seeing is it's far too widespread and in terms of the clinical use of those drugs it's actually not what they're there for.

MR GRAY: In respect of food, you say in your statement there are consistent reports of an overall inadequate provision of adequate nutritional and attractive food in care. Perhaps it's obvious but what are the – what's the significance of those reports and what's the level of concern you have about those matters?

MR YATES: We've been concerned about this for many years and it's certainly an area of controversy. In any congregate situation I think it's probably fair to say that food is one of the most sensitive indicators for people. So even, for example, in the quality agency's consumer reports which overwhelmingly give quite positive indications of consumer responses, food is lower than some of the other responses. But our concern – I mean, this goes I think to a whole range of issues. On the one hand clearly people in residential aged care – and indeed home care but there the provision is more complex obviously – but in residential aged care people ought to be provided with high quality nutrition. Now, the nutritional needs of older Australians are specific to being older and whatever health issues they have.

In some cases that can't be provided by food in its normal state, for example, with someone with significant swallowing difficulties. But the way in which that is then provided to them can either be attractive or unattractive and in the industry there are plenty of ways of doing that and that is not always – you know, providing it attractively and so on is not always how it's done. Secondly, consistent reports all of the time of people who have difficulty feeding themselves, missing meals because no one sits with them to actually make sure that what has been worked out as nutritionally appropriate they actually take. And these kind – you know, food is fundamental. Food is also fundamental to us in many ways in social interaction.

So how that happens in residential aged care is also an issue. Does it take place in a big impersonal dining room or are there more – other ways of doing it? Is it always something that's served up or is it something, for example, that in certain services people with – people with dementia, for example, who otherwise have a capacity to do other things in their life, participate in the preparation of food. All in those kind of ways food is quite central to the quality issue. But fundamentally it's important that there is good nutrition and there are surveys that would seem to indicate that that's not a 100 per cent across the sector and it ought to be.

MR GRAY: In your statement, you refer to recent reforms that were supported by COTA regarding safety and quality. Perhaps chief amongst those is the single agency or the commission of quality and safety, but also there's a single quality framework - - -

MR YATES: Yes.

MR GRAY: - - - soon to be implemented and already on the statute books and that also was supported by COTA?

MR YATES: Absolutely. We've strongly supported those. We argued in particular with the – well, the quality and safety commission was recommended by the Carnell

and Paterson review. That recommendation bore remarkable similarities to a recommendation that wasn't implemented fully of the Productivity Commission, although the Productivity Commission also tacked a pricing authority onto the same independent body. But they recommended there be one independent body. Carnell and Paterson recommended that we supported it. An important part of Carnell Paterson in our view, and we had advocated to them, was the focus on engagement of residents, service users and families, and we argued strongly for that to be included in the bill and our arguments were listened to by government and department, and it was included in the bill and passed by Parliament as a key function of the commissioner and a key object of the commissioner to achieve that. And I think that along with transparency, which I think you might ask me more about, engagement of people is quite fundamental to the future development of this industry.

MR GRAY: Just before we go to those topics, going back to what you said about the Productivity Commission's original recommendations, including a pricing regulatory function for its proposed agency, does COTA have a position on that?

MR YATES: We certainly have a view I think that having independent advice to government – and I think I mentioned that in the witness statement – independent advice to government on pricing, that government currently is undertaking a resource utilisation study in aged care – and, in fact, announcements in yesterday's package are about resourcing a trial in that area to get a new funding instrument – but it has been a bit of a characteristic of every new funding instrument over some decades that governments give the instructions to the designers of it that it's to be cost neutral. So no one has ever sat back and actually said, what are the components of good aged care and what are they going to cost.

Now obviously that's not a precise measure but we haven't had an objective look at that and we think that would be worth doing and then looking at price movements because aged care funding has generally been funded by a Treasury-related index about government owned purpose measures that operators will consistently tell you doesn't keep pace certainly with the cost of even of indexation of wages. So there are funding pressures that exist in the system and no one periodic reviews, whether the funding that is being provided is fit for the purpose for which it is being provided.

MR GRAY: I will come back and ask you more questions about a funding model and your views on that and in particular the Aged Care Sector Committee's road map in a little while. Just staying with the new agency, the Aged Care Quality and Safety Commission, in your statement you make a suggestion that the Commission should perhaps be given additional powers. You specifically suggested an additional penalties power, what did you have in mind in that regard?

MR YATES: I think we should discuss that but it does seem to me, and it relates to comments from others, it would be worth having a conversation about whether certain measures of financial penalties, other than the complete financial penalty of no, you can't admit anybody else, you know, for the next six months, whether there are other penalties for things, but also I think – and I think of this in the context of

the work we do in financial services where we sit on ASICs consumer advisory panel and their powers, for example, to ban people. Say sorry, you can't be in this industry after what has happened. Now, you know, there are lots of legal issues in doing that but I think having a conversation about what kind of compliance and sanction powers such an agency could usefully have in the sector would be worthwhile.

I think, you know, there is the capacity to actually withdraw the approved provider status but are there others? It goes also with the other issue I raise which is what are the incentives to do well? You know, should we not just have a pass/fail system of accreditation, but actually recognise those who do far better than others?

MR GRAY: Again, I will ask you about that.

MR YATES: Sorry.

MR GRAY: No, not at all, but with respect to how one would get to the new Commission imposing either the existing sanctions powers that it has or some new form of penalty such as you propose, I suppose you would agree with the proposition that an effective avenue of complaints and follow-up with respect to complaints is critical; is that right?

MR YATES: Absolutely. The new Commission brings complaints and accreditation visits together into the one entity so there's – there ought to be no excuse for those not knitting together as information sources to government, quite – to the agency or the Commission quite quickly. But encouragement of complaints is really important. We – I mean, this is broader than the Commission. This is an industry-wide issue. We argue to providers that the encouragement of complaints is a really important quality mechanism for them, being open and really clear that you are – that you want people to say what has gone wrong. You can also ask them to say what's going right, but you want people to tell you what's going wrong so you know early and that you will tell them what happens about that and you will tell other people what happens about that and you will be transparent about it to people interested in coming to you. That kind of thing has to happen into the future in our view.

You know, it's worth noting that there's a very significant imbalance of power between a resident or a service recipient in high level home care and the provider of that service. They're in a condition where they feel vulnerable. And where there is absolutely no intention that there might be repercussions from complaining, there will be a natural fear amongst most people about doing that. That means we have to go the extra yard in making people feel comfortable about that. If that makes sense?

MR GRAY: Indeed it does, and in your statement you've expressed some views about that. I'm thinking in particular of paragraph 34 and 35. In paragraph 34 you refer to a perception that residents and families are reluctant to make complaints to approved providers. You've referred to the power imbalance. Are there other practical matters that you consider are in play and how could they be addressed?

MR YATES: Yes. So it's not all providers who widely advertise how you can make a complaint and don't necessarily take the time to go through it carefully. People may be given a pamphlet when they commence or when they're making arrangements for the service. This is a fairly traumatic time. It's about the day-to-day experience of knowing that what you might want to say is welcome. It's about being welcoming of family involvement with the care. Too many times families tell us that they've asked questions and get no answers. Now, that's not all providers, but it oughtn't be happening at all. When you talk with the OPAN representatives I'm sure that they will have examples of difficulties they've had sometimes in actually accessing aged care services and spending time with people who want them as an advocate.

All of these things are barriers, sometimes silent barriers, whereas you actually ought to be saying if something goes wrong in this place we want to know about it. We want to fix it. We want to look at why it happened. And we will tell people why that happened. And, personally, I prefer to trust a provider that says sometimes we will stuff up. We will tell you when we've stuffed up. And we will fix it and we will tell everybody about that. Because that's also a learning experience for the whole organisation and, indeed, for the sector as a whole.

MR GRAY: Thank you.

COMMISSIONER BRIGGS: Are you saying, Mr Yates, that government regulators have a – they use a veil of privacy that prevents getting to the bottom of an issue?

MR YATES: I'm not sure that – you would have to ask them if they feel that that's an impediment. There are some issues about the publication of information about complaints that we've been told relate to a particular provision in the Act that means that that – that their outcomes are not published as widely as we would like to see them happen. And – but I was really talking then about the culture for all providers. You know, I think it's tough. You know, we started this bit of the conversation with we maybe suggested there ought to be more penalties.

But, as tough as any regulator is, we're not going to have a regulator sitting in every room in every residential aged care facility 24/7. You know, all regulators miss things. The question is how do we actually raise the quality of this whole system so that providers are the front-line of encouraging complaints, identifying things that go wrong. And then they're saying to the regulator, we need to tell you that we made a mistake here. This is what we've done about it. This is what we've addressed. Did it show a weakness in our systems or did our systems actually work and pick up the mistake that this person made? That's the kind of openness that I think we need to embrace going forward.

MR GRAY: With respect to the other matter concerning publication of complaints, including by government, a specific provision you mentioned seems to be the ones picked up in paragraph 35 of your statement, which is currently displayed on the screen, in division 86 of the Aged Care Act. I will ask that the operator display

RCD.9999.0002.0014, division 86. Thank you. Mr Yates, is this the provision to which you refer? And I will draw your specific attention to the definition of protected information in section 86-1 and the fact that protected information includes information that if it was acquired under or for the purposes of the Act or another Act, and if it meets the definition that it relates to the affairs of an approved provider, then it falls within the definition of protected information?

MR YATES: That's the one. Now, I'm not a lawyer and we haven't taken legal advice on it, so you may have a view about that. But it is that provision that we have been told by the former complaints commission is a constraint on publishing information about the – about complaints and the decisions of the Commissioner – then Commissioner about complaints. If that's the case, then we think it needs to be addressed. If it's not, that it's actually practiced, then it ought to be explicitly rejected by government and there ought to be an instruction that there is much greater transparency about what happens with complaints and their resolution, which are, in the end, both important information for consumers and part of the industry's overall learning. If a decision has been made about a complaint, everybody ought to know about it.

MR GRAY: In your statement, you say that:

> *Complaints mechanisms should be broadened so that the new Commission can consider the conduct of agencies regarding My Aged Care and other pre-service delivery matters, for example, the conducting of assessments by Aged Care Assessments Teams, ACATs.*

What are your thoughts in respect of the importance of broadening the Commission's remit in those ways?

MR YATES: This is, from our point of view, just a fairly straightforward issue. When I, as a consumer, approach the aged care system, I think and move through it, there really ought to be just one channel if I want to complain about something. That's how we just see it from a lay point of view. Because of the fact that those – the Commission applies to people who are defined by that Act you had up a while ago as recipients of aged care, if you're in the process of being assessed and going through the My Aged Care process, you're not a recipient and that's not covered.

We have argued – we argued, in terms of the Commission Act, that that should be the case, that it should be broadened. It's just making it easy for consumers to not to have to say I've got a complaint about this, I have to go there; I've got a complaint about that, I have to go there. We see this as fairly straightforward. The department and, obviously, the government saw it more complex than that. As you would be aware, there's another phase in the development of the new Commission, which is the transfer of all those compliance and sanction powers from the department to the Commission, which is going to require an awful lot of work on the Act. We've been verbally told that our issue will be looked at again in that process.

We argued it to the government, to the department, to the Parliament. We argued it before the Senate Committee. It wasn't taken up by any of the major parties. I think – I would have to check, but I think it might have been included in the Greens statement. Anyway, it it wasn't – it's not put into the Act, so there are different ways you have to go about complaining. We just think it's simpler for people.

MR GRAY: That second phase that you refer to, is that 1 January 2020?

MR YATES: Correct.

MR GRAY: So there's some urgency around that issue, if that's to be done by that date, I assume?

MR YATES: Absolutely. So workers are certainly already in process thinking about how to change those functions and the amendments to the Act which are, I understand, much more complex than the merging of those two bodies, the Complaints Commission, the quality agency, which had their own standalone legislation which enabled them to be merged. Taking things out of the Aged Care Act, which has become an extremely complex document, is a significant task, I understand.

MR GRAY: Mr Yates, I want to now begin some of the precursor issues leading to the funding model and topics of that kind. In your statement, and I'm thinking in particular paragraphs 23 and 24, you refer to what you perceive to be – these are my words, really – a disconnection between the community's expectation of universal care, on the one hand, and what might be called system gaps in respect of aged care compared with, say, health services and disability services on the other. I'm assuming might one also consider dental care?

MR YATES: Absolutely.

MR GRAY: What are the gaps in the system as you perceive?

MR YATES: This is complex. I think, as in you said in your own opening remarks this morning, we live in a society where ageism and aspects of discrimination on the basis of age are still far too common. We haven't made the advances in having a whole new paradigm of what it means to be older that we have made in gender issues, disability issues and other issues. And I think that permeates our human services, as well. So we would be of the view, for example, that after age discrimination in workplace and workforce contexts, the next major arena of concern about discrimination is actually in the health system and the health services system.

Older people are principal customers of that system, but there has been a slow process of recognising that they are equal citizens in that system. It is, if I use a colloquial example, still very common to hear people say my doctor told me that's what you need to expect at your age, whereas we know that that is not always the case, and certainly with regard to things like oral and dental health issues, with

regard to mental health issues. Depression is depression at any age. It can be treated as depression. It's not something that you're more likely to catch because you've got older, as one example.

So I think that part of what we have done and historically – and I think for some years we've been moving against this, but we're still not there. With older people, we bracket them off into the aged care system which, I might say, apart from prisoners is the only institutionalised system we still have left. And older people are voting with their feet by saying I prefer to go and have – I prefer to have home care at home, rather than residential care – which is not me advocating that we don't have any residential care.

But we've expected that when people go to residential aged care, somehow everything that they have as needs will be looked after by that facility. If that's our expectation, that's not what government is funding. That's not what it's actually requiring of them to do. As a citizen, albeit I'm an older person as a citizen, I'm able to access my GP, my specialist, etcetera. That becomes harder, both because of frailties, physically getting there and so on, but also because I would say, notwithstanding some of what has been said, that many GPs don't give that the priority that they would.

Or, as I heard it said the other day, well, when I go home from my work at night and drive past the nursing home at 7.30 or 8, sometimes the nurse is busy and there's no one to hand over to. Well, why is it something you do on your way home after the rest of the day? Why is it not core business? And do we need to focus on that?

Transfers between aged care and health services are notoriously a problem both ways. And sometimes that's because the aged care provider is afraid of being accused of not having dealt with the issue, so they shunt the person off to hospital when perhaps they didn't need to be. But, also, hospitals don't necessarily discharge people back with full information. This is a notorious problem. It has been around for a long time. But those interfaces are important.

In the last federal budget, we won a program of mental health services directed to people in residential aged care. We fought for that specifically, because people in residential aged care were not being able to access the mental health services that as citizens they should be able to access. And, indeed, there is at least one major government program designed to facilitate GPs linking people to mental health plans that specifically excludes residents of aged care facilities. So that's why we need a special program for them.

But as you – as this Royal Commission goes through its work, I think the dynamic between what degree of health care, mental health care, dental care, etcetera needs to be inroaded into residential care or how do we change how people in residential care access those services is a critical issue. And it's not conducive of a silver bullet answer. And, as I've tried to say by my comments about ageism, it's multi layered in why it happens like that.

MR GRAY: Thank you.

MR YATES: I could give you some silver bullet answers, but, to be honest, I think it is a complex issue that I hope this Royal Commission will shed light on and give government and the community clear choices about how we're going forward, because if we want everything in aged care, we're going to have to fund it quite differently.

MR GRAY: One topic I just notice that you didn't mention specifically was the NDIS. But in your statement you do refer to that in part, in respect of this idea of the differential funding treatment that different services or different areas receive.

MR YATES: Yes.

MR GRAY: What are your views on that?

MR YATES: So we need – I always find I need to say, when we're talking about the NDIS, of which I'm not an expert, but with which I'm reasonably familiar, we need to remember that the NDIS doesn't cover the needs of everybody with disabilities in our community. Indeed, in disability that's becoming an issue, because services have been withdrawn in some States to put into the NDIS when other people with disabilities still need support.

But, in terms of older Australians, if you acquire a disability at the age of – a severe disability that would qualify you for NDIS support at the age of, say, 64 years and 11 months, you're eligible ; and if it's at 65 years and one month, you're not eligible and it's assumed the aged care system will look after you. Well, the aged care system actually isn't set up to deal with the kind of high levels of support that many people receive in NDIS.

MR GRAY: And what difference does that make to the individual?

MR YATES: Well, to the individual it would, obviously, mean that they either have to pay for levels of service that they would have – been paid for them by the taxpayer if they had acquired it a few months earlier, or it means they don't get access to it, or – and/or it means that there's pressure on aged care providers to provide a level of service that they're not funded for. And I – you know, I think – I think we need to work those things through pretty carefully.

There's a real challenge – and I haven't said this in the witness statement, but there is a real challenge going forward in this country, because of the very strong preference for people to receive care at home, we have let the four levels of aged care, home care packages – the Tune Review recommended another level. Let's say that the cost of care component is the same whether it's a package or in residential care, which is actually what the roadmap says that you're going to come to – what happens if I want to stay at home and the cost of doing that is going to be higher than it would be in residential care?

We need to have a conversation with the Australian people about what we're doing with aged care, because if you pursue that line, the line leads itself to a pressure for an NDIS – for older people to stay at home, even though that's going to cost quite a bit more than residential care. Now, the cost of that would be substantial. What do we – what are we prepared to pay for and who pays for it? Those are the issues. Now, there are not snappy, easy answers to those questions, but we need a much more honest dialogue about that in the community.

People – and I've mentioned the NDIS in the statement, because there are people who are used to a universal health system, who are used to other universal services like pensions and so on, means tested, but otherwise universal, who assume that's what happens when you go to aged care and then get a shock when they discover that, actually, they're expected, if they have means, to pay. We're not as clear about that in advance, partly because the community doesn't like to talk about aged care.

MR GRAY: I want to go back now to a point that you've raised in a number of places in your statement around long wait times or queues or waiting lists, in particular in respect of home care. And I'm thinking here of paragraphs 22, 25(a) and 53 of your statement. What do you consider the issues causing the waiting list in respect of home care packages, and is there some connection with what you've just been telling the Commission?

MR YATES: If you go back over the history of the aged care system in Australia, you will find that right back into the '50s and onwards there was a recognition that people had a preference for staying at home and receiving supports. Quite small programs were developed for that purpose. Even originally, Meals on Wheels, for example, was a response to that kind of service. And then we developed a more sophisticated and wider programs. The Commonwealth developed the Home and Community Care Program in the mid-80s, which is a joint Commonwealth/State program, provided supports. Then we invented home care packages. So we've gone on more and more lifting the level of care that you can bring into the home.

And we knew that there was more demand for that, more need for that, than – it was commonplace for people to talk to us about long waiting times for a level 3 or 4 package. But all the packages were distributed to providers. So you might be, as an individual, on four or five waiting lists around the country because you were trying to find a provider that had a package for you. In February 2017, a new system, which we strongly supported, came in, which is that the package is assigned to you, not to a provider. The logical consequence of that is that the Commonwealth, who's doing the assigning, has a waiting lists. So all those waiting lists got consolidated into one list and ,whoa, all of a sudden we had a measurable waiting list.

There are some people, I think, in politics and senior public service circles, who think that was one of the worst public policy decisions for a long time, because it did exactly what it has done, which is it applied pressure onto the Commonwealth to catch this up. What I think that told us is this has been a really remarkably successful experiment in the provision of high level home care, because people want

it. There has been a shift, a quite seismic shift, in preference for that, against residential care. Overall globally, we do not have a waiting list for residential aged care. We do have waiting lists for really good residential aged care. And that's something we can talk about later, because that's an issue. The expansion of those services is an issue into the future.

Collectively, we actually have the highest vacancy rate in residential care we've had for a long time. And we have this growing home care packages ..... it is a preference. It caught government by surprise. The number of packages that were in the system when that list was consolidated – and there were no more people who joined the list overnight; it was just a consolidation of lists. The number of packages that were in the system and coming into the system were set in the Living Longer, Living Better reform in 2012, which was a 10 year reform.

And, like many new initiatives in government with funding constraints, a lot of the extra packages were what is called the out years, that is, after the forward estimates. So they're in the back end six years of Living Longer, Living Better, not the first four years. They flow through. Clearly, they were inadequate. And, over the last 13 months, as of yesterday, the government has either inserted into that or brought forward 40,000 packages into the future – into the current time. That still doesn't make up the list. If we made the jump to get rid of that waiting list or bring it right down – we've suggested in practical terms no more than three months – then I think demand would be quite predictable after that. But this switch in preferences has taken government by surprise.

MR GRAY: I want to ask you a couple more questions about that just before the Commission rises. Operator, please bring up COT.1111.1111.0002. Mr Yates, this is a document in which COTA has, amongst other things, done some work and set out some recommendations on the waiting list issue; is that right?

MR YATES: Correct.

MR GRAY: Could I ask you to go to page 8. I will come back to this document later in your testimony, but if we just go to page 8 on this question of the waiting list. This is in a series of recommendations or initiatives that you say are pressing; is that right?

MR YATES: This document was produced and released, I think, in September – yes, September last year – quite explicitly to follow-up the conversation I had had with the Prime Minister when he announced this – when he was announcing this Royal Commission, just before he did announce it, about ensuring that reform initiatives that were in train already, given we've had a number of reviews, not stop, but that the Commission would then look at them and see are they adequate.

And this document plucked five fairly immediate issues – and I could have made it 10, but journalists don't like more than five. In fact, they kind of prefer three. And, clearly, we were about influencing opinion. So one of them, as you said, was that

more home care packages should be inserted so that older Australians never wait more than three months. Now, we put a figure of 30,000 on that. And we did that with – by an arithmetic look at the list. And that wouldn't mean ..... clear, that everybody would get within three months the package they were assigned, but they would get some kind of support.

I don't know, because the department doesn't know, the experts don't know, how many packages you have to put into the system to meet that three months targets. And, for us, it's the three months target. Right now, if you're assigned a level 4 package, it's likely you will be told you won't get it for a year. Now, you may well pick up some lower level support before then, but I think in modern Australia if we're saying – and this is the government's assessment service – yes, you need a level 4 package, waiting any longer than – even waiting three months is a challenge, but waiting any longer than three months is not acceptable.

The pressure it puts on people, on families, the implications for health that flow through into hospitals, the implications for premature admission to residential care, all of those things, actually mitigate against setting good public policy. But, as I said, the challenge for government is how do you get that many extra aged care packages into the system in a hurry when you've set yourself a target of having a surplus in the budget, as well?

MR GRAY: I just ask the operator to go to page 11 on an aspect of the analysis that underlay this in the document. Operator, the third paragraph on page 11. So, without taking into account the government's announcement of bringing forward funding yesterday, was this COTAs analysis as to the practical consequences of the waiting list on older Australians assessed as needing higher levels of home care at the time?

MR YATES: Yes. And we were drawing there from the government's own home care packages program and data reports, indicating that people might wait six to nine months before being offered any level of care. And often that's level 2. The reason it's level 2 is because before there were four levels, there were two levels, and the most common package, what were called community aged care packages, and there are lots of them. And then they might wait longer for a level 4 package. That time is coming down, because not only is there an announcement yesterday, there was an announcement in ..... last December, as well, of another 10,000 packages. So they're coming, but - - -

MR GRAY: Just - - -

MR YATES: - - - we would – sorry – those kind of waiting times are unacceptable, in our view.

MR GRAY: And just to pause there, on the levels that you're referring to, home care packages have four levels I think you said.

MR YATES: Yes.

MR GRAY: And, just briefly, do they go in terms of assessment of greater need starting at one that's lower - - -

MR YATES: Yes.

MR GRAY: - - - levels of need? Two is a little higher, three is higher again, and four is high need?

MR YATES: Yes. So they run, from memory, in the 9,000s to 50,000s from levels 1 to 4.

MR GRAY: In amounts of dollars that are - - -

MR YATES: Dollars, yes. Of dollars available.

MR GRAY: - - - available in terms of .....

MR YATES: And there are lots of complexities about paying for them and so on, but – having your co-contributions. But, yes, they are – so level 4 is the highest level. And, as I said, the Tune Review recommended that government consider a level 5.

MR GRAY: And with respect to the announcement yesterday, has COTA had time to analyse what the effect of that announced, bringing forward of funding, will be on the wait list?

MR YATES: No, we haven't. The announcement yesterday is really, effectively, bringing forward another 10,000 packages across all levels. So one of the effects of that – I can't go into precision, but one of the effects of that is that you get more packages – sorry – for the dollar values, governments getting a mix of packages that mean that some people have been assessed, so the 3 or 4 might get a 2 faster then it's said in here. But the previous 10,000 and the previous 14,000, from memory, and the six before that were all high level packages, 3s and 4s, because that's where a lot of the demand has been.

There is a lot more work to be done to understand the composition of that list that's called the waiting list. There are some people on there that have been assessed that actually don't want to proceed to a package at this point of time. There are clearly – and I'm not using this as an excuse for government. There are clearly people who have been assessed, because the assessors have told people this when they were asked, they've been assessed as a level 4 who don't need it at the moment, but, because of the waiting time, they assess them as a level 4 in anticipation of how long they would have to wait.

This kind of contrasts with another part of we argue, which is that we actually need a more re-ablement wellness approach to people anyway, rather than assuming that they're on a conveyor belt where it's going to get worse and worse. This is complex stuff, but these packages – these announcements by government will all help, but they won't solve the problem.

MR GRAY: Commissioners, is that a convenient time?

COMMISSIONER TRACEY: Yes, it will. The Commission will adjourn until 2 pm.

ADJOURNED **[12.59 pm]**

RESUMED **[2.00 pm]**

COMMISSIONER TRACEY: Mr Yates, would you return to the witness box, please. Mr Gray, have you completed the section of your questioning that relates to the packages and the delay in delivering them?

MR GRAY: Yes, I have, Commissioner.

COMMISSIONER TRACEY: Yes. Well, before you proceed, Mr Yates, you were giving evidence earlier about the extra 30,000 packages that had been brought forward. Presumably that is only going to be a realistic solution if the resources, personal and otherwise, are available to provide the services that go with those packages? Can we be confident that those resources are available? Because presumably if they're not, then any reduction in waiting time is not going to materialise.

MR YATES: That's a really good question. I – and we don't have a clear evidence base to answer that, but my intuition – my intuition from my own experience and talking to colleagues in the sector is that in terms of the packages that we've been – that have been brought online either by addition or bringing forward, we should be okay with those, but I think that's a really interesting question if you tried to cover the whole gap at once. To scale up to that degree of staffing, noting that there's competition between aged care sector, the disability sector – I mean, the NDIS is a very major employer and expanding employer – and indeed parts of the health system. And the recent report of the Aged Care Workforce Taskforce suggested – based on a number of metrics it did on comparators of wages in different sectors and looking at international comparators – that the aged care sector overall is underpaid by a factor of at least 15 per cent, that's a real challenge, yes. And I think getting that stuff right is going to be a very important part of the focus and outcome of this Commission.

COMMISSIONER TRACEY: And looking ahead, presumably there is going to be an ongoing and increasing need for qualified personnel to deliver these services. Are you able to give us any indication of whether the necessary training courses are in existence, whether the enrolments in those courses are going to be adequate to meet future needs?

MR YATES: I think you will have witnesses who will be better positioned to answer that in detail, but overall I would have to say that even going back to the Productivity Commission report and anecdotally now and in terms of the Tune report that – and the workforce report, there are concerns that not all of the courses out there for, say, certificates III and so on are adequate and that there are components of those courses that are frequently absent. I think you will probably hear from colleagues in – from Dementia Australia that there are issues about dementia-specific training not being present in all courses, whereas given the nature, you know, the prevalence of dementia in aged care, our view would be it ought to be compulsory in all those courses.

So I don't think there are – but I do think that the implementation of the recommendations of the taskforce on workforce, which have now – that implementation is starting – that that's really important and encourage the Commission to inquire of people in that sector about that implementation and their plans going forward. But I again think in terms of potential enrolments we need to look at the competitive position of aged care in the work forecast, in the marketplace. If it's being underpaid then people are going to go elsewhere. And as we learnt – as we learnt – I've referred to the competition, if you like, in like sectors, so in disability, in health services.

What we learnt, for example, in the mining boom in Western Australia was that people went to a totally different industry, i.e. mining. Maybe they cooked in an aged care home and then they went and cooked for three times the amount of money in the Pilbara. So those issues are still there as well, and therefore I think there are issues about whether we need to give more attention to aged care in migrant intakes, for example, but then we need to give attention to things like culture and language training if we're doing that, too.

COMMISSIONER TRACEY: Yes. Thank you, Mr Yates. Yes, Mr Gray.

MR GRAY: Thank you, Commissioner. One question arising from those answers, Mr Yates, you mentioned the Aged Care Workforce Taskforce and I understand there was a report of that taskforce. What's that body, its organisation and in brief terms what was its remit for that report?

MR YATES: The Aged Care Workforce Taskforce was established by the Minister for Aged Care, Ken Wyatt, to report to him on the current and future needs of the sector and how to develop them and it produced a report in the middle of last year to the Minister which he released, from memory, in August or September, without checking – which had a set of 14 recommendations which I assume the Commission

will have and be familiar with. And those are about what the industry itself should do as well as what government should do, but it will go very much, I think, to the question of funding of the sector because as I've just said in answering his Honour's questions, you can do the training and so on, but if you're not paying par, you're not going to attract people. That's a reality. I mean, we need people who want to come into aged care for a vocation but are we going to actually ask them to do it at a discount.

MR GRAY: I want to now go to another document, one you've already mentioned, that's the Aged Care Sector Committee Roadmap.

MR YATES: Yes.

MR GRAY: We're now displaying RCD.9999.0002.0001, and Mr Yates, you mentioned you were on this committee.

MR YATES: I am on this committee and indeed I was on the subcommittee of this committee that developed the roadmap.

MR GRAY: Thank you. Broadly, what is the roadmap designed to lead to?

MR YATES: The roadmap was developed at the request of the then Minister for Aged Care, Mitch Fifield, who – he had another title but he was responsible for aged care – to – following his decision to implement a number of reforms, including the decision that by February 2017 home care packages would be put in the hands of the consumers, so it was an important step. And he asked the sector committee to develop a roadmap about the other reforms that needed to be done, either that hadn't been addressed as a result of the Productivity Commission report or subsequently felt they were needed, including in residential care. And the roadmap was an attempt to spell out a destination for the reform process and then some way points along the way. So after two or three years we should have achieved this, after five years or something, we should have achieved this, after 10 years we should have achieved this.

The value of the roadmap in that sense was to try and describe the destination. And I don't want to be facetious but there are many people in the aged care system who have been watching as reports and reviews are implemented who are asking, "Are we there yet?" Well, the roadmap was an attempt to say what would being there mean and then what would be the steps that were realistic to get there. The Aged Care Sector Committee has been chaired for some time now by David Tune who did the Tune review, but whose final full time work with the public service was a secretary of finance and he has a realistic perspective on what steps are needed to – you can't reform everything at once overnight. So that's what it was about.

MR GRAY: If we go to page 4 – thank you – if we scanned on the destination column, I take it that at a glance, Mr Yates, the descriptions in the Destination column are the destination you were adverting to a minute ago.

MR YATES: Mmm.

MR GRAY: And if we go to What Care is Available, it's in red - - -

MR YATES: Yes.

MR GRAY: You see there the destination is said to be a single aged care and support system that is market based and consumer driven with access based on assessed need. That's an example of one of the destinations, is that so?

MR YATES: Correct.

MR GRAY: And could we, operator, please go back to the keep fixing document. That's COT.1111.1111.0002. COT.1111.1111.0002. Thank you. If we go to page 6 of that document – thank you. At the top of that document you refer to the aged care roadmap, amongst other documents, including the blueprint documents developed by NACA, and I just ask you to comment on the last full paragraph on that page. Do you see there:

> *However, COTA is acutely aware that the journey to a more consumer-controlled system is far from complete.*

Is this a shorthand description perhaps of the intended effects of the destinations listed in the roadmap and comment that that journey is far from complete?

MR YATES: Well, that journey certainly is far from complete in two senses. One, the greater consumer control has been achieved in principle in home care packages when they're assigned to the consumer, but whether that's fully able to be exercised is dependent on a number of factors, including the amount of information that people can gather, and as I said earlier today, the power and balance between a consumer of service and the provider services is profound, and if the consumer – if the provider is not inclined to be responsive to consumer needs, not all consumers know what to do about that. So they still find themselves offered menus or told they can't have things that they want even though they're supposed to be in control of those packages. In residential care, of course, we don't have that situation yet.

The government made an in-principle decision after a lot of lobbying from us at the last budget to do that and called for an impact study to be done which has only just started, although the budget came down last May. We are a long way from having the kind of information provision, transparency, confidence of consumers and regulatory environment and as I've said before and as these documents say, a key part of that is changing how we allocate particularly residential care places so that good providers can expand and if the funds are in the hands of the consumer and we stop regulating how the providers expand or only regulate them in a lighter way, let the good ones expand, and put the pressure – so that a poorer provider is not only under regulatory pressure but they don't get customers.

MR GRAY: It's a very important point that you make, but there's a distinction between the status with respect to home care packages and residential care places, and do we understand the position to be that your evidence is that with respect to home care packages it is now the case that those packages are allocated to the consumer, not to the provider, however there are information issues around whether they can be utilised.

MR YATES: Yes.

MR GRAY: With respect to residential care, those places are still not allocated to the consumer.

MR YATES: Correct.

MR GRAY: They remain the subject of allocation rounds.

MR YATES: And there are two – you know, there are two issues here. One is the sense of control, ownership that a consumer has if they are holding the package, remembering that many of them – most of them – well, all of them are making some financial contribution. Many are making substantial contributions.

Anyway, so it's actually completing the circle for them. But the flip side is that it means you change what's called the aged care approvals round method of allocating residential care places, which is what constrains a provider. A good provider who knows that they could expand in a certain area because the provider operating there is poor in quality and they could actually take them out of the market. But they can only do that if they win beds in an annual approvals round. And, in the meantime, that poorer provider has still got the beds that they got some time ago, haven't been kicked out of the industry, but, you know, are just scraping through.

MR GRAY: Does that mean the system is missing out on using competition as a tool to advance quality?

MR YATES: Yes.

MR GRAY: I would ask that you refer to paragraph 48 of your statement. Perhaps if that could be brought up on the screen, as well, please, operator. In this paragraph you refer to one of the aspects in which there seems to be delay in the implementation of steps to reform the system in the manner you've described. And you make specific reference to Aged Care Allocation Rounds, ACAR. ACAR.

MR YATES: ACAR, yes.

MR GRAY: What is the status of the review you mentioned a minute ago?

MR YATES: So the impact analysis of allocating residential aged care places to consumers instead of providers, to quote the budget document, was commissioned

very late last year, and has – well, is just starting work, in fact, either tomorrow or the next day. I'm having one of the first meetings with them to look at it. That's being undertaken by Professor Mike Woods, who is currently at the University of Technology Sydney, but was, in fact, the presiding Commissioner over the Productivity Commission's inquiry into care at home and assisted by Stewart Brown, who are consultants and accountants in the sector, to look at how you would do it.

Because everybody agrees that you can't switch the system overnight, because you've got approvals in place and so on and you would need preparation for it. But it's quite possible to spell out the steps for that to happen. And I understand that review is reporting by mid-year. So it will be interesting to see what happens. We had been hopeful the process might be fast ever than that and we could look to government making an announcement in the forthcoming budget that they were progressing in that direction, but that will be a bit slower than we had hoped.

MR GRAY: And you suggest in your statement that the impact analysis should be the subject of a report by about the middle of the year, do you?

MR YATES: My understanding is they're reporting by the middle of the year, yes.

MR GRAY: When you mentioned the impracticability of switching overnight from the allocation of places to providers in particular regions – that's the case, isn't it, these allocations - - -

MR YATES: Yes.

MR GRAY: - - - are in particular regions?

MR YATES: They're generally done in regions, yes.

MR GRAY: When you mentioned that topic, you said it couldn't be done overnight because there were approvals in place. Is it also the case that there has got to be analysis on the potential impact, in the sense of determining whether, perhaps in particular regions, there are sufficient – a sufficiently deep market to be able to provide the services on the premise that the reform might occur and the places might be allocated to consumers, rather than to approved providers directly?

MR YATES: Part of what the impact analysis will look at is areas, say, extreme rural and remote areas, but also areas of so-called thin markets where there might not be a lot of competition. I would make the observation that the fact that you have an ACAR in place does not guarantee – and even the fact that people bid for and get beds – does not guarantee that you end up with live beds in thin market areas.

The real question over time is going to be what does it cost to deliver the same cost – same level of service when you don't have, perhaps, the scale of number of beds and so on that you would have in a competitive metropolitan area? What is the cost to do that? And that needs to be priced, whatever system you've got for allocating it.

You've either one of two things. We're either expecting people to run it at a loss, which doesn't work for very long, unless you're cross-subsidising – and I think you would find that some of the church agencies operating in remote areas are cross-subsidising from the rest of their operations.

Or you end up with, as I'm familiar with, ACAR places are allocated into those regions but people don't bid for them. They're areas where there are shortfalls for the very reason that it's not economic. So having a regulatory system that says that's how we will hand the beds out doesn't guarantee that people are going to build there, if it's not economic. There is a costing issue as to what are we prepared to pay for having those kind of services available in areas where, compared to the rest of the system, it's not economic to do it.

MR GRAY: Thank you.

COMMISSIONER TRACEY: Presumably, this system will only work effectively if the consumer can make an informed choice.

MR YATES: Correct.

COMMISSIONER TRACEY: And, from what we know of the system at the moment, there's no basis on which that informed choice can be made. There may be anecdotal material available to a particular consumer who would, therefore, seek to go to one institution rather than another. But, surely, the advancement will only succeed if there is information out there that allows the consumer to decide, "I would rather go to this place, rather than that, because it offers a higher quality of service"?

MR YATES: That's correct. What I would say is that the amount of information and the channels for the information are currently inadequate. And – but there are plenty of people who do make those choices. And the grapevine often works well, even though it also oftentimes it doesn't work. Well but the grapevine often works quite well. There are some very good providers in Australia that you just can't get into because everybody know that is they're very good and you can't – I mean, obviously, people do get in there. What I'm saying is they would have a capacity to expand and the ones that you go to because you can't get in there would start to feel the real pressure. And, you know, that's irrevocable.

Now, in terms of the rural and remote areas, again, I might say, if we have to look at other means to get them in there – and, you know, there are lots of different ways, but in the end it's – in the end, frankly, it's about what you're prepared to pay. So a mechanism has been suggested that the government would hold what are called reverse auctions. People bid for how much they would provide the service in that area for, the best price for the best outcome wins. I think, as I said, you can regulate that government will hand out the bed licences, but you can't make people build if it's uneconomical.

But yes, we need better information. So the points I've made before about government requiring providers to publish information is important. In our witness statement we talk about that. And we note that although in the home care packages area, as opposed to resi, at the moment, the Minister required providers in that area to make services and pricing information available by 30 November. My understanding is that 40 per cent of the sector has so far failed to do that. So it's a bit like answers to the Commission's questionnaire. I think there needs to be a bit of a spotlight on why people are not doing that.

MR GRAY: Thank you. I will ask the operator to put paragraph 69 of Mr Yates' statement on the screen. Mr Yates, in paragraph 69, you urge the Royal Commission to obtain detailed modelling of costings, including government contributions and user co-contributions. You contend, in effect, that there should be a focus on putting a price on the amount of funding needed to meet community expectations. What do you mean by modelling of costings of government contributions and user co-contributions in that context?

MR YATES: Okay. So what we're saying is that – and I referred to this in answering some of your earlier questions – that we don't really know whether, what government – what the total amount that providers are receiving is adequate. And if I can just make a brief segue in that respect. One of the really important questions is the different performance of different providers in the same regulatory and financial environment. So I was asked recently by the media, in fact, I think outside of the Commission's directions hearing, by the media if poor medication was caused by understaffing caused by poor financial – you know, inadequate financial support and my answer to that was unequivocally no.

There may be financial pressure, but there are providers out there that do not overmedicate, who have good responses, who have good staff training and lack of turnover, who have – who work with people with difficult behaviours very productively. And they do that under the same government financial regime and the same pricing and all that that the others do. So it may well be that pressure is put on the system, if it's not adequately financed, but that is not a cause for poor behaviour. So I just wanted to bracket that.

But the answer is we don't really know what the total amount of resources required to do the job are. And, in that context, what proportion should be being paid for by the government, the taxpayer, which is, in the end, a subsidy to our care and in many cases to our accommodation, and what should be paid by individuals who have capacity to pay. And, at the moment, we do not have a coherent policy about that.

In very practical terms – I will give you two examples. As we discussed earlier, home care packages have levels 1 to 4; they're of different financial value. But a provider can charge the same user contribution for each level, up to 17 and a half per cent of the pension. That's a legacy issue from when we only ever had one level of package. Should have been fixed, hasn't been fixed. That ought to be proportioned:

you contribute 20 per cent. If you can't, fine, but that's what we expect you to do. People complained for that.

In residential care, if you are a single and living in a home you own, the value of that home will be assessed in your means test when you're going into residential care, but only up to $167,000. Now, if you live in rural Tasmania, that's the bulk of the value of your house. If you live on the lower North Shore in Sydney, it's the difference between what the real estate agent will quote you as the top and the bottom of what you're likely to get for the house. Where's the equity proportion in that? Whereas, if we said in the means test we will take into account 40 per cent of the value of the home. Just – I pluck that figure out of nowhere.

We need a coherent system that people understand, can plan for and passes, to use the colloquialism, the pub test about what's fair in our country. People might not like paying more for aged care, but in our dialogue with consumers they say I will pay more on two conditions: I get better care and it's fair. And people know the system isn't fair now. And it then distorts behaviour, because you get people who accumulate packages on the Commonwealth Home Support Program, which is not what it was designed for, with, as you noted in your introductory remarks, much lower fees, who don't want to move to a level 1 package, because they could be charged this amount of money.

MR GRAY: Looking at paragraph 69 of your statement, you make a point which, in effect, clarified, in the answers you've just given, about constraints on resources available in the system. I'm not saying you've referred to all of the constraints, but you've referred to some of them. That's so, isn't it, Mr Yates?

MR YATES: Mmm.

MR GRAY: An you've said there aren't sufficient resources available in the system. You seem to be suggesting in the first sentence that there could be an impact on quality from that. Elsewhere in your statement, though, you made a point, and you made it in your oral evidence a minute ago, that funding issues can't be an excuse for poor service provision or unsafe service provision. And you made the point that a number of operators have very different performance levels, even though they 're existing in the same – existing and operating in the same regulatory and funding framework. Now, that's a long lead-up to a question: who is responsible? Who's responsible for the provision of quality aged care?

MR YATES: Okay. In terms of what I said there, obviously if the government cut its subsidies for residential aged care – just leave residential for the moment – by 50 per cent overnight, I would say that is a significant risk to safety as well as quality, right, because there's not that amount of slack in the system. We are suggesting expectations that the community has of the aged care system that we say require a higher level overall of resourcing than the system is by and large getting now. So within those kind of parameters, I think government – governments have a clear responsibility to define what their subsidy is supposed to be buying and that they

have an evidence base that what they're offering can buy that. Does that make sense? Governments have a clear responsibility.

But providers have a clear responsibility also for being clear about what they're offering their customers. What they're holding out that they can deliver, and for delivering that. And in terms of very basic safety issues, in the way our system is right now, lack of resources is never an excuse.

MR GRAY: Thank you. In your statement you refer to the current pass/fail approach to accreditation, and before lunch you referred to this in one of your answers and I said I would be asking you a question about it. I will do so now. Mr Yates, you seem to suggest, and I'm thinking here of paragraph 25 at the end of your paragraph there in your statement, and also paragraph 33,you refer to this pass/fail approach to accreditation, and you suggest that it generates a lack of incentive to strive for excellence once ACAR places are obtained by a particular approved provider in a residential context. You are criticising the lack of incentive to strive for excellence and my question to you is: why is it that the current approach is inadequate in your view and what could be done to improve it?

MR YATES: So, we are interested in building incentives for excellence into all aspects of the system. So I guess I've referred to that financially, that is, if I'm doing a really good job and I've got long waiting lists, why can't I expand and grow and, you know, be more dominant in my sector. That's one set of rewards. Another is if I'm being assessed as to the quality, measured against the standards, and the agency has a sense that not only are you doing this to the level that we would expect you to do it, you've gone far and above that, you know, you are really spotless and the way you're doing it is exemplary. Why cannot they give them, if you like, to be a bit blasé about it, a star?

In the UK there is actually a system that says, no, sorry, you failed or you're okay but you've got quite a lot of improvements and these are the improvements we require, or you're fine, or actually you're above and beyond. And that is also then information to consumers about this lot. They've got five years where they've been assessed as being above and beyond. They're worth a look. Whereas this one here is struggling. That doesn't mean that people wouldn't go to one. I mean, for a start there may be financial differences between it. But I just think we could look for some indicators of that as well similarly to what we get in other rating systems, consumer rating systems in other areas.

MR GRAY: What's the thinking of COTA on the metrics that would be used?

MR YATES: I – we think that they're – firstly, that there's a need to do some pretty rigorous work collectively and I would just say at this point that COTA is a very under-resourced organisation with a very small number of people and to do that by ourselves is beyond us. But we would be – we have made the offer to government and providers to sit down and work out how to do that, but it would be a combination

of, if you like, measures that the – that the Commission had about what passes for doing the basic, acceptable or the even better.

MR GRAY: This is the Aged Care Quality and Safety Commission.

MR YATES: The Quality and Safety Commission, sorry, not this Commission, that Commission, who are doing the inspecting. In some areas there would be some pretty objective tests if you look at the standards. But in others it's actually interweaving into that of assessments from consumers and families as to how they think it's going. You know, you can do a number of measures in terms of dignity and respect, but in the end the people who know whether they're being treated with dignity and respect are the people who are receiving the care.

MR GRAY: I understanding there is a program called the National Aged Care Quality Indicator Program. What's COTAs views on the sufficiency and participation of that program?

MR YATES: The National Aged Care Quality Indicator Program is the program that measures the three criteria of extreme weight loss, sorry - - -

MR GRAY: Yes, I understand it's weight loss, I understand it's the use of physical restraints.

MR YATES: Physical restraint and one other, measures those three measures, it's a voluntary program. Yesterday in its announcements, the Government announced that's going to become a compulsory program and that they are going to add additional indicators. And it stands to reason that you need some additional indicator – round those out, three was always in our view insufficient and potentially liable to give – I mean, when you measure physical restraint and you don't measure chemical restraint you set up a bias to not physically restrain but you're not measuring chemical restraint, so we are looking for A, something in that area but B, to consult with the Government, which I'm sure they will, about what those additional indicators should be.

So those are part of measuring the safety, the care issues that we talked about earlier. They don't give us that quality comparator. They're an essential part of it, they're necessary but they're not sufficient to good quality.

MR GRAY: Thank you. You may already have addressed this in the course of some of your other evidence, Mr Yates, but in your statement you refer to a lack of financial equity. I think you have addressed that on the issue of contributions with respect to the various services we've been through so I will move on.

MR YATES: Yes, there are, just very quickly, another one I want to address is a by-product of the waiting system in home care packages.

MR GRAY: Yes.

MR YATES: In effect, what we are doing is saying to people who have been assessed as needing care but can't get into the system that you are for the time being means tested, having to pay 100 per cent yourself. If you want the care that we've assessed you need, you will have to go and buy it. Some of the people on the list could do that. As are some of the people in the system now, could have paid for it themselves. But many of the people waiting on that list can't, so either they or their family go into debt to do it or they don't get it or they buy it from people who aren't accredited and may be questionable in terms of quality.

So there's a financial equity in the way that our not having uncapped supply operates. It means that those people are all automatically means tested as having to pay 100 per cent. It's a subtle point but I think it's an important point to understand, that people without means assessed by government as needing care aren't getting it unless they pay for it themselves, whereas people with means are getting it.

MR GRAY: In the roadmap document, I will ask the operator to bring that up again. Thank you. On page 3 there's a description of the particular objectives. They're not numbered off but there are nine of them. And on the next page there is the document or the page I've already shown you.

MR YATES: Yes.

MR GRAY: And my question is: is it the case that the objectives can be advanced and promoted and implemented separately, one from the other, or are they all interrelated? For example, if you take the objective concerning a single aged care and support system that is market based, to which I referred you before, which is about the fifth - - -

MR YATES: Yes.

MR GRAY: - - - objective or destination and also if you take the seventh one which touches upon the matters that you've just been adverting to around potential funding issues and it refers to the sustainable aged care sector financing arrangements where the market determines price, those who can contribute to their care do and government acts as the safety net and contributes when there's insufficient market response. Is it the case that you can't advance to those destinations without (1) empowerment of consumers with information and sufficient means to navigate the system being promoted first or at least in tandem with those other objectives?

MR YATES: I think, while obviously – well, obviously to me it's possible to advance towards each of those destinations, not absolutely equally at the same time but in the end you actually need the whole lot, they're a package. And arguably there are one or two more if we reviewed it again. And if I might just for a minute say, I've become somewhat cautious lately about using the term "market" in this context because it then sometimes gets critiqued as total deregulation. Nowhere do we, or indeed other advocates – most other advocates that I'm aware of – advocate a substantial deregulation. We're proposing a differently regulated system in which

consumer pressure applies competitive pressure onto providers but not a deregulated market environment. But it is true, for example, in terms of the one you have on the screen at the moment that there would be some market testing about what a price is but within clear parameters that government would set. This is a care industry after all.

MR GRAY: And, for example, when you say that it would be differently regulated, regulation would remain, do you have in mind, in particular, safety and quality?

MR YATES: Well, the whole safety and quality regime has just been lifted by creation of the single Commission which will be expanded again, the new standards which I think are stronger and hopefully more effective, the single quality regime, unannounced visits, all of that stays. That's 125 or 150 per cent backed by us. It's really about saying that one form of regulation has outlived its usefulness and that's about the allocation of places. But also to give really strong signals across the system that consumers are in control and that means providers have to provide information.

MR GRAY: Thank you. In your statement, in a number of places, you say that – you variously describe it as case management, sometimes navigation, assistance about navigation and access. These were things that were always recommended by COTA as integral to what became the My Aged Care portal. And you say that this is an integral element that is currently lacking with a pilot program only just commencing?

MR YATES: Yes.

MR GRAY: And I have in mind, we won't go to them all, but paragraphs 37 to 9, 41, 54 where you refer to there having been a case management funding program but it has been downgraded. 39.

MR YATES: Yes.

MR GRAY: 60 also refer to this issue. I will come to those in a minute. That's a long lead-up again, Mr Yates, but can I ask you, what is this pilot program and when is it likely to produce data that might be available to the Royal Commission?

MR YATES: The pilot program is called the System Navigators Trial. It's in the process of starting right now. It was – the tender was decided literally immediately before Christmas. We actually manage that program with 30 other organisations. And it's trialling a limited number of the methods that we, and through a National Aged Care Alliance paper on consumers supports, recommended needed to be up there.

And the idea is that you make available to people who are looking at aged care advice through a combination of methods, some of which, a very small number of professionally trained people who will assist, others who are train – information hubs

that are a mix of staff and volunteers, and community hubs which are, essentially, all volunteers, that assist people, particularly focussed from vulnerable communities. So people, for example, in remote areas, people from Aboriginal and Torres Strait Islander communities, people from non-English speaking communities, and so on to connect with the aged care system and go through it.

When COTA proposed to the Productivity Commission the creation of what we called gateways into the system, we always envisaged there would be a face-to-face component to it, but that would be an integrated system. When My Aged Care was created as part of the Living Longer, Living Better program, the expectations that were created for it then by the then government were very limited. It was purely online and phone. The amount of demand that it would attract was not properly estimated at the time. And we were concerned that there was no face-to-face component. It has become the entry point – you know, assessment is now part of it. It has got loaded up with a set of expectations that its initial IT capacity and whole system design capacity was never designed to deliver.

So System Navigators is an attempt to say can you plug some more support onto that. A lot of money has been poured into that – into My Aged Care. It is better than it used to be. And you have to say people do use My Aged Care and get connected into beds and into places and so on. It does work. But it works differentially, depending on the population that's trying to access it. And the System Navigators is an attempt – it's an 18 month trial, and it's set up to provide information in a progressive way through that trial.

It's not huge and we have been quite public that we would have preferred government to make a more clear commitment to do it and then, you know, start trialling bits of it, but – and the way its terms of reference are written, it could be expanded on the basis of progressive evaluation of the information. It's an important step forward, but we think it should have been there all along.

MR GRAY: Is there any prospect that, given its progressive nature and the possibility of phases, as you mentioned, that there might be some data available, say, by around July, August, September of this year?

MR YATES: There would be some data. The reliability of it, I would have to talk to my data people about.

MR GRAY: In your statement - - -

MR YATES: Sorry. I might say – I think that some things may well be obvious by then and others may not and, you know, we may be going back and asking questions about what the data is telling us.

MR GRAY: Thank you. In your statement, you mentioned a service that's now called Mabel. And I understand there's also another service of a similar kind called Care Connect. What are those examples? And are they relevant to this topic of

assisting people to, really, use the information that can be gained from, not only My Aged Care, but other sources?

MR YATES: These are actually different sources. I might start with Care Connect. Care Connect is an approved provider in the aged care system. In other words, it can take a package from an individual and it will account for that package. The fact that the individual owns the package doesn't mean they account for it. The government system can only deal at the moment with organisations, so they then have to account for it.

In Care Connect – in summary terms, the Care Connect model says you can come to us and we give you several different levels of managing your package: one pretty small. We're just doing the basics. You're pretty good. You know what you want to do or your family knows how to organise it. Or we can very strongly manage it for you, and in between. And then they work with you about how you put together a package of service from subcontractors, effectively, if you like. So it is about a consumer directed putting together a package. We actually have a pilot project running at the moment, which is much more about the consumer doing that and holding, actually, the money themselves. That's just a pilot project. That's an experimental project.

MR GRAY: Is that a COTA project?

MR YATES: Yes. It's funded by the government, but it's a COTA project. So that's something we believe is an important part of the landscape. Mabel, which was known to most people as Better Caring – it recently changed its name – is actually different. They are not an approved provider. So they can't accept an account for a package. What they are is a platform that connects individual consumers or consumer and family with carers and they vet those carers in terms of police checks and if they say they've got certain training, they've got that training and so on. And they provide certain levels of insurance. And they provide a platform for people to negotiate caring relationships directly.

We have never thought that would be the totality, you know, that everybody would switch to that, but it was an important offering. And, frankly, it was an important disruptor of the essential cookie cutter approach to aged care that we've had for far too long. And some approved providers are linking with them, so that if people want to put together a self-managed package, because there are controls in how they operate, that the provider will say you can use your package with these people; we're happy with how they do it. Although, I have to say, overall, they haven't been popular with the cookie cutter providers. So it is a disruptor. But we think it – and there are others now doing that, as well. There are a number of others in the market doing a similar thing.

MR GRAY: And Mabel puts the person using the service in contact with individual people - - -

MR YATES: Correct.

MR GRAY: - - - who provide whatever is needed - - -

MR YATES: Whatever is needed.

MR GRAY: - - - to fulfil the home care package?

MR YATES: Classically, I met at one of the openings of their enlarged premises, a woman who had been a dancer. And I can't remember her name, but I think she's been in the media. And she has obtained, through the platform, firstly, someone to help her with dance; secondly, someone to help her with physio and keeping herself limber, because dancing is important. And then she said I thought I might get a cleaner, as well. So that's about constructing, according to her priorities, what she wanted for support. But people have people who come and do class physical care and support services. Someone might take someone out on social outings. There's a whole variety of – so someone might want someone who can speak their language, someone who can play chess. Those are the kind of whole variety of things.

MR GRAY: Now, can I ask just for clarification here. This whole topic of, in effect, the accessing of information and the construction of packages, this is presently just the preserve of home care package discussion.

MR YATES: Correct.

MR GRAY: And this is not something that is, at least as yet, in the residential care space. Is that correct?

MR YATES: It is neither in the residential care space – because the provider holds the bed licence, you have to go shopping around. But it's also not in the Commonwealth Home Support Program basis. Right? So the Commonwealth is talking about how it can create better incentives for consumer direction. Our experience in the home care packages space, after Living Longer, Living Better, was that creating rules and regulations that said you have to be consumer-directed worked really well for the providers who were keen to be consumer-directed in their approach anyway and didn't work very well for all the other providers.

Changing it so the consumer actually owns the package is starting to change it overall. Hasn't fully yet, for all the reasons we've partly already canvassed, and culture change takes a while. But it is changing and we're getting new providers offering more diverse approaches to the sector. But that has not been hang in residential or home care. Now, in residential care we are starting to get some people thinking this is the way the world's going, we're going to start behaving like that. But there's no system incentive to do that.

MR GRAY: What's the roadmap, say – I'm not going to ask you to turn to it – and also what's COTAs thinking on whether the future might actually hold out something similar for residential care, as well?

MR YATES: Absolutely that's where we want to go. And the roadmap talks about allocations of care funding that is agnostic as to where you spend it. So the notion that you need this amount of care, you want it in residential care, you want it at home, you want it through some other housing arrangement, that's your call. That's what the roadmap points to.

MR GRAY: But a prerequisite of that would be the decoupling of the funding from being a place that's allocated to the approved provider - - -

MR YATES: Correct.

MR GRAY: - - - and the attaching of it to - - -

MR YATES: The consumer.

MR GRAY: - - - the particular individual; is that right?

MR YATES: Correct, which is what the Productivity Commission recommended, roadmap recommends and Tune recommended and we recommend and the National Aged Care Alliance papers recommend.

MR GRAY: Mr Yates, I want to now ask you about some other matters mentioned in your statement.

MR YATES: Sure.

MR GRAY: These are in effect, a disparate group of topics.

MR YATES: Bibs and bobs.

MR GRAY: One of the things you mentioned, these are all still very important matters, of course, is the inclusion of carers, so not just the people directly needing aged care, but the people who may be informally - - -

MR YATES: Yes.

MR GRAY: - - - providing care to them, that is, on an informal basis, family members and so forth, how they must be included in the planning process.

MR YATES: Yes.

MR GRAY: Why is that important?

MR YATES: The inclusion of family in planning and in things like complaints, in inclusion in activities to the degree that they want – all right – is a really important part of understanding that this person who is the primary person coming to you is part of a family, of a network. And disconnect from that network is actually dysfunctional to the person. And one of the principal fears that people have of going into residential care is that they get disconnected. And certainly there are providers that do not encourage that. There are others who do, but they don't. So that's important.

But the other thing to say about informal carers is they hold our whole system up – out there in the consumer land. And, even in residential care, people – family members who have come in, oven daily, we hear – we've heard from Minister Wyatt about residents who don't have a family member from one end of the year to the next come to see them, but there are many others who come daily or a few days or weekly and they're important. And the stress that's put on them often is enormous.

One of the things that was said in Living Longer, Living Better was that the carer should be recognised as a consumer in their own right and care supports looked at. That has proceeded incrementally, and I'm sure my colleagues from Carers Australia will have quite a lot more to say about that, but it is absolutely fundamental. So if you're a provider and you have a customer, your other customer is the family, because that's – you know, they're potentially, your partner in that care processes.

MR GRAY: Another topic is a conflict of interest – or at least a conflict of sorts that you allude to in respect of the fulfilment of the ACAT function, the Aged Care Assessment Team function on the ground. That's a function that is part of the Commonwealth funding system - - -

MR YATES: Yes.

MR GRAY: - - - in that there's assessment of need and then funding subsidised by the Commonwealth, that is, flows from that. But who is it that actually performs that function and why do you say there's a potential perceived conflict, at least, in that respect?

MR YATES: So the ACATs are creatures of State and Territory governments and health systems and serve their interests, which are not always the same. I mean, it used to be common, but I think we've knocked it on the head a bit. But it would be quite common to have State Health Ministers refer to time to time as old people as bed blockers, a very derogatory term, as if they somehow captured the bed and wanted to stay in hospital, in terms of getting out.

The process in a State hospital system is, frankly, how fast can we get these people out? And if that means putting them in a nursing home, because there's a vacancy, that's what we will do. What we're saying is that the aged care assessments service needs to be singular, it assesses the person holistically against their needs, whether – and, in terms of where we're headed now, whether they have capacity for re-

ablement, for support to re-establish their capacities. We don't need to assume that you put someone on a care conveyor belt that increases all the time. Maybe we can enable people to go back independently after a period of support. Or whether they can be cared at home with a minimum level of supports or whether, in the end, they really need residential care. And that needs to be integrated.

The Commonwealth has made an in-principle decision to move there. It announced that in the last budget. And it's currently consulting on a paper on a streamlined assessment, a combined assessment service across all the current programs. And we strongly welcome that.

MR GRAY: Thank you. I want to go to perhaps a connected topic in relation to your reference a minute ago to reablement, and perhaps your implicit recognition there that a stay in a nursing home might not be of long duration. You, at paragraph 49, refer to the potential for the removal of what used to be called – or accommodation bonds and are now called refundable accommodation deposits in respect of short stays. What are COTAs views on that topic? And if you wish to then go to refundable accommodation deposits in general, please do so.

MR YATES: There are a number of different things in there. One is to point out that we see the future of residential care as having quite diverse components to it. There's a discussion that the Commission – I would encourage to engage in about palliative care. Many people are entering residential care for what everybody knows will be a short stay. Palliative care is actually predominantly at the moment a function and responsibility of State Governments, although the Federal Government started looking at improving palliative care in residential care. But residential care providers don't get funded at the level that palliative care gets funded in the rest of the health system. That goes back to some of our earlier discussions about rights. So there clearly will be part of residential care, that's about the palliation process but that needs to be much more integrated into that process.

Then there will be residential care that is about people with dementia, although we want more people with dementia staying at home and in community, but people with dementia who otherwise are not ill, apart from their dementia. And so that kind of care requires a different approach than palliation. And then there are people for whom residential care can be rehabilitative, restorative. They might be at home by themselves without a lot of support on a package and deteriorate and can go into residential care and then come back out again. But to do that you have to be consciously taking up that approach. Because otherwise residential settings, whether they be in care homes or hospitals can actually lead to decrease of people's functions unless you've got a whole rehabilitative approach.

A very dangerous place for older people, hospitals. You can age years in a few weeks in hospital in terms of your physical capacity, so it needs to be that kind of approach. So all of those ways. So some of those are short-term measures. So why do you get mixed up in decisions about bonds and things? We actually need some other ways to support people financially to pay for those things. The Productivity

Commission recommended an equity release, equity access scheme. The government of the day decided not to do it, somebody else has. We perhaps are seeing something like that happen with the changes to the pension loan scheme that are about to come into place.

In terms of refundable accommodation deposits, generally speaking, we have a number of concerns about them that cause chief financial officers in some of our residential care providers to get very nervous when I talk about them, but refundable accommodation deposits are an unusual mechanism. The government itself has concerns about the prudential arrangements with regard to those. That is, are they being used according to the constraints on them. It's not unusual to find providers who talk about them as their capital, forgetting they actually belong to the consumer, they're actually the consumer's funds that are on loan. The scheme as it's set up says that if there's a major collapse and a refundable accommodation deposit can't be refunded the government will guarantee that and refund it. But it will then, if it meets a certain criteria, levy all the rest of the industry that didn't collapse to pay for the provider that did collapse. There's a certain dislogic in that.

We would like to see the industry set itself over time to be an attractive place, and this goes then to solving those bigger resourcing issues I talked about. You need stability if you are going to get investment, either debt borrowings or an equity investment requires some longer-term stability. You're not going to go into aged care and make hyper profits, not going to happen. There's too much attention on the sector now, but it could be a source of stable long-term return on capital for major super funds, for example. To do that you need stability and adequacy. You don't need flip-flopping about the funding of it. And you need proper discipline in how those operate.

Now, if you borrow money from a bank they keep a very close eye on what you're doing with their money and making sure you're doing the right thing so you can repay it. If I'm invested in you I keep a very close eye on how you are utilising my money and that I get a proper return on capital because I could go somewhere else to get a return on capital. But if a whole lot of individuals give you a refundable accommodation deposit, their capacity to keep an eye on how you're using that money is much different with the single exception if you're a listed company – remember there's only a very small number of those in the industry – because then market keeps an eye on how you're using that money.

You see what I mean; it's not a desirable, I think long term, major funding source. It suits some people, and at the moment we're getting a very clear trend of people preferring to pay daily payments or a combination of a rate and a daily payment, rather than the RADs.

MR GRAY: Just one very brief follow-up question. I think it's an unstated premise of your answers that you gave then – it's actually mentioned in your statement – one of the things about the refundable accommodation deposit system is that it very often

in effect compels the sale of the family home. And that's presumably one of the reasons why you have those views at COTA?

MR YATES: I – we're – if you know you're entering residential care and it's high quality residential care and you're going to be living there for a while, don't see any issue with the fact that the home is sold. But to make decisions about selling the home in a hurry, in a situation of internal family crisis, often, is not ideal. And the government says that you have 28 days to make a decision between the method of payment. We hear regularly of interviews with providers where you're told that it's your choice and for the next hour they talk about the RAD. In other words it becomes if you really want to get in here, you need to pay a RAD. There are other providers who don't use RADs very much at all. I mean, there are different business models out there and we need to look at that. But an overdependence on RADs, in our view, is not healthy.

Selling of the family home is something that should be done in a considered way after financial advice. A lot of people don't take financial advice because they're making these decisions in a crisis. In fact, an Aged Care Financing Authority report referred to financing decisions about aged care frequently being made in the hospital car park. It's not an ideal context.

MR GRAY: Mr Yates, another of these topics – and you touched upon it in your evidence before lunch – is the difficulties in gaining access to health services and you mentioned that GPs – this is at paragraph 50 of your statement, complain of disincentives. What's COTAs position on what a resolution to this might be? Are there any answers?

MR YATES: I would like to see some expert work done on the financial, whether there are financial disincentives or incentives done, rather than seeing that that all being played out through National Press Club addresses from the AMA and media responses from Ministers. I would like to see some evidence base and the survey. The survey that the AMA did and relies on is of questionable statistical validity because it was a voluntary return. I would like to see some real research done into what GPs are being paid for accessing – for providing services. It's a complex area that we need to sit down with, bodies like the AMA and the Royal Australian College of GPs and others and work through. There are some GPs, doctors who just don't want to do it. Who just don't want to do it.

There are others where homes have arrangements with a group of GPs, for example, that does cover it. One of our aged care providers experimented for a while with having doctors on premises but that's not a solution for everybody either because on many days there won't be much demand at all.

MR GRAY: In the very next paragraph, paragraph 51, you allude to the staffing issue and in particular COTAs position on the disclosure of staffing ratios. I hasten to add that it isn't, as I understand it, COTAs position that ratios should be fixed. Is that correct?

MR YATES: Our position is that we do not see the – we do not see that the answer to aged care staffing and aged care quality is to start with, we should have fixed ratios of certain kinds of staff. Many of the horror stories that we hear in aged care are committed by people who have qualifications – nursing and other qualifications. I don't want high ratios of them, to be kind of blunt. We have to focus on how, as we talked earlier, how we improve the quality of staff, how we make aged care an attractive, desirable career, how we build career pathways into aged care so that people can progress. And I can tell you, it can be done. There are good providers who build career pathways, who build managerial positions out of their ordinary staff over time. And so it can be done, but on a sector-wide basis we need to put more effort into it.

We also then need to look carefully at the evidence, so we're not opposed that after you come up with what would be a complex set of ratios for certain circumstances, but I don't want to start there when – and I don't want to get into demarcation disputes between different players and representatives of parts of the workforce about how many of one or how many of the other ought to be without good evidence. That's our starting position. Also the evidence is both from some studies that we cited in the five fixes document and from talking to aged care executives that I've done that sometimes you can satisfy the ratio but actually you're not convinced you've got the proper staffing mix for the situation.

MR GRAY: You also make a point in paragraph 51 about the inclusion in the roster of time. I take it you mean this should be part of the job description involved.

MR YATES: Yes.

MR GRAY: For social interaction with residents.

MR YATES: This goes somewhat to part of an earlier question we had about the difference between basic safety and quality and the bits on top, right. So I will accept that if there are financial pressures it becomes harder that you've got staff who spend time with the older person who listen, who share in dialogue, who touch, who relate to that person as a human being. And there are many, many ways of – in doing that, some of that's through staffing, others through kinds of intergenerational programs that some providers have set up, colocation of child care centres and aged care centres and so on. Lots of ways if you think that's an issue. But yes, that ought to be built into what it means to work in aged care.

It's not just about nursing, it's not just about pressure wounds, it's not just about all those things. It is about those things but it's not just about those things, it's about the human interaction that constructs the person. And putting time into those things is an important component of working out what a ratio is.

MR GRAY: I want to ask you about workforce issues in a little more detail but I won't spend too much time doing it. If we go to paragraphs 56 and 57 of your statement, you've already given the Commission in written form a summary of

COTAs position but you didn't have time or space in the statement to develop it. What you do say is that this is perhaps the single most important issue facing the aged care system in the coming decade.

MR YATES: Yes.

MR GRAY: Now, it's the case, is it, that if we go to the Keep Fixing document – operator, if you wouldn't mind – we actually get the detail of COTAs position on workforce issues more clearly in that document. And in particular, could I just ask you to look at the page 4 summary. So this is ending in suffix 0002. That's COT.1111.1111.0002. If we go to the part of the executive summary on page 4 – I should say it's recommendation 4 on page 9. Can we just expand recommendation 4:

More funding to secure the right quality and mix of aged care staff.

MR YATES: Okay. I think I have answered some of this. We've endorsed in this document the report of the workforce taskforce which has 14 strategies, which I might say – I'm pleased to say also addresses the ageism and so on that I talked about much earlier, as an important part of attracting people into aged care. So what we're saying is you need a holistic strategy. As I said, improved staffing levels but better training, better pay, better career structures, making it an attractive place to work. The reason that it's so critical – I mean, you could probably talk about this in other industries – but the reason it's so critical is to pick up on his Honour's earlier question to me, which is if we're going to have to expand the workforce by so much, getting the quality of that expanded workforce right is fundamental, absolutely fundamental. And probably is the biggest cost issue we face going forward if the taskforce on the workforce was correct that as an average overall we've got a 15 per cent gap with comparable industries.

MR GRAY: Thank you, Mr Yates. I will just ask you to go to page 20 whereby where there's – well, page 18 is where it begins – there's a detailed section on the analysis behind that position. That is behind COTAs position on recommendation 4.

MR YATES: Yes.

MR GRAY: It begins at page 18 and can we take it that this is in effect an expansion of the analysis underlying the opinion you just gave to the Commission.

MR YATES: Correct.

MR GRAY: And then when we get to ratios, I just – you've already given COTAs position, that is fixed ratios are a very difficult area and much more reflection would be needed. On staffing levels on page 22, is it COTAs position that there should be publication of staffing levels by each approved provider?

MR YATES: Absolutely. We include that in the transparency recommendations that we make regularly, and we specifically supported what is called the Sharkie Bill

in the Federal Parliament to – with some technical qualifications, but that people should be able to find out what staffing is in place, and what I would call good providers know that and can tell you that, is so why shouldn't it be available now. To the layperson that may need some interpretive work but it ought to be something that's transparent because it's comparable. The issue is to work out the comparability, because as I kind of said earlier, it depends on your mix of residents in terms of residential care. It depends. But there are other criteria as we say in there, your point, like do I get the same staff person. I might have the right numbers but if they switch each day, and that's highly relevant in the home but it's also relevant in the residential care setting, and it's very relevant to someone with dementia. It's not just the numbers.

That's part of our apprehension about staffing ratios, it's a quick easy answer, increase the ratios. No, there are lots of other components and dimensions to good staffing in aged care. And one of them is that everybody from the person you meet when you walk in the front door to the gardener to the cooks to people who clean as well as direct care staff all need to understand about dementia because that's how you make a dementia-friendly environment.

MR GRAY: On the next page – we don't need to go to it – but is it COTAs position that subject to perhaps exceptional circumstances, a registered nurse should be available 24/7.

MR YATES: That is our position, recognising that there are some very practical issues about that, and significant debate in the New South Wales Parliament about that and what it would mean in remote areas for example. But it's important that everybody who is – who has residents who are clinically vulnerable has access to good clinical advice rapidly. Now, it may be that in remote areas you've got to look at more telemedicine issues more but as a general principle, yes, it is about having that clinical support available, but again be careful about that that's sufficient. I've got a nurse; that doesn't necessarily make things safe or quality.

MR GRAY: I'm coming to the end of my questions, Mr Yates, but there are three interesting initiatives you mentioned. I will ask you first to go to the initiative at paragraph 66 in relation to dementia. And it's in this paragraph that you refer to the concept of dementia-specific environments like the soon to be built dementia village by Glenview in Hobart, Tasmania, and dementia-specific building designs for residential care like those build by HammondCare. What are the – if you can in a sort of brief and general way, describe how those initiatives, what sort of design is needed and what sort of forethought is needed and how they help?

MR YATES: So, firstly, it is about research and learning and design. The notion of a dementia village has become quite popular in discussion in the industry lately and we're having one being built. Based on some Dutch experience where effectively you build a village that's – reminds people of the likely age cohort that are going to be in there of that era and so you're not creating an institution, you're creating a locality in which they can live. And so there's a lot of interest in that. And certainly

the results seem good. Our view is let's have a variety of models and let's evaluate them. The other, of course, is the HammondCare – HammondCare have been approaching – specialising in dementia care for a long time and have a more cottage-type approach where residents, as I actually alluded to earlier, for example, when able to, many participate in food preparation or looking after the place.

It's a small – it's still quality of living but it's an awful lot less and there's a lot of other things about the HammondCare model. It's not just the numbers but they've specialised in that for a long time. All of these approaches – and I might say they have invested as an organisation in research and development and, for example, host an international conference on dementia every two years as part of the learning process, a very strong commitment, as they have in nutrition and attractive food.

MR GRAY: Well, it's nutrition to which I would ask you to now turn. In paragraph 64 you mention the two other initiatives I had in mind to ask you about. One is nutrition initiatives and you mention Maggie Beer Foundation and Southern Cross Care in Goodwin Homes in ACT and if you want to deal with that first. The other is the culturally-specific aged care services, but perhaps if you address nutrition first.

MR YATES: I have to say that I'm really, really conscious when we mention specifics as I've just done with Hammond, for example, that all – my friends in other really good aged care providers out there that I haven't mentioned are going to say, well, you were sitting in front of the Royal Commission and all these people broadcasting, you could have mentioned us. There are very many good providers out there. What we were trying to do – and in this State people would be familiar that Maggie Beer has made a big push to get – and been engaged by many aged care providers to look. What we are trying to do is say it's happening out there. It's not everybody who's bad, there are good things happening out there where people are looking at how you improve the food, not for more cost.

A major provider – a very major provider a couple of years ago in northern New South Wales – New South Wales/Queensland, the executive team brought to the board a proposal to substantially expand their production line for frozen foods, right, for pre-prepared meals that are frozen and for them to become a wholesaler effectively to lots of the industry. I have to say – and this was a point I wanted to make in terms of the future of the sector – it was members of the board of that agency that said, "Hang about, we're not sure that is the future. We keep hearing about how people actually prefer to have fresh food and food that's prepared on premises, and these kind of things. We want you guys to go away and think and look about this." That was a board calling its executive team on that issue and we would like to see more of that happening.

One of our concerns about aged care is the quality of the governance of aged care. I used to talk about the variability of the quality of management of aged care and then it occurred to me, who employs the managers? It's the boards. And aged care for too often has been seen as a charitable exercise and you're doing a good work if you sit on the board of your local aged care facility and if it doesn't get caught up by the

accreditation agency and it keeps its door open you're doing a good job. I think the community now expects a higher level of governance in this going forward to the kind of consumer-directed world that I'm pointing to.

MR GRAY: Thank you. I will leave it there and just ask you one final set of questions on community expectations.

COMMISSIONER BRIGGS: Can I just interrupt and follow up something on the workforce side. I'm very conscious – and I understand what you're talking about about getting the career paths and the training arrangements right but I'm pretty conscious of the fact that the ratios have changed between qualified and enrolled nursing staff and the other personal care staff quite dramatically in recent years. What do you think has been driving that and do you think that's appropriate, Mr Yates?

MR YATES: That will be something that the Commission will undoubtedly delve into, I think, in some depth. What I've been – so I suspect that some of that has been driven by difficulties in recruiting. Some of it has been driven by changes in practice. I mean, is everything that a nurse used to do have to be done by a nurse? And sometimes, in fact – and I am going to get into trouble about this – but sometimes the strong command culture of nursing historically – and I recognise that that's also being addressed – has meant that in terms of things like consumer-directed care, consumer-centric practice, that there has been more resistance from nurses and nurse administrators and that than there have been to others whose experience might be, for example, in the hospitality industry where understanding that you need to please the customer is really important.

So I would want to ensure, going forward, that we understand what proportion of the workforce that we need to be nurses for clinical reasons, for what populations of residents, all right. Or home care recipients, and that's clearer because if it's something that needs nursing, you send the nurse into the home. But what proportion need – and other mixes may be necessary for other populations. All right. So the behavioural interaction stuff may not need to be anywhere near the proportion of nurses that a home that specialises in taking people with quite severe post-acute symptoms would need. And certainly the providers I know in that space have – were much more agitated when certain changes were made to the aged care funding instrument that affected the top end of the clinical funding because they're employing a lot of nurses because they've got intravenous feeding and all that happening. They obviously need a much higher – and that's the kind of differentiation that I think is really important.

MR GRAY: Mr Yates, just finally, last but very much not least, you mentioned, for example, under the meeting community expectations in your statement, an attitude to elders in general in the community and you refer to that attitudinal change, an attitudinal change being needed before there will necessarily be a flow through to aged care. You refer elsewhere in your statement at 46 to, in some instances, families not giving their aged relatives the attention they deserve. You refer to – and

there is at 58 to 59 – a human rights perspective being considered as a worthy starting point. You refer to the work of the UN open-ended working group on these issues. You refer to a movement towards elimination of elder abuse, drivers of ageism and Every Age Counts campaigns. You also refer to an integrated national plan for older Australians. Mr Yates, is it the case that it's COTAs view that attitudinal change at a general level in the Australian community is needed?

MR YATES: Absolutely. In discussions with Commissioner Briggs and some other staff before Christmas at an informal consultation, I opened with the fact that the construction of the aged care sector in Australia, aged care institutions as we know them, has to some degree been an outcome of ageism and that separation off and the lack of priority attached to aged care in public policy terms, what we're seeing today is pretty unprecedented. That is a function of ageism which is, like sexism and racism, embedded in many ways in which we all interact, the jokes we have about being over the hill, past it, best years have, you know, gone by, all those things.

We tend to discount the citizenship of very old people, because they don't have the obvious utility to us that our society frequently values, and that is a really important issue. We have a – not a use-by date, but a best by date attitude to life, rather than assuming that life is something about growing through different stages and phases. And countering that it lies behind this. So I make the point that elder abuse in home care or residential care is absolutely unacceptable, but most elder abuse in our society occurs in the community between and within families. And, you know, to think we can wipe it out in aged care if it's existing in had the whole community is unrealistic. We need to tackle it. Now, we started to see some national tackling of elder abuse. It has taken a long time. But that's a mini example of the fact that too often we are discounting older people and discounting their citizenship when it ought to be 100 per cent citizenship until they're dead.

MR GRAY: Commissioners, subject to any further questions you might have, that concludes Mr Yates' evidence today.

COMMISSIONER TRACEY: Mr Yates, thank you for your evidence, which has been of considerable assistance to the Commission. You have not passed your use-by date as a witness. You may well hear from us again before the year is out.

MR YATES: Thank you. And can I thank you for the opportunity to spend the time with you and raise these important issues. I think you made the remarks in the preliminary hearings about this is a once in a generation opportunity. And I think it is. And I wish you well in that endeavour.

COMMISSIONER TRACEY: Thank you, Mr Yates. Yes, Dr McEvoy.

DR McEVOY: Commissioner, I call Professor John McCallum.

<JOHN McCALLUM, SWORN [3.33 pm]

DR McEVOY: Operator, could you please bring up document WIT.0004.0001.0001. Professor McCallum, could you give the Commission your full name, please.

MR McCALLUM: My full name is John McCallum.

DR McEVOY: And what organisation do you represent?

MR McCALLUM: I'm CEO and research director for National Seniors Australia.

DR McEVOY: And, Professor McCallum, is this statement on the screen the statement that you have provided to the Commission?

MR McCALLUM: Yes, it is.

DR McEVOY: And do you wish to make any amendments to that statement?

MR McCALLUM: Not at this point.

DR McEVOY: And are the contents of that statement true and correct to the best of your knowledge and belief?

MR McCALLUM: I'm sorry. I didn't - - -

DR McEVOY: Are the contents of that statement true and correct to the best of your knowledge and belief?

MR McCALLUM: Yes, they are.

DR McEVOY: Commissioners, I tender that statement of Professor John McCallum. I will tender separately some annexures, if the Commission pleases.

COMMISSIONER TRACEY: Yes. The witness statement of Professor John McCallum and the attachments thereto, dated 31 January 2019, will be exhibit 1-4.

EXHIBIT #1-4 WITNESS STATEMENT OF PROFESSOR JOHN MCCALLUM AND THE ATTACHMENTS THERETO DATED 31/01/2019 (WIT.0004.0001.0001)

DR McEVOY: Professor McCallum, could you describe, please, the membership of National Seniors Australia.

MR McCALLUM: National Seniors Australia was established in 1976. It started life, really, as an advocacy group for independent retirees when the peach of the lobby was very strong and now finds itself in the mainstream of superannuation era

and working on similar issues to many other bodies and many other businesses, in fact. It's a consumer lobby for all older Australians. We advise older Australians on different issues and represent their interests at levels of government, in business and the community, which is also important. And, through advocacy, research and policy development, we're trying to make a positive difference to the discussions.

In particular, in recent years we've really focussed on trying to understand what consumers are thinking and feeling, so that we can bring that into the discussions. That's very important, because things are changing so rapidly, we have to engage with consumers to understand what's happening. We do a substantial amount of research, as much as we can, actually, and support a productive ageing agenda. And we have the support of about 130,000 members. It varies from time to time, so I can't – that would not be accurate at this point in time; it will change from day to day. About 120 branches across Australia, and cover the wealthy, the middle. And probably about 40 per cent of our members are pensioners or part pensioners.

DR McEVOY: Professor McCallum, can I begin by dealing with the issue of prior inquiries in the aged care sector. On page 12 of your statement, you say that there have been 20 or more reviews and inquiries into aged care over the past 10 years, that many of their recommendations haven't been fully implemented and that there have been major problems in prosecuting those recommendations. Can I ask you what recommendations from prior reports, in particular, come to your mind as not having been implemented?

MR McCALLUM: That's a question I take on notice. I have not been CEO since May last year and I have not reviewed all inquiries. There are too many. I do know quite a bit about the Productivity Commission's reports, which are always very – very useful and a previous Royal Commission. But what I would like, I think, to focus on is what we're left with after all that work, which is, I suppose, significant shortfalls in home care which are not being redressed; consumer directed care which has been in the pipeline for a long time, which is struggling but getting there; regional provider issues, which are perennial and probably difficult to struggle.

We certainly have had – we've dealt with the regulators, and that we're in a very new phase of that. We had two regulators, now we're moving to one. And issues of dignity and respect, I think, are on the table more than they ever have been, so I would like to focus in that way, rather than have to go through detail of items. That's not the way we've been working.

DR McEVOY: One of the things you say on page 12 is that a case can be made to re-imagine the industry and government structures who would have the power to implement recommendations. What sort of re-imagining do you have in mind?

MR McCALLUM: So we took the Commissioners' point of view that this is a once in a lifetime opportunity. And then you look back and think, well, what happened because of other inquiries and commissions? And we need to analyse that to think through why this one would be successful, why it would pass some of the political

barriers that have to be got through, some of the this is too difficult to do sort of barriers and work out how to do it.

The little mind game I played was to think about the banking Royal Commission, because it was a present activity and it had a Royal Commission. So in that, if we compare that, we have probably three major representative bodies of industry in aged care. The banking industry has the ABA. We used to have two regulators, we now have one, and it's very new. In the banking industry, we have two that are established and quite powerful, and a third one coming in on the top. So we have to think about are the industry structures capable of supporting the sort of recommendations that are going to come through this, and should we not be reviewing and talking about that and making that part of it? Clearly, in the case of the bank ..... it was part of it establishing an oversighting body for the regulators. So that's one side of it.

Then we have the plans that exist. We have a roadmap which is very strongly government driven. I describe it as one that's sort of short on actual hard targets, which is understandable, but it's somewhere we have to go in some cases, and one where the five to seven year period is relatively blank in terms of what's going on. And that's the period we have to look to. So I'm putting that on the table, I think, as an independent body saying we're looking at the industry wondering do we have to think harder about its governance and its representative structures and to talk more about that to get the capacity to deal with strong recommendations.

DR McEVOY: Well, what would National Seniors Australia like to see in that regard? Can I ask you that.

MR McCALLUM: I think we would like to see a single body as an industry rep that brings the industry together. We have major players that are not in any of these three bodies, for example. And a capacity to create a code. We have an acceptance of the code from the last workforce strategy report. So that has been accepted by the industry; they will do a code. We need to relate how that relates to a roadmap. We need to think through a lot of things about it.

There's a meeting tomorrow of the industry reference committee which has carriage of that. That's its first meeting. So some of those things will be discussed. I'm just saying these things are not quite as defined as they would be in other industries. And I think one of the things we have to regard aged care as is an emerging industry. It's not something that's in part cottage and part big time. It's an emerging industry which has to be treated and has to think of itself that way.

DR McEVOY: Well, in that connection, you're critical, on page 11 of your statement, of governments and public servants dodging recommendations. How do you – what do you have in mind when you make that criticism and do you see some reimagined body as being able to address some of these problems?

MR McCALLUM: I think there needs to be a harder line on some of these things. I think, you know, the running sore, really, is the waiting lists for home care. And that's, really, profoundly a critical failure. We know that home care, on level one evidence, is preventative for death and preventative for hospital admission. And we have a study here from ..... showing that if you spend six months longer waiting for home care, when you first then get into home care you're 10 times more likely to go into residential care. So that's very crucial ..... evidence. So we know that that's the case.

We haven't really dealt with that and really dealt with the fact that people then have to go into residential care, into hospitals, which are much more expensive. And it's economically irrational, but we haven't dealt with it. We haven't dealt with it, because it is hard. And so I think that's what I mean by dodging. And it's this is hard and we will leave that for next time or – and it's something we really have to deal with, because it's – as I said, it's the most difficult immediate issue we have to confront.

DR McEVOY: One of the aspects of what is hard might be said to be some of the matters addressed by the Aged Care Workforce Task Force in its report and recommendations. And you've referred to National Seniors as being supportive of those recommendations on page 12. Can you explain what it is about those recommendations that do find favour with National Seniors?

MR McCALLUM: I – and they find favour with us because, well, they're the most recent, for a start, and, therefore, they're the most in touch with the way things are. But because there's a strong industry analysis that I think comes from the way that was set up, and I think that's very helpful. In particular, the idea that you have to be driven by some sort of strategy and vision that aged care isn't, health care isn't, quality and safety in the sense that there's a commission into safety, and quality and health care and it's something that's looking more holistically at people and has to deal with that and be focussed on that goal.

And then designer workforce that is built around that sort of strategy and is trained to do that sort of things and is skilled in ways that mean that people can do those sort of things in the aged care sector. The important point, I think, is that we do need – and I'm talking very much about getting more money into home care – to deal with the waiting list. We need to get money into the right kind of services. We don't just put money in. It has to be pointing towards some sort of goal. And I think that has been a good description of the Aged Care Taskforce.

DR McEVOY: So it's partly a function of money, you say, but money in the right areas. What else would you say needs to happen for the recommendations to be acted upon?

MR McCALLUM: It's very strong on the industry and having an industry code, which is, you know, going to be very new and very challenging for the industry. It's very strong on that. And I think it's also saying that there needs to be a research base

for this that covers the industry in setting up something that does think and lead it forward. And I think that's where you get the interest in the sort of emerging industry approach to aged care and bringing that forward. I think they're two things that come through strongly.

DR McEVOY: You've mentioned, Professor, the issues that attend home care. And we've heard already today from Mr Yates a good deal about that. The first exhibit to your statement is a National Seniors Australia report entitled Accentuating the Positive, Consumer Experiences of Aged Care at Home, dated April 2012. Commissioners, I would seek to tender separately that document. Its number is NSA.9999.0001.0001.

COMMISSIONER TRACEY: What's its title, Dr McEvoy?

DR McEVOY: Accentuating the Positive.

COMMISSIONER TRACEY: Yes. The National Seniors Australia document entitled Accentuating the Positive, dated April 2018, will be exhibit 1-5.

EXHIBIT #1-5 NATIONAL SENIORS AUSTRALIA DOCUMENT ENTITLED ACCENTUATING THE POSITIVE DATED 04/2018 (NSA.9999.0001.0001)

DR McEVOY: Professor, can you explain the context in which that report was prepared.

MR McCALLUM: This report, I suppose, commissioned by the Aged Care Workforce strategy. It comprised a national survey of just under 5000 people, interviews with service providers in various places across Australia. But also interviews with their – the person who received their care. So we matched the person with the provider, so that we didn't have some imbalance in the providers and the consumers. It covered indigenous, it covered multicultural areas. And we combined the – if you like, the survey evidence to set where the proportions were and then the interview evidence to explain what – why more people were saying that sort of thing.

DR McEVOY: And what key gaps in the home care sector did the survey identify?

MR McCALLUM: The key gaps, I think, are well represented. It's around the organisation of care, the inconvenience of the way things are happening. I think a major black hole is when the home care interacts with medical care or other care, acute care of various kinds, and then you get both payment sort of system interruptions and also disconnects between the two. And the medical care system always proved to be more powerful than the home care system, except where there were people of goodwill to do it.

So we have to begin to work with those, because people fall through those gaps. It's quite a hard process to move from one to the other. And it becomes very difficult. Even with very skilled advocates and children, very well educated, it's very difficult to work those through. So they're some of the areas where there are significant gaps. And there are in what would be more minor areas, around cleaning, for example. But I emphasise that while these things might seem domestic and minor tasks, in terms of what they do and what they prevent, they're very powerful. So that low level home care and the observation that occurs during it, and the sort of maintenance of activity in older people is powerfully done through those particular activities.

DR McEVOY: And you mentioned the disconnects between home care and medical care as being something that flowed out of that analysis. What's National Seniors' position in relation to improved training for personal care workers and how do you see that working?

MR McCALLUM: They're a key part of the system. I think they have been really underdone in terms of the VET system and its training and we need better access to training for personal care workers. The personal care worker role changed dramatically with the introduction of consumer-directed care. The personal care worker then had to deal with talking to people, not just an in and out service. They had to become creative in the terms of working through what the problem was and how to solve it for that person and to become advocates, that is, to advocate for the person for services outside their own service provider. So it became much more difficult. So that training hasn't really come into play yet, and it's really needed. It's one of the major barriers to consumer-directed care becoming better in its functionality within the system.

I think training is critical so there are mandated courses that need to be graded and developed up and that will be one of the issues dealt with in the IRC starting tomorrow. There is a dementia unit as part of a personal care workers training but it isn't compulsory. It must be compulsory because if people don't understand dementia they don't understand why people appear to be behaving badly and you get consequences in terms of abuse and neglect of older people because people don't understand. If you are properly trained and understand dementia it's quite a challenging but interesting role to take on. Short courses are in short supply so people can drop in and drop out and get short courses and on-the-job training is often not of the quality it should be. If you went to different industries it would be very high quality on-the-job training so that needs to be developed.

And one of the things that has worked well in the British health occasion system is something called a skills escalator where people can see a pattern of where they can go. It's worked very well with immigrant workers in the UK so they can work through from perhaps being a supporter in mother groups then working as maternity aids and then working through to enrolled nurse to nurses and that sort of thing. And that's true also particularly of people returning to work after having a long period of caring for an older person to be able to return to work in that way. So there are a range of things that we need to do to develop that workforce but they're all very

doable. We just need to put the money into it and give the, if you like, the strategy that's needed, it will happen.

DR McEVOY: So if that's the position in relation to training what did the survey reveal in relation to what was needed by providers of care who were family and friends? So informal provision of care?

MR McCALLUM: So most people believe that they have the skills to do it, but 40 per cent of them feel they've suffered ill health because of their caring duties. They've also lost money. There are other things that happen along that way that are very hard for people. Again we need to be able to provide training for those care workers to make it easy for them to access, so they have the skills so that they don't injure themselves in the care. We need to provide more respite care. Respite care has been a tricky thing forever in trying to provide and becomes sort of almost a tryout and see for residential care rather than a respite where a carer can take a break and recover and then come back to caring. There are two critical things: the training and the respite care.

DR McEVOY: Well, just turning then to residential care, there's a good deal in your statement from about pages 4 to 7 dealing with gaps in residential care. I wonder if you could tell the Commission what work the NSA has done to identify the personal experience of members in residential care?

MR McCALLUM: We've only taken reports of people writing back into us in residential care. Our focus in my time has been on home care and we've reported those as verbatim as they came in and that gives you a good sense of it. You will see the gaps there are really in terms of the care, the quality of the staff, the meals. You know, it's the – I think the set that was provided from the original analysis of this Commission in the initial statement, the same sort of themes emerge in our reports of that. So we haven't focused on that, we've focussed on – our main focus is on home care.

DR McEVOY: Have you recommendations that you would make to improve the consumer experience in residential care to the extent that you've considered that?

MR McCALLUM: I mean, I go back to bigger picture issues. I mean, the consumer literacy about what's going on and what to do about it is very limited. Most people who have been through assessment don't know that there are places where you can make a complaint. So in our survey 47 per cent of people knew that there was somewhere you could make a complaint. We have a critical problem there if we have a complaints commission, people didn't know it existed. We saw in many of the media reports on this, people went to putting up cameras rather than going through a complaint systems. Some people did go through a complaints system. Some people were obviously well done through; some people weren't.

We've got an issue, really, of making these things better known. This is an issue common to health in a way and in health we work pretty much with the providers

and make sure they're actually educating people, explaining things to people and I think that's something we have to work at at that point of contact, for example, in assessment. For example, when home care comes that there is a connect and those explanations are done in plain English and clearly and reinforced over time.

DR McEVOY: Well, that's a consistent theme, really, in your statement, isn't it, that there are problems with aged care literacy and people becoming confused or having a lack of knowledge about the system. What does the NSA say in a practical sense can be done about that?

MR McCALLUM: Well, I mean, the data show that 85 per cent of people think they're going to live longer. 22 per cent have no plans. About 50 per cent have financial plans. 46 per cent have health plans so that sort of planning is going on. If you ask them, and do you plan to spend more money on residential care? They're not thinking about that late stage in life. Do you plan to spend more money later in life? Only three per cent are thinking about that. So we're looking at a problem of negativity which I think a Commission like this is going to create more negativity as people do come in and give real stories about what has gone wrong. I really like the emphasis the Commission has on what are the positive things, what are the good things, because we have to push that.

Home care gives us an opportunity. People – when we ask people, tell us about your aged care service journey, they don't talk about home care. It's part of the furniture, as it were. They do talk about residential care and what they've heard or what they've experienced in that. So that gives us the opportunity. This is where people do prefer to be. We can expand that service. We can actually catch up with where the need is and we can have a positive effect from that because people are quite confident in that sector and much more comfortable. So I think home care – well, the reason we stress home care is its importance in that category of building the positive around the aged care services.

DR McEVOY: You've mentioned in your statement just in the way that you've alluded to it now, failures in some models of care but you've also mentioned the Wintringham social justice model and the Scalabrini villages model of dementia as examples of good practice. Can you give the Commission a bit of an insight into what those two models are doing that you regard as being so useful?

MR McCALLUM: I mean, what we admire about Wintringham is it has created a culture around a concept of social justice, so it's building that into its culture, into the way it works. It works on – for that reason, on independence and dignity, whatever people's condition is. It creates that in its physical environment with outdoor facilities and so on and private spaces. So it enables that sort of care, that holistic care to happen through a physical and cultural environment around that. Scalabrini is another good example. They're probably more technologically driven with some of the new things that will come through, provided they're well co-designed with consumers and created for what people actually want, not coming from a technological space and saying we've got something for you.

There are a couple of others I would mention. A home care group that grew out of a community information centre took on residential – sorry, aged care assessment and home care and very much works as a community group still within that. It's quite a large group now. It emphasises creativity in what people are doing and responding and solving the issues of, say, someone with dementia who is upset when the different Meals on Wheels people come, the different people, and then designing a solution that takes them out to a cafe, as a café qualified as a quality food provider under the Act. And then the people don't have Meals on Wheels coming. They go to the restaurant, they have lunch, they do the normal routine, they get some sandwiches and they to home at night. So it's that sort of creativity and problem solving.

So that group really emphasised the fact that you really have to be very creative in this business to do it properly and they take that through – right through the culture to board level and emphasise it there. So there's some really good things going on.

DR McEVOY: The emphasis, really, in what you've just said is on what people actually want.

MR McCALLUM: Yes.

DR McEVOY: And as you say, creativity in program design is a part of that.

MR McCALLUM: Yes.

DR McEVOY: What else is required to have this consumer care focus which you identify as being so important, this consumer-centred care which you identify as being so important?

MR McCALLUM: I think it's a certain flexibility, so if someone is interested in music – I think I mentioned this case – that they could go to a concert, rather than have that service for the day and the money could go to that. And they might not be cleaning that day or something might not happen, but that sort of flexibility that does respond – and it is – that's why we go back to the training issue for personal care workers. It's something where you have to be very creative in domestic problem-solving and normal life problem-solving which is quite challenging.

DR McEVOY: Has National Seniors – well, you say that National Seniors has undertaken research in the community's views about ageism. This, of course, is something you will have heard addressed by Mr Yates. What are your members telling you about their lives as elderly Australians?

MR McCALLUM: Well, we asked this in a survey and had comments as well and that's in one of our reports but people do feel that they should be respected because of their age. They do feel that they should be rewarded because they've made major contributions, so that's about three-quarters of people believe that. They should be rewarded because they have raised children, they've worked and paid taxes all their

lives, so they have some deserving of respect. I think what's shaking that up, really, is the fact that we now have middle age shifting into old age so people are working quite a bit later. So their parameters are shifting and that mix is quite difficult. I think we would probably differentiate the severe disrespect that can occur in abuse of people in care from that sort of world, but there is, I guess, a loose link and we have to work with it.

The Benevolent Society, along with us and quite a few other groups have a program called EveryAGE Counts and next week there will be a sort of covenant signing at Parliament House of parliamentarians to think about that. So there are issues and they're not all one-sided. I think there is a debate that is promoted by some of young versus old, that the old are doing better than the young. And I don't think that's helpful. I think most older people feel they do provide more to the young, except when they're much – when they're much older and then it does reverse and there's quite a burden on their carers then. But on average they're contributing more to their children than the opposite. So that's something that's quite happy and quite normal and it's the intergenerational respect and connections that are very important in that.

DR McEVOY: And do you have views about how that culture of intergenerational respect can be improved? What do your members say on that question?

MR McCALLUM: I think one member said something like, you know, you have to realise that we've worked very hard all our lives. We haven't had, necessarily, a lot of money through that time. Now we're a little older we need a little bit of help and a little bit of respect just to get through. So there's that sort of gentle side of it. I mean, it can be more extreme and putting up cases for ageism and writing some of those issues and they do matter, I think. Particularly in areas where people want to work longer, that comes through very clearly and in that sense that people are worthless when they're in care. I don't think that's as predominant as some of those issue would say, but it's very important that we kind of work with that and raise people's voices so people understand what older people are thinking and so they can respect that or not, as they feel fit.

DR McEVOY: Yes. I have no further questions for Professor McCallum, Commissioners.

COMMISSIONER TRACEY yes. Thank you for your evidence, Professor McCallum. The Commission is most grateful to you.

MR McCALLUM: Thank you.

COMMISSIONER TRACEY: No further matters this evening?

DR McEVOY: No further matters, Commissioner.

COMMISSIONER TRACEY: Very well. The Commission will adjourn until 10 am tomorrow morning.

<THE WITNESS WITHDREW [4.00 pm]

MATTER ADJOURNED at 4.05 pm UNTIL TUESDAY, 12 FEBRUARY 2019

Index of Witness Events

Index of Exhibits and MFIs