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TRANSCRIPT OF PROCEEDINGS

O/N H-985229

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

10.01 AM, TUESDAY, 12 FEBRUARY 2019

Continued from 11.2.19

DAY 3

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

MR S. FREE SC appears with MR CROCKER for the Australian Bureau of Statistics and the Australian Institute of Health and Welfare

COMMISSIONER TRACEY: Please open the Commission.

MR S. FREE SC: May I announce my appearance. My name is Free. I appear with my learned friend MR CROCKER for the Australian Bureau of Statistics and the Australian Institute of Health and Welfare.

COMMISSIONER TRACEY: Yes, Mr Free. You have been given leave to appear. Mr Gray.

MR GRAY: Thank you Commissioner. I call Justine Boland of the ABS.

<JUSTINE LOUISE BOLAND, AFFIRMED [10.02 am]

<EXAMINATION-IN-CHIEF BY MR GRAY

MR GRAY: What is your full name?

MS BOLAND: Justine Louise Boland.

MR GRAY: Could we make sure, please, that Ms Boland has before her a paper copy of document WIT.0001.0001.0001.

MS BOLAND: Yes, I do.

MR GRAY: Thank you. And if that could please be brought up on the screen. Ms Boland, I understand, before I ask you to identify this document, you may have an amendment to paragraph 86?

MS BOLAND: Yes, that's correct.

COMMISSIONER TRACEY: Paragraph?

MR GRAY: 86.

COMMISSIONER TRACEY: Eight?

MR GRAY: Eight six. What is the amendment you wish to make?

MS BOLAND: Paragraph 86 refers to the ABSs role in compiling statistics on the labour force. The second to last sentence refers to the occupational classification that's used by the ABS. I would like to amend that second to last sentence to also refer to the industrial classification as well, so the relevant occupation and industrial

classifications used are determined by the ABS in conjunction with Statistics New Zealand. So these classifications combine health, aged care and disability workers.

MR GRAY: Thank you, Ms Boland. Are there any other amendments you wish to make?

MS BOLAND: No, thank you.

MR GRAY: Are you satisfied that the document before you bearing the code number I read out is a copy of the statement that you've prepared?

MS BOLAND: Yes, thank you.

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

MS BOLAND: Yes.

MR GRAY: Commissioners, I tender that statement together with its identified annexures.

COMMISSIONER TRACEY: Yes. The witness statement of Justine Louise Boland dated 31 January 2019 will be exhibit 1-6.

EXHIBIT #1-6 WITNESS STATEMENT OF JUSTINE LOUISE BOLAND DATED 31/01/2019 (WIT.0001.0001.0001) AND ITS IDENTIFIED ANNEXURES

MR GRAY: Ms Boland, what's your current position in the Australian Bureau of Statistics, ABS?

MS BOLAND: I'm the program manager for the health and disability branch at the ABS.

MR GRAY: And do I understand that there are a number of divisions of the ABS referred to in paragraph 16 of your statement?

MS BOLAND: Yes.

MR GRAY: And the two that are of relevance for the work of the Royal Commission are the population and social statistics division and the census and statistical services division?

MS BOLAND: Yes, those two divisions are the ones from which we drew the most information in this statement. I would clarify though that I've already referred to the

occupation and industrial classifications, so that more economic side of the work program is undertaken by the macroeconomics statistics division and the industry statistics division.

MR GRAY: Thank you. In relation to that more economic data that may be available as a result of the work of those divisions, that information is not in your current statement but you're indicating that that sort of information may be of relevance to the work of the Royal Commission in the future; is that correct?

MS BOLAND: Yes, that's right, so paragraph 86 the one to which I just made an amendment certainly refers to work of those divisions.

MR GRAY: Thank you. With reference to paragraph 22 of your statement, you refer in particular to branches within the population and social statistics division. And you mention two branches, Population Statistics Branch. What's the work of that branch in short compass?

MS BOLAND: That branch is largely – it performs demographic analysis. So I've included within my statement some population projections information and that's led out of that branch.

MR GRAY: Thank you. And the other branch that is specifically mentioned as being relevant to the production of ageing related statistics within the population and social statistics division is the Health and Disability Branch. In short compass, what's the work of that branch?

MS BOLAND: So that's the branch that I lead. It includes health information, disability information, information on ageing and carers, mental health, vital statistics and by vital statistics what we mean are births, deaths and marriages data. Within the branch as well we're responsible for coding causes of death data for Australia and health services information as well. And then beside all those sort of very health-focused pieces of information, I also have a role leading the development of the content for the 2021 Census.

MR GRAY: Thank you. Just stepping back to the higher level of the organisation of the ABS into divisions, the second division you mentioned is the Census And Statistical Services Division. Perhaps the name gives the job away, but could you just in short compass elaborate on the work of that division?

MS BOLAND: Of course. So that division is responsible for the operational running of the census, so they're currently planning for the census. But as well as the census planning, they also have a role managing our interviewer workforce. So these are the people who collect directly the surveys from the Australian populace.

MR GRAY: Thank you. And not to suggest that you haven't explained all of this in more detail in your statement. That will be available to those who wish to read in more detail what the work of the ABS that's directly relevant to the Commission.

But I will move on to some other topics concerning that now. I want to ask you about some of the foundations for the data that's collected, and am I correct in thinking that it's largely surveys that result in the data that is collected by the ABS?

MS BOLAND: I probably would characterise it slightly differently from that. So yes, surveys play a very large part of the data that we collect in the ABS. The census is also a sort of foundational element so that's conducted every five years and the census is different to a survey in that it's something that's collected of all Australians. And then as well as that, we have sort of a large program using administrative data. So for example, when I referred to my branch collecting data from births, deaths and marriages or from the Registrars of Births, Deaths and Marriages, that's an administrative data source. And then I suppose alongside that, similar to the admin data – administrative data, we now have programs where we combine administrative data with those – with either surveys or other administrative data or even with the census and then sort of analytical programs around those sources.

MR GRAY: Thank you. With respect to the administrative data sets, in paragraph 22(b) you refer to an example of those in the form of the Medicare benefits schedule, or the medical benefits schedule and the Pharmaceutical Benefits Scheme; is that right?

MS BOLAND: Yes, I do.

MR GRAY: And I think you just mentioned births, deaths and marriages. So are these administrative data sets data sets that result from the administration of government in respect of various programs of Commonwealth Government; is that right?

MS BOLAND: Yes, and State and Territory programs as well.

MR GRAY: Thank you. And the births, deaths and marriages is an example of a State and Territory dataset.

MS BOLAND: State role, yes, that's right.

MR GRAY: Thank you. With respect to the survey program as you see it as being potentially relevant to the work of the Royal Commission, you mention at paragraph 31 a number of specific survey programs, or a number of specific surveys within the survey program. Could I just ask you to elaborate on the National Health Survey. How often is that done; what's its current status?

MS BOLAND: So the National Health Survey is a survey that we run every three years at present. In fact, we released data from the 2018 National Health Survey at the end of last year, so in December the first results came out from the National Health Survey.

MR GRAY: Thank you. And the second one mentioned there in paragraph 31 is the National Aboriginal and Torres Strait Islander Social Survey. Again, what's the current status of that one. I see it's mentioned as a six-yearly survey; is that right?

MS BOLAND: Yes, that's right so our – if I talk sort of in more fulsome nature about our Aboriginal and Torres Strait Islander Survey Program, we usually run every six years the social survey and then three years, apart from that one, a National Aboriginal and Torres Strait Islander Health Survey so it's a sort of six-yearly cycle for the social survey and then the intervening six-yearly cycle for a health survey. It's quite likely, though, that the social survey and health survey might get merged together in coming years.

MR GRAY: Okay. And when was the most recent?

MS BOLAND: Sorry, the most recent social survey, we've currently got – I think we've currently got a health survey in the field so that means that the social survey would have been about three years ago.

MR GRAY: Thank you. I will not mention all of these. I will go now to (d), the Survey of Disability, Ageing and Carers, I believe I can refer to that as the SDAC; is that right?

MS BOLAND: That's right. That's how we save ourselves some breath.

MR GRAY: Later in your statement you refer to this as quite an important source of potentially relevant information for the Commission's work.

MS BOLAND: Yes.

MR GRAY: Ms Boland, can you elaborate on that survey: what's its general, in short compass at least, what's its scope, what's its current status, are there any limitations in the current survey that's being conducted?

MS BOLAND: Right, so that survey is also usually done every three years. We've currently got one in the field so we're hoping to finalise that one very soon so that one we will refer to the 2018 SDAC because it was commenced in 2018. It's three yearly. It includes a sample size of generally around 20 to 25 thousand households and as well as households, it's a little bit different to some of our other household survey program in that this particular survey also includes a sample of residential institutions as well. So it's a survey that the ABS is appropriated to do, so our appropriation funds that survey every six years and we've made it more frequent, I guess, at the behest of a lot of our partners in government to make it every three years and generally we're reliant on funding from those partners, State governments and the Commonwealth agencies with interest in that survey for every second cycle of it.

So this current one that's in the field, for example, is one that we received funding from four jurisdictions and two Commonwealth agencies to run. It primarily collects information, as you can tell from the name of it. It's on disability, ageing and from people who provide care to people in Australia. So it's used, really, as the measure of disability prevalence in Australia because it has quite detailed information that it asks of respondents about their functioning and any health limitations. As well as that, it asks about – sort of includes specific questions of the ageing population and also questions about people who provide care. So that's how we conduct it in households. I would clarify that when we conduct that survey in the residential settings, we usually have a sample that's about 1000 institutions and we send out the forms to an administrator of the institution and they're expected to pick a random sample. We give them instructions on how to collect that sample of usually 100 of their clients, and that actually – sorry, that administrator completes the survey for the people. So in that case it's not completed by the respondents themselves.

MR GRAY: In terms, briefly, of its scope, in your statement you refer to it as probably the most comprehensive source of data in relation to, amongst other things, ageing and who's caring for ageing people in households; is that correct?

MS BOLAND: Yes, that's right.

MR GRAY: And I understand it has got more than 100 detailed questions, and that the age of the person being cared for within the relevant household is included?

MS BOLAND: That's right, yes.

MR GRAY: Now, the current 2018 SDAC, is that going to have some limitations in respect of various areas in Australia?

MS BOLAND: Yes, that's right. So when I mentioned before that we're reliant on States and Territories to support every second iteration of the survey, for this particular survey that's in the field, only four of the jurisdictions were in a position to fund the survey. So as a consequence, we have much smaller samples in the non-funding jurisdictions. Until it comes out of the field and we've compiled the data, I can't tell you with great certainty about the quality of the estimates that we will get for any of the jurisdictions but we've designed the sample to collect the information, such that we should be able to produce quite statistically reliable estimates for the four funding jurisdictions who were New South Wales, Victoria, Queensland and Western Australia. For the four smaller jurisdictions, it's unlikely we will be able to produce reliable data at that smaller level and certainly we would also produce national level estimates from the survey.

MR GRAY: So in respect of those jurisdictions, there will be 2015 data available, I assume?

MS BOLAND: Yes, that's right. So the 2015 survey which was an ABS appropriated survey, now, our ABS appropriation is usually only sufficient to

provide a sample size that's large enough to produce nationally reliable estimates, but in the case of the 2015 survey we received some additional funding from the Department of Social Services and were able to enlarge the sample and therefore we produced estimates reliably for all jurisdictions.

MR GRAY: Thank you. As to timing, in the ordinary course of business when would you expect the results of the 2018 SDAC to be available, that is available for publication?

MS BOLAND: Yes, we – as I mentioned before, the survey is still in the field so we would still have interviewers at the moment knocking on household doors and collecting information. We're hoping – we set a sort of target in terms of the sample size we try to achieve and we're getting quite close to that and we would hope to finish the survey soon and then ideally we will publish information in late October. That's the timetable we're working against but until we've come out of the field we won't have a good feel for whether we've met that sort of target sample.

MR GRAY: And I think I mentioned the number of questions in the SDAC a minute ago and I think I was significantly under. I see it is referred to in paragraph 36 of your statement as containing around 1800 questions. In respect of disability and severity, there are more than 200 questions; is that right?

MS BOLAND: Yes. That's right. So it is quite a lengthy survey, so on average we often do a test for the average time it takes to complete a survey in the household because I guess it's important that we don't overburden households by including too many questions in the survey. So that particular survey usually takes about an hour to complete in the survey but, of course, it could take a lot longer if the respondents to the survey are people who do have lots of chronic health conditions because then you would be channelled into extra questions, for example, about those conditions.

MR GRAY: So continuing the line of questioning about the sources of data that are available, and in particular still focusing on surveys, is it the case that there's a less detailed module of questions that is included in the number of kinds of households surveyed that is still of use in the collection of data which might shed light on care of ageing people and similar issues that are of relevance to the Royal Commission?

MS BOLAND: Yes, that's right. So that's – there's a module that we call the short disability module, so as well as the survey of disability, ageing and carers, the SDAC collect in quite detailed information on a person's functioning. In a lot of our other household surveys we include what we call a short disability module, 14 to 16 questions that ask questions to establish a person's functioning or their disability status. Because it's much shorter, it then means those surveys which often have a different focus we can collect a lot more detailed social information but still have the ability to cross-tabulate by disability status.

MR GRAY: Thank you. Could you just explain that cross-tabulation notion in a little more detail. Specifically, would I be right in thinking that the SDAC gives you

very detailed information but it's a relatively narrow population that is sampled, or a narrow sample size that's surveyed, whereas the household surveys might be administered to a broader sample or a broader range of samples across the country?

MS BOLAND: Well, the SDAC does give us a representative sample of all Australians but because quite a lot of the time in the survey instrument is devoted to asking questions about functioning and ageing impacts, it means that we don't ask a lot of other detailed questions, perhaps, about risk factor behaviour or detailed questions about employment history for example. So I wouldn't necessarily characterise the scope of the sample as not being – as being smaller. It certainly is always designed to be a representative sample. However, we would, I guess, focus more of the time in the survey to these detailed questions on disability, ageing and carers which then limits the other information you can collect. And also, I guess the sample is largely made up of people who are – have a disability or who are carers, so if we identify a household where there's several people in the household who are either a carer or have a disability, then all of those people are usually in scope to respond to the survey questions.

MR GRAY: I will just ask the operator to bring up paragraph 43. That's perfect. These are the household surveys into which the short form list of or module of questions is included, as I understand?

MS BOLAND: That's correct, yes.

MR GRAY: And in respect of each of these surveys, they might give you – I'm just trying to summarise. Please feel free to correct me. They might give you contextual information about the respondents to the survey which would be of use to the ABS in understanding whether there are any correlations between results on disability and caring and ageing, on the one hand, and other social factors on the other hand; is that right?

MS BOLAND: Yes.

MR GRAY: Thank you. Ms Boland, I will just ask you a little bit more about something you adverted to right at the start when I asked you about the data sources that are available, and you made it very clear it's not just a matter of survey data that's available but there are administrative datasets and there may be other forms of data. You mentioned work that's being done by the ABS in relation to linking the datasets or using them in a linked fashion. Is this what's referred to in paragraphs 52 and 53 of your statement under the heading Integrated Datasets.

MS BOLAND: Yes, that's right.

MR GRAY: And could you just explain a little more about that exercise or that project, and how is that progressing and when might it yield results?

MS BOLAND: That – those particular paragraphs are referring to a specific project called the Multi-Agency Data Integration Project which is -I will use the acronym MADIP. That actually is a partnership with a number of Commonwealth agencies where we've joined up the census data with a range of other government information. So, for example, there's the Medicare services information, pharmaceutical benefits data, there's tax information, there's social security and related benefits information. There's also education data in there. I would clarify that it's linked up in a – using de-identified information in the case of the census because the ABS makes an obligation to the public that we will destroy name and address information – so when we link the census data, we link using a range of other variables to those sources. So we've linked that data up and with those partner agencies we've created a big dataset. We've made some, what we call a confidentialised unit record file or some subsets of that data available in research facilities and also people are able to become in-posted to the ABS and access the full dataset.

MR GRAY: Thank you, Ms Boland. Now, in your statement from about that point in your statement you're discussing the demographic information that's available. In fact, you start discussing it from paragraph 45 under the heading Demographic Statistics, Population Estimates and Projections. And one of the topics you then move to after that discussion is analytical tools – that's on page 11- where you're responding to a question about what analytical tools exist, or if they don't yet exist, could they be created or repurposed in effect to assist the Royal Commission on the question of how well the aged care system meets the needs of people accessing the system. And you then set out a number of depictions of data that will be of assistance on demographic questions in particular. I just want to first go to paragraph 61 on page 13 and then I'm going to proceed to a number of other images that have been produced by the ABS and ask you to explain those. But just starting with this one, if we're able to expand that text a little bit, please, operator, under paragraph (a) you're referring to the proportion of older Australians in aged care, and what is it that this bar chart or bar graph is depicting, Ms Boland?

MS BOLAND: So this particular bar chart which is using census data is showing you by age group for males and females. I think we've lost some of the colour in this particular version that's appearing on the screen but there should be some bars there showing the males, females and persons, although it looks like it's currently only showing one, the females there. So it's showing you the proportion of people in each of those three age categories, 65 to 74 who are in cared accommodation. If we had it sort of with a good image on the screen you would actually see males, females and persons as well. So, for example, taking that final bar, it looks like it's around about 27-28 per cent of females aged 85 and over who are in residential care.

MR GRAY: Yes. Well, we will make sure that there is a better image of that bar chart available in due course. In a nutshell, is that showing that it's really overwhelmingly in the 85 years old and over cohort that there appears to be take up of the option of cared accommodation, and proportionately speaking, cared accommodation is taken up at ages below 85 in a far smaller degree, relatively?

MS BOLAND: Yes. I would agree with that, so it certainly looks like we're getting up to almost a third of the population in that 85 and over category. Whereas it's certainly in the 65 to 74 age group, for females which we can see there, it looks like it's less than two per cent.

MR GRAY: And I think you mentioned this comes from the census.

MS BOLAND: That's correct.

MR GRAY: Off the top of your head able to say whether the census asks for specification as to the form of cared accommodation?

MS BOLAND: Off the top of my head I would actually think we do collect some information about the facilities that we go to. We built an address register and it does have some information about what exists at each location that we've collected information from. So yes, but I would probably need to confirm that.

MR GRAY: And can there be a regional analysis performed from that data?

MS BOLAND: Yes. Certainly the census, that's sort of one of the big benefits of the census because it is a census of all Australians that we can really drill down to quite small information. So commonly we're even asked to produce things at local government areas, for example.

MR GRAY: Thank you, Ms Boland. Operator –

COMMISSIONER BRIGGS: Might I ask Ms Boland, that graph for those of us who can see your submission also shows that at least in the two older age groups that women are significantly more highly represented. Is the work of the ABS able to determine whether that's because they don't have carers at home to look after them? In other words, their partners may have died or whatever, or that the level of disability of elderly women is greater than the level of disability of elderly men as a cohort?

MS BOLAND: If I take your second question first, so yes, we could definitely look at the levels of disability by sex by age group and, in fact, I can confirm that you're correct, that the level of disability is higher for women. Now, in terms of the reasons that they're in cared accommodation, I'm sort of running through my head, I don't believe from the census data you would be able to get that information. So in the census when you complete the form, it wouldn't ask about the existence of a spouse if you're in a cared accommodation. And yes, I think once you've made it into cared accommodation, for want of a better phrase, then yes, I think we wouldn't really have information on your status of whether you're married or single.

COMMISSIONER BRIGGS: Okay.

MR GRAY: Operator, I would ask you now to bring up a set of images which should appear in colour, RCD.9999.0004.0001. Thank you. Ms Boland, this is taken from paragraph 76 of your statement. Firstly, could you explain what series A, B and C are. What are the assumptions involved in those series?

MS BOLAND: Certainly. So this is part of our demographic work program, this information, and as part of that program we produce population projections. So quite recently – I think it was late last year – we produced what we call rebased population estimates. So we rebase them against the new census data every five years. So in this particular instance you've got the latest population projections for the population aged 65 and over. We produce three series out of that, so in producing those sorts of estimates you have to make a range of assumptions about fertility patterns of the population and migration patterns of the population. And ultimately we then end up producing three series with series A being the highest series there, the blue line, series B the middle series and series C. We've found historically that series B tends to most closely align with the patterns of what actually occurs in the population. So it's the one that's commonly used, for example, as denominators when we're calculating estimates.

MR GRAY: Thank you. There's an extract of text underneath and that's taken from – in fact, I think it's identical to paragraph 76 of your statement. If we just use series B, given what you just said about it tending to be, over the long term, something you found to more accurately reflect trends, is this graph showing that the number of people aged 85 and over is projected to increase both in absolute terms and as a proportion of the entire population?

MS BOLAND: Yes, that's correct.

MR GRAY: Thank you. And, in fact, is the relative increase of the 85 years old and over cohort expressed as a percentage of the total Australian population, does it look like it will roughly double from its present percentage?

MS BOLAND: Yes, it's actually – I think if we look through to 2066 it will actually more than double.

MR GRAY: More than double. If we please now go to the next page of this same document, is this a document taken from the ABS website?

MS BOLAND: Yes. That one comes from a media release following our recent release of the new population projections data.

MR GRAY: And is the text of the media release in the text box in the bottom right hand quadrant of the document?

MS BOLAND: Yes. That's a quote from that media release.

MR GRAY: Thank you. What's the dependency ratio?

MS BOLAND: The dependency ratio is traditionally a sort of ratio that's produced from what's an estimate of the working age population. In this case it's estimated to be the 15 to 64 year olds in the population to the total number of people in the population.

MR GRAY: And is that intended to be perhaps a rough guide, but a guide to the proportion of the population who are earning, that is earning income from work during their working years and in that sense could you described as the fiscal base compared to the rest of the population?

MS BOLAND: That's right.

MR GRAY: And is it a ratio of the people who are outside the fiscal base, so to speak - - -

MS BOLAND: Yes, sorry, I think I just sort of misrepresented it saying it was to the total. But yes, it's those who are in the fiscal base to those who are outside the fiscal base.

MR GRAY: Thank you. I think it was probably my question that was to blame. Thank you for clarifying that. And in respect of these diagrams, what does the left one show?

MS BOLAND: So you've – at the moment you've got it dialled to the year 2018. So it's showing for males and females, the population in thousands as you step through age ranges. So typically often you refer to these diagrams as pyramids and they show sort of bulges where, for example, that bulge at the 30 mark there, as you can see there's likely to be more people there and some bulges sort of later on as well, around that sort of late 50s as well.

MR GRAY: Yes. Thank you. And that shows the profile, if I can use that word?

MS BOLAND: Yes, that's right.

MR GRAY: The profile of the population by age as at 2018?

MS BOLAND: Right.

MR GRAY: That one on the left.

MS BOLAND: Yes.

MR GRAY: And then the one on the right is the same thing projected for 2042; is that right?

MS BOLAND: That's right.

MR GRAY: Do you know on what assumption, is it series B or something of that kind, that has formed the basis of that projection?

MS BOLAND: I believe the one you've got here is series B. I couldn't say with certainty but I believe that's what we would have produced in our media release, so yes, series B which is that mid-level one that I said was usually the one that most aligns with trends.

MR GRAY: Thank you. Now, going to the text of the media release, when the text of the media release says that:

> *The dependency ratio would increase from 52 in 2017 to 58 by 2042 under medium assumptions –*

what does that mean to the layperson?

MS BOLAND: To me, I consider myself a layperson looking at these data, it actually means that we're likely to have a lot more people who are reliant on that fiscal base. So it's going from 52 for every 48 who earn, and by 2042, that's going to elevate and it's likely to be 58 people who are reliant on those in that working age range to produce, you know, the taxation base for Australia.

MR GRAY: So by 2042, for every 42 people in the fiscal base, there will be 58 people who are not, and who are therefore dependent on the people - - -

MS BOLAND: That's correct.

MR GRAY: - - - who are in the fiscal base.

MS BOLAND: That would be certainly the interpretation I would make.

MR GRAY: Thank you. I would like to go to the third document now, please. This is taken from paragraph 66(b) of your statement. We've got three lines depicted in different colours, blue, red and green. What is this graph showing, Ms Boland?

MS BOLAND: So this graph is depicting the number of deaths from dementia, ischaemic heart disease and cerebrovascular disease over the period of time 2006 to 2015. This is the underlying cause of death which is the main cause that preceded the sequence of morbid events that led to someone's death. Now, what you can see here is the interesting pattern of dementia becoming something that's increasingly likely to be a cause of death and, in fact, you can see, for example, that dementia has overtaken cerebrovascular disease around that 2012 or 2013 point. At the same time we've also seen a gradual decrease in the number of deaths from ischaemic heart disease so that's reflecting Australians' good treatment and care of people who have ischaemic heart disease.

So what we found in analysing deaths is that a lot more people are surviving having ischaemic events or having ischaemic heart disease because of the better treatment or prevention available to them. And then as a result of surviving they're living for a longer period of time and we're also seeing that dementia, which is typically more often seen in – amongst much older people, that dementia becomes something that's more prevalent in the older population and is increasingly likely to become a cause of death. So in producing this data, in fact, we have in our causes of death series estimated that dementia is likely to take over and become the leading cause of death for Australians in the 2020s. At the moment it's become the leading cause for women.

MR GRAY: Thank you. I would like to go to the next page, please. The diagram on the left is taken from your statement at paragraph 61(b). Perhaps, what's the source – let's start with the source of each of these two graphs. The one on the left, what's the source of that one?

MS BOLAND: So the diagram on the left is some information from the census. So in the census, we ask three questions about whether people are – people need assistance in certain core activities. So the three core activities we focus on are mobility, communication or self-care. And so in asking those three questions in the census, we establish what we call need for assistance or it's a proxy measure of disability. And generally we find that that set of questions elicits something that's quite similar to how we categorise severe and profound disability. So what that graph is showing you is that the people in the census who've responded that they need assistance. It's separated by sex and we've also got a person line there. You can see that females, I think – which is what the Commissioner alluded to earlier – that females are more likely to need assistance than males. Particularly that becomes more evident as you go up to the 85 and over category.

MR GRAY: Thank you. Now, you mentioned in the course of giving that explanation that it seems to correlate, that is, the answer to the question, need for assistance in the census, or those questions around the topic correlate quite well with profound or severe limitation. Could we now turn to the right-hand diagram. Firstly, what's the source of that and secondly, can you explain how that differs from the diagram on the left?

MS BOLAND: Certainly. So the diagram on the right is from the survey of disability, ageing and carers, SDAC, the one that I referred to before as having a very detailed set of questions on disability. So the diagram on the right shows all of the age groups but if you focus in on that sort of final segment of the graph you will see sort of the similar proportions amongst the older age ranges. Now, the diagram on the right is actually showing disability rates in total. So that would include mild, moderate, severe and profound, which are the top two lines, the blue for the males and the sort of red colour for the females and then we've also sort of singled out only those with a profound and severe limitation, being the lower two lines as well.

MR GRAY: Thank you. If we go to the next page, please. These two diagrams are really dealing with different topics; is that right?

MS BOLAND: Yes. So – and they're also, again, from different sources.

MR GRAY: Perhaps if we start with the diagram on the left. What's the source and what's it depicting?

MS BOLAND: So the diagram on the left is once again from the survey of disability, ageing and carers. This one is a diagram showing the response to a particular question about why someone took on the caring relationship. So when someone is providing care to another person, we've asked them about what was the main reason which they – for which they provide that care, you know, you can see some of the possible response categories there with family responsibility being the overwhelming response to that question. So in that particular survey, SDAC, in this case we would have asked these questions of people who have responded that they provide care to someone, and if it happens that the person who's the recipient of care is in the same household, SDAC becomes an even more important resource to you because you will get a lot more information about that person who is the recipient of care as well as the caregiver and be able to look at facets such as relationships between those people.

MR GRAY: Thank you. The three colours correspond to the relationship between the person responding to the survey, do they, and the recipient?

MS BOLAND: That's right.

MR GRAY: So in the case of partner of recipient in red and child of recipient in blue, and assuming one knows the age of the partner or the child, because they're responding to the survey, one might be able to infer something about whether they're caring for a person over 65 years old?

MS BOLAND: That's right. And off the top of my head I'm aware that we see an interesting pattern where usually, for example, those around about that 40 to 45 to 60 to 65 age range are people who are caring for a parent, and then you will often see the next sort of age cohort above that of people who are caring for a partner.

MR GRAY: Thank you. And as you just mentioned, I think, assuming that the receiver of the care is in the household you will actually know the age of the recipient as well.

MS BOLAND: Yes, that's right.

MR GRAY: So you will be able to analyse that.

MS BOLAND: So the survey would establish a lot of demographic detail about the people who are responding in the survey.

MR GRAY: In respect of the diagram on the right, that's dealing with a different topic, I think you agreed. What's the source of that and what's that dealing with?

MS BOLAND: So the source of this one is the census. The census includes a question asking people about whether they provided unpaid assistance to a person with a disability or a person who had a chronic health condition or, of course, an aged person as a result of problems associated with ageing. So what you're seeing here is a graphical representation of the answers to that census question. Just note that it could be assistance to someone outside of the household, not necessarily someone inside the household. We've just produced for you there three age categories split by males and females and again showing persons as well. So you can see an interesting pattern with, initially in that 65 to 74 age range, it looks like it's approximately 17 and a half per cent of all females in that age range have reported that they're providing unpaid assistance to a person either with a disability or problems associated with age or with a health condition. And then you can see that drop down to a lower percentage in the 85 and over, for example, for females.

MR GRAY: Thank you for clarifying that the percentage in question is a percentage of, when it's a blue line, percentage of all females, when it's the green line percentage of all males and when it's the yellow line, it's the percentage of all persons; is that right?

MS BOLAND: Yes, that's correct.

MR GRAY: And could I just ask – I think you mentioned that the census question concerned whether the person is caring for a person with a disability, chronic health condition or for an aged person.

MS BOLAND: That's correct.

MR GRAY: Are they distinguished? Can you break those out?

MS BOLAND: No. It's all in one question so we can't actually split it out in the census.

MR GRAY: If we go now, please, to the next page. The diagram on the left, do you recognise that as something that has come from an ABS website, I believe?

MS BOLAND: Yes, it is.

MR GRAY: And is this an example of analysis of administrative datasets?

MS BOLAND: Yes, exactly.

MR GRAY: And what is it showing?

MS BOLAND: So this is the result of some work where we linked up the census data in 2011 to Medicare, subsidised mental health related services and PBS subsidised mental health related prescription medications. So by linking the census to those two datasets it enables you to sort of get the benefits of that sort of broad set of demographic information from the census, which you might not necessarily otherwise know about Medicare and PBS use. So in this particular case, what we're showing is – you can see the MBS, the Medicare data is the blue line. You can see that there's sort of more Medicare mental health services than PBS-subsidised medicine use for younger people. And then the pattern diverges beyond 35 to 44 when PBS-subsidised medications become quite more commonly used as a treatment type for mental health.

MR GRAY: And is it the case that both of these datasets are restricted to mental health related items, that is, medical services items in the MBS and pharmaceutical items in the PBS?

MS BOLAND: Yes, that's right. So the scope of this particular work was such that we only linked up the mental health-related services from Medicare so that means it had to be billed as a mental health service. It might include psychiatrist visits, for example, and then again only the mental health-related prescriptions.

MR GRAY: So it doesn't track, for example, the possibility that a GP might be prescribing a mental health-related pharmaceutical product in the course of a general consultation?

MS BOLAND: Yes, so in a general consultation – and I'm assuming you're meaning like a standard consultation which would be billed as an item 23 in Medicare data, so a standard consultation isn't a mental health consultation. Whereas if you went to your GP, for example, and had a mental health care plan drawn up, that would usually be billed as a specific mental health MBS service and it might be possible in that particular consultation that you did get a prescription made. But generally it's only those services or it is only those services billed as mental health specific Medicare services.

MR GRAY: Thank you. If we turn now to the diagram on the right-hand side of the page, this is also, I understand, from the ABS website; is that right?

MS BOLAND: Yes, it's from the same analytical project.

MR GRAY: Now, what is this diagram showing?

MS BOLAND: So in this diagram we're looking at only the PBS medicines and showing the patterns of prescribed medicines by age for the different types of drug categories there used in treating mental health. So, for example, you can see that top yellow line which is the antidepressants, this one is for the total population, so all people and you can see that that one, for example, is heading up around the 75 to 84 age range that around 20 per cent of people are filling their script for an

antidepressant. And, in fact, I'm sort of reasonably familiar with this one because I think one of the interesting findings from this particular study was that it was up close to a quarter of women aged 75 and over who were being prescribed – or filling medication prescriptions for antidepressants.

MR GRAY: Thank you. I notice that there's, on the blue line, which is captioned Antipsychotics, there's quite an increase that seems to appear from about age 65 to 74 and onwards. Is that a correct interpretation?

MS BOLAND: Yes, that's correct.

MR GRAY: And it keeps increasing, including into the 85 years and over category?

MS BOLAND: Yes.

MR GRAY: If we go to the next page, please, operator. Ms Boland, I'm probably running out of time so I won't ask too many detailed questions about these sources, but is it the case that these have come from the ABS census?

MS BOLAND: That's correct.

MR GRAY: And in a nutshell, is this showing that the population is not only changing in the ageing sense that you've already discussed, but the make-up of our Australian community is also changing by reference to the places where people have come from and the languages they speak?

MS BOLAND: That's right.

MR GRAY: And in a nutshell is it the case that there's a tendency for the older part of the population to be more represented by people from European origins and for younger people in the population to be more represented by places outside Europe?

MS BOLAND: Yes. When you're referring to people who are born outside of Australia, that's correct.

MR GRAY: And there are similar patterns in first language; is that the case?

MS BOLAND: That's correct. So this is – the question asked on the census is the main language spoken at home to produce that graph on the left.

MR GRAY: Yes. And just before concluding, we will keep – could we put the next page up on the screen, please, operator. With respect to the economic statistics functions of the ABS, which you alluded to earlier but as you said you hadn't gone into that topic in your statement in detail. You just noted that that might be a source of data of interest to the Royal Commission in the future. With respect to that, could I just ask you about the industry and occupation classifications under which, as I understand it, that data is collected or with respect to which it has some influence.

MS BOLAND: Classified, yes.

MR GRAY: Is it the case that these are the industry classifications for, on the one hand, residential services that, or residential care services that include aged care and that's under that heading 860 residential care services, subdivision 8601, or the group 8601, aged care residential services. So there's a specific reference to aged care residential services by industry classification.

MS BOLAND: That's correct, yes.

MR GRAY: When we go to the topic of home care, it's the case, is it, that there isn't a specific classification for home care? If we just pull back, operator, we can see other social assistance services.

MS BOLAND: That's right. So what you've got on the screen here is a snippet of the classification, the ANZSIC or Australian and New Zealand Standard Industrial Classification. The most detailed level it goes down to are those four-digit categories that you've got on the screen there. And what you've just highlighted, which is the fact that the aged care services, residential services would fall in 8601 but if it was a service provided in the home it would be classified to 8790, and then you can see in 8790 that we've rolled quite a lot of activities into that classification. So you would find that the aged care services provided in the home would be combined with other services as well, such as what you can see there, adoption services combined with aged care assistance service.

MR GRAY: Thank you. Now, I haven't asked about occupation categories, but is it the case that there's a similar issue in respect to occupation categories?

MS BOLAND: Yes, that's my understanding, yes.

MR GRAY: When we turn to workforce issues more generally, am I correct in thinking there are surveys available, for example, periodic workforce surveys?

MS BOLAND: Yes. So the ABS does a monthly labour force survey and then we produce from that sort of quarterly estimates which we release which include estimates of numbers of people by industry. It's only produced down to the three-digit level. That's sort of one example. There's a range of other work such as our labour counts and then also there are even some linked datasets now. One that's called the linked employer-employee database which also would allow you to dig into some of this data and pull out that lead, linked employer-employee database would enable you to pull out some of the detailed data at a four-digit level.

MR GRAY: I have no further questions. Subject to any questions the Commissioners may add that concludes Ms Boland's evidence for today.

COMMISSIONER TRACEY: Thank you, Ms Boland. Your evidence has been most helpful.

MS BOLAND: Thank you.

<THE WITNESS WITHDREW [11.03 am]

MR GRAY: Commissioners, I next call Ms Louise York of the AIHW.

COMMISSIONER TRACEY: Thank you.

MR GRAY: And concurrently, I wish to call Mr Mark Cooper-Stanbury of the AIHW.

<LOUISE ALISON YORK, SWORN [11.04 am]

<MARK COLIN COOPER-STANBURY, SWORN [11.05 am]

MR GRAY: Ms York, what is your full name?

MS YORK: Louise Alison York.

MR GRAY: And Mr Cooper-Stanbury, what is your full name?

MR COOPER-STANBURY: Mark Colin Cooper-Stanbury.

MR GRAY: Ms York, I will ask that you be shown document WIT.0002.0001.0001. Do you have a paper copy of that document in front of you?

MS YORK: Yes. Yes, I do.

MR GRAY: If you just familiarise yourself with it by leafing through it; is that a statement you've made for this Royal Commission?

MS YORK: Yes, it is.

MR GRAY: Do you wish to make an amendments?

MS YORK: No.

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

MS YORK: Yes, they are.

MR GRAY: Commissioners, I tender that document and its identified annexures.

COMMISSIONER TRACEY: Yes. The witness statement of Louise York dated 31 January 2019 will be exhibit 1-7.

EXHIBIT #1-7 WITNESS STATEMENT OF LOUISE YORK DATED 31/01/2019 (WIT.0002.0001.0001) AND ITS IDENTIFIED ANNEXURES

MR GRAY: Ms York, what's your current position?

MS YORK: I'm head of the community services group at the Australian Institute of Health and Welfare.

MR GRAY: Can I call the Australian Institute of Health and Welfare the AIHW.

MS YORK: Yes, you can.

MR GRAY: Thank you. In brief compass what is the organisation and the function of the AIHW?

MS YORK: Okay. The function of the AIHW is to collect, analyse and disseminate statistics and other information about the health and welfare of Australians and our purpose is to make that information available in ways that inform decisions and thereby improve the health and wellbeing of Australians.

MR GRAY: Thank you. And its organisation, is it a statutory body?

MS YORK: That's right. It's an independent statutory authority in the health portfolio.

MR GRAY: Thank you. Now, you mention health and welfare, is it the case that there are differences in respect of the way the functions of the AIHW are exercised with respect to health on the one hand and welfare on the other?

MS YORK: That's right. Well, the legislation enables us to look at both health and welfare and it has a specific function of looking at aged care services.

MR GRAY: And aged care services, which category do they fall within?

MS YORK: They're regarded as welfare services.

MR GRAY: And that's just a matter of the statute having dictated that; is that the case?

MS YORK: That's right.

MR GRAY: I ask that, operator, if you could put up the document RCD.9999.0004.0001 again. If we could go to page 9, please. Ms York, we've assembled a number of the diagrams and another documents, text that you've produced to the Royal Commission into this set of pages, and I'm going to show you these pages and ask you to explain, with the help of Mr Cooper-Stanbury if required, what is depicted, what the data sources are, if there are any limitations in those data sources? Firstly, on page 9, there are a series of topics dealt with here. Just speaking to the first topic "Who uses aged care services", what's depicted in that pie chart?

MS YORK: Okay. So this first pie chart shows the distribution across different aged care service types in terms of the numbers of people using them, and it shows that about two-thirds of the people using services are using home support services, or it's about 800,000 when last measured here. And about a quarter are using residential care services.

MR GRAY: Thank you. In terms of its source, are you able to explain how the AIHW is able to produce documents of this kind, and if you're able to mention the 80-odd datasets that are available and the GEN website that would be of assistance, I think, to the general public as well as to the Royal Commission.

MS YORK: Okay. Thank you. So the AIHW is funded by the Australian Government Department of Health to bring together a whole range of data sources and make them available via the GEN Aged Care Data website. The sorts of data that we draw on are primarily aged care program administrative by-product data, but we do also draw on things like ABS surveys and the census and other surveys such as periodic surveys of the aged care workforce, or longitudinal surveys. And the 80 data tables that you refer to draw from the program data that we receive from the government – from the Department of Health, and they are made up of things like data that come from administering residential aged care services, the home care packages program and Home Support Programs as well as administrative data that we are provided with in relation to the aged care assessment program and the aged care funding instrument. So they're the primary data sources we use to build the database and then we use the GEN website to display that in way that is make it more meaningful and easy for people to understand.

MR GRAY: And is it also the case that using the GEN website, the AIHW or for that matter other users are able to combine those 80-odd data tables or datasets in the manner of their choosing?

MS YORK: Yes, so the 80-odd datasets really combine the aged care data used for GEN and they are merged in various ways to answer specific questions. But in addition that information on request can be linked to other data that's available, and that can include things like hospital data or Medicare data or Pharmaceutical Benefit Scheme data, and there is a potential to link the aged care data with those sources to get a better picture and understanding.

MR GRAY: Thank you for clarifying that. When that is proposed is there an internal process with the AIHW before that's facilitated?

MS YORK: Yes. Yes, there is. So to undertake any data integration activities requires the clearance of our AIHW ethics committee which is established under our Act and also the approval of the data custodians who provide the data to us. So, for example, the Commonwealth in relation to Medicare data or and aged care data and States and Territories in relation to hospital data.

MR GRAY: Thank you. Staying with page 9 of these pages showing graphs and other text, if we move to the right-hand side of page 9, what's depicted and explained there, in particular what's shown in the pie chart at that side of the page?

MS YORK: Okay. So that, contrasting with the distribution of aged care service use, which is dominated by home support, the two-thirds of the expenditure on aged care services is directed to residential care, so that's the pale blue in the pie chart and about a quarter to home care and support services.

MR GRAY: Thank you. Is there a way of separating home care packages, if one wished to, from CHSP, that is Commonwealth Home Support Program funding.

MS YORK: These data are compiled by the Productivity Commission for the report on government services. I might just ask my colleague, Mr Cooper-Stanbury. Do you know?

MR COOPER-STANBURY: Yes, it is possible to split that expenditure into the Home Support Program and the home care packages program.

MR GRAY: Thank you. If we go now to the next page, page 10. In effect, the same questions, Ms York. Perhaps, first, if we start with the sources and then an explanation of what is depicted in the bar chart or bar graph, and explained in the text.

MS YORK: Okay. So again, this data comes from the report on government services, so it's compiled by the Productivity Commission each year using data drawn from the Commonwealth and the States and Territories. And this shows that over time we're seeing a steady increase in expenditure on aged care services and that that is true both for residential aged care and for the home care and support categories.

MR GRAY: Thank you. Again, home care and support is combined but are we to assume it could be split out if required?

MR COOPER-STANBURY: Correct.

MS YORK: I would imagine that they could supply that on request.

MR GRAY: On the next page, page 11, what's the source of this diagram and what's it depicting?

MS YORK: This – this is the – drawn from the GEN Aged Care Data, the program data supplied to the AIHW from the Department of Health and it is, again, showing the steady increase in the numbers of people using mainstream aged care services and that the increase particularly in recent years is larger in the home care types of aged care service.

MR GRAY: So whereas the previous graph is spending, this is the number of people using the services?

MS YORK: That's right.

MR GRAY: If we go to page 12, please, operator. Perhaps just taking the top graph first, what's the source of this diagram and what is it depicting?

MS YORK: Okay. I might actually ask Mr Cooper-Stanbury to describe this one.

MR GRAY: Perhaps if you move a bit closer to the microphone, please, Mr Cooper-Stanbury.

MR COOPER-STANBURY: This chart is derived from the aged care funding instrument data that we receive as part of operating the aged care data clearing house and the ACFI instrument, as we call it, assesses care needs across three domains: activities of daily living, cognition and behaviour, and complex health care. And for each of those domains, people can be assigned a rating of nil, low, medium or high, depending on the assessed care needs. This is showing the distribution of those care ratings from 2009 through to 2017. And you can see that there has been a reasonably strong growth in the high care need rating across that period.

MR GRAY: Yes. What about the bottom half of the page, that diagram is directed to a different topic for care, is it?

MR COOPER-STANBURY: So this is the second care domain around cognition and behaviour. It's derived from five questions within the ACFI instrument.

MR GRAY: Are you able, if you've got knowledge of the sources for the two of these diagrams as they are represented by the questions in the ACFI instrument, are you able to give examples to the Commissioners of what would be care in respect of cognition and behaviour, on the one hand, distinguished from care in the activities of daily living on the other?

MR COOPER-STANBURY: I can give some examples of what's included in those domains. So under cognition and behaviour, it's the care associated with a client's physical behaviours, or their cognition and so the aspects of dementia as it is brought to bear on their care needs. Activities of daily living, as the term suggests, is around

the personal care needs, moving around from, say, bed to a chair or having your daily shower or the like.

MR GRAY: Thank you. Operator, if we now go to page 13, please. Ms York, to the extent that there are differences because the top diagram is home care and the lower one is permanent residential care, please refer to those by all means, but otherwise if you're able to deal with these diagrams together, please give us the data source and again what are they depicting?

MS YORK: Okay. So again these – the data that we're looking at here are drawn from the Department of Health aged care program data, and what they're showing is the – across all of the different age groups and by different levels of remoteness – geographical remoteness – the likelihood or the usage of different types of aged care. So the top figure is showing the usage rate per thousand population and it's showing that of home care and showing that it increases as people get older, although in very remote areas which is the orange bar there, you can see that people are starting to use home care services, or home care aged services at earlier ages. It also shows in the bottom panel that permanent residential aged care is used at higher rates in major cities and lowest rates in very remote areas.

MR GRAY: Thank you. And this is, in terms of its source, that same answer that you've given before, I assume.

MS YORK: That's right.

MR GRAY: The combined datasets available through GEN.

MS YORK: Yes. That's right.

MR GRAY: Thank you. If we go now, please, operator, to page 14; what's the source of this information, Ms York?

MS YORK: Again, this is GEN Aged Care Data or data supplied by the Department of Health as a by-product of their running the aged care programs that they administer.

MR GRAY: In terms of the numbers of organisations identified as operating services, that's information from 2017, is it?

MS YORK: That's right.

MR GRAY: And – or is it 2016/17?

MS YORK: Yes, depending on whether we're presenting here as at 30 June figures or whole year figures.

MR GRAY: Right.

MS YORK: But it's current at 30 June 2017.

MR GRAY: Thank you. And it's the case, is it, that it's breaking out how many organisations there are in the five categories of care mentioned across the top, how many services are - - -

MS YORK: That's right.

MR GRAY: Through which those forms of care are provided and so forth.

MS YORK: That's right. And how many places, where places are a relevant concept to the program.

MR GRAY: And when there's reference made to "places" that means funded places for a recipient.

MS YORK: That's right.

MR GRAY: Thank you. If we go to page 15, I suppose that's perhaps self-explanatory but in brief that's coming from the GEN datasets, I assume.

MS YORK: Yes.

MR GRAY: And what's it depicting?

MS YORK: So it's from the GEN datasets and it's depicting geographically where – the locations of those services. So where the location would be, the base from which the service is delivered, rather than the location of the people receiving the services across all of the different program types, and this is obviously a static map. When you look at this interactively on the website you can drill down and have a look much more closely at the types of services available in a local area.

MR GRAY: So if I choose South Australia and the Adelaide area and zoom in, I'm going to be able to see some of the other colours, and I'm going to see much more detail about their precise geographic location in South Australia?

MS YORK: That's right.

MR GRAY: Page 16, what's the source of these data, and what's the diagram depicting?

MS YORK: These are drawn from the report on government services. So they – this is data that has been supplied separately to them via the Australian Government and the State and Territory Governments, and what this one is showing is spending in each Commonwealth – in each State and Territory in terms of whether it was spent on residential care, home care and support, and the various different programs.

MR GRAY: Thank you.

MS YORK: Per person – per person spending, thank you.

COMMISSIONER BRIGGS: Do you mean Commonwealth Government or State and Territory Government or a combination?

MS YORK: This one is a combination, so it's Commonwealth and State.

COMMISSIONER BRIGGS: Thank you.

MR GRAY: If we go to page 17, what are the sources and what's it depicting?

MS YORK: Okay. So the bottom panel of the – of the exhibit here is from the GEN Aged Care website and the top panels are infographics from the Australian Bureau of Statistics, I expect, drawn from their census data. What this is really – this page is conveying is that the – that there are – that most of the people that live in residential aged care facilities are older than 85 and women, that more than two-thirds are women. The bottom panel is actually combining residential aged care and home care and looking at all of the people receiving those services. And showing that in the older age groups, that it does – really that it's mostly older people and the – a lot of women receiving those care services.

MR GRAY: Thank you. Page 18, the same questions: what are the sources and what is it depicting please, Ms York?

MS YORK: Yes, so this is a GEN Aged Care Data and again looking at the distribution or the – of the people receiving care by age and by indigenous status. So in this case it shows that the – that the proportions are much higher for non-indigenous – that, sorry, that the indigenous people tend to be younger when they're receiving services than the non-indigenous people, and the part of the exhibit that you had up previously also showed that indigenous people are underrepresented in mainstream services.

MR GRAY: That's the text above the graph.

MS YORK: That's the text above, yes.

MR GRAY: If we can go to that text, please, operator.

MS YORK: So what that's saying is that while Aboriginal and Torres Strait Islander people make up three per cent of the population less than one per cent of the people using mainstream aged care identified as being indigenous. And there are – this is partly an artefact of – that there are some specific indigenous aged care services and they're not reflected in the chart below. That's mainstream services.

MR GRAY: So there's a gap in this particular depiction of the data in respect of some indigenous services?

MS YORK: That's right, yes. So in the figure there, that shows the – how many, or the distribution – how many indigenous people are using mainstream services at each age group, but they – there are more indigenous people receiving services through some specific indigenous programs.

MR GRAY: Thank you. If we go to the next page, please, operator, page 19. This is an infographic, I think you described these sorts of diagrams.

MS YORK: Sure. So this, again, is drawn from the GEN Aged Care Data so it's – in particular, this information is drawn from the types of information that are collected through the Aged Care Funding Instrument about people's – either their needs as they relate to their care or just a whole range of different health conditions. And so from somewhere on the record of those – of what's recorded about their needs, we know that six and seven people who are in permanent residential aged care have at least one diagnosed mental health or behavioural condition and that around one in two of those people in those settings have dementia and/or one in two have depression.

MR GRAY: So that's an and/or, is it?

MS YORK: That's right.

MR GRAY: The next page is page 20 on how people – how permanent residential care comes to an end in respect of the individuals who have been in it. And what's the data source, please, Ms York?

MS YORK: The data source is the GEN Aged Care Data and this chart shows that the primary reason for being discharged from permanent residential care is at death.

MR GRAY: There's a segment of the pie chart relating to other residential care, not particularly large; one could quantify it, could one, if you're using the GEN database, you could find - - -

MS YORK: Yes, that's right.

MR GRAY: - - - find what the actual figure is.

MS YORK: Yes. So – and on the website, if you hovered over that piece of the pie, you would be able to see how much it is. So that's people transferring to another residential aged care facility.

MR GRAY: Thank you. If we go to page 21, GEN website, I assume, is it?

MS YORK: Yes.

MR GRAY: Thank you. And what's this bar graph depicting, please, Ms York?

MS YORK: Okay. So this – at the time of discharge from residential aged care this is showing the average length that people stayed in aged care. And it's showing it for all of the different age groups accessing, at the time that they were discharged from aged care. So the centenarians are there for the longest period of time on average, with some of the younger age groups, such as those 65 to 69 tending to be in aged care for a shorter period of time.

MR GRAY: Thank you. What's the explanation, if any occurs to you, in respect of some of the durations around the 50 to 54 and 55 to 59 age brackets?

MS YORK: They, in terms of why they might look like they're a bit longer?

MR GRAY: A bit longer, yes.

MS YORK: Look, that could reflect – it really – it relates to when they came in, how long they were there for which is not a very helpful answer. Have you got anything else you could - - -

MR COOPER-STANBURY: I don't have anything to add.

MS YORK: No, I'm sorry. It's a bit - - -

MR GRAY: It would require more inquiry, no doubt.

MS YORK: Yes.

MR GRAY: Thank you.

MS YORK: Which we could do. So we could look more closely at the care needs of those age groups and their average age at entry. There's different things we could explore there.

MR GRAY: Thank you. Page 22, I see now we're moving to workforce issues. What's the source of this information that's depicted on page 22?

MS YORK: This data we've republished; it's from an aged care workforce survey that was conducted by the National Institute for Labour Studies at Flinders University commissioned by the Department of Health.

MR GRAY: And in brief compass what is it depicting in respect of each of those four years?

MS YORK: Okay, so this is looking at direct care employees, so people who are actually delivering care by their occupation type and year. So if you start from the 2003 panel, I can explain that along the bottom axis it's describing the estimated

number of nurse practitioners, registered nurses, enrolled nurses, allied health professionals and then personal care attendants and community care workers in the orange bar. And so what this is showing, this is across all types of care, residential and home care, and support, and it's showing that over time the growth has been in the personal care attendants and the community care worker category.

MR GRAY: Thank you. And it's showing increases year on year up to the last depicted year, in particular for personal care attendants? Is that right?

MS YORK: That's right.

MR GRAY: And one would have to look more closely at the precise figures in respect of some of the other categories, but my question is, this is a depiction of absolute numbers as opposed to proportions - - -

MS YORK: That's right.

MR GRAY: - - - of the aged care workforce at a given time; is that right?

MS YORK: That's right, this numbers.

MR GRAY: So one would presumably want to inquire into what has been the growth of the sector as a whole and compare it with this information; is that right?

MS YORK: Yes. Yes.

COMMISSIONER BRIGGS: Could you break down the numbers between home care and residential care?

MR COOPER-STANBURY: Between home care and residential care is possible but the home care also includes the home support so it's the community-based programs versus residential care.

COMMISSIONER BRIGGS: Yes.

MS YORK: Yes.

MR GRAY: Thank you. And it would not be possible to break down between home care and home support in respect of this data series; is that right?

MR COOPER-STANBURY: Correct.

MR GRAY: Page 23, please, operator. Ms York, is this from the same source?

MS YORK: Yes, that's right.

MR GRAY: And what's it depicting?

MS YORK: It's looking at the – by State and Territory, the average ratio of direct care workers, so again the people who are actually spending time delivering care to people, to operational places, just in residential aged care, and I should note that it's not a measure of the full-time equivalent, you know, the amount that the direct care workers are working. It's a fairly – it's just a count of their – the fact that those workers are employed.

MR GRAY: Thank you. And if we go to page 24, please, on the topic of language groups in the workforce, what's the source of these diagrams?

MS YORK: This is also from the aged care workforce survey from 2016.

MR GRAY: And in brief compass, what's the top diagram showing?

MS YORK: The top diagram is showing for residential aged care, the proportion of services who reported that they had a worker who could speak a specific language. So, for example, the orange bar there shows that somewhere between 25 and 30 per cent of services said that they had a care worker who speaks Filipino and slightly more speaking Indian, and that less – that under 10 per cent say they have no workers who are speaking a language other than English.

MR GRAY: Thank you. And when you refer to that criterion, you were careful to say that it refers to a service reporting that they have a worker.

MS YORK: Yes.

MR GRAY: It doesn't ask for information to be provided as to how many workers speak a particular language; is that right?

MS YORK: Not to my knowledge, no. We think it's more of a – any – any worker.

MR GRAY: Yes.

MS YORK: But we can clarify that.

MR GRAY: Thank you. And in respect of the diagram in the bottom half of page 24, what is that depicting?

MS YORK: It's the same. Okay. So this one is now for home care and actually shows that a higher, you know, a much higher proportion of services in the home care sector have – aren't able to have workers – do not currently have workers who can speak languages other than English.

MR GRAY: Thank you. And page 25 is the final diagram I wish to show you. Is it the same source?

MS YORK: Yes.

MR GRAY: And what's it depicting?

MS YORK: This one is showing that for both residential aged care workers, which is the purple on the left, and home care workers, which is the blue on the right, that this is quite an ageing work force, that it's – that the highest proportions of workers are in the 55 to 64 or 45 to 54 age bracket.

MR GRAY: Thank you. Commissioners, subject to any questions you may have for Ms York or Mr Cooper-Stanbury, that concludes their evidence for today.

COMMISSIONER TRACEY: Yes, thank you both very much. The statistics you've provided will be extremely useful in structuring our report, and founding our submissions because we really do need to know what the real world looks like and those statistics are a big help in allowing us to do that. Thank you both very much.

MS YORK: Thank you.

<THE WITNESSES WITHDREW [11.40 am]

COMMISSIONER TRACEY: The Commission will adjourn until midday.

ADJOURNED [11.40 am]

RESUMED [12.01 pm]

MS HUTCHINS: I call - - -

COMMISSIONER TRACEY: Yes, Ms Hutchins.

MS HUTCHINS: I call Mr Craig Gear.

MS T. STEVENS: Commissioners, before Mr Gear is sworn to give evidence, my name is Stevens. I appear for Mr Gear and also for the Older Persons Advocacy Network.

COMMISSIONER TRACEY: Thank you.

<CRAIG GEAR, AFFIRMED [12.01 pm]

<EXAMINATION-IN-CHIEF BY MS HUTCHINS

COMMISSIONER TRACEY: Yes, Ms Hutchins.

MS HUTCHINS: Operator, please bring up document number WIT.0007.0001.0001. Is this your statement?

MR GEAR: Yes

MS HUTCHINS: Do you wish to make an amendments?

MR GEAR: No.

MS HUTCHINS: Are its contents true and correct to the best of your knowledge and belief?

MR GEAR: Yes.

MS HUTCHINS: I tender Mr Gear's witness statement document WIT.0007.0001.0001 and the identified annexures.

COMMISSIONER TRACEY: Thank you. The witness statement of Craig Gear dated 31 January 2019 will be exhibit 1-8.

EXHIBIT #1-8 WITNESS STATEMENT OF CRAIG GEAR DATED 31/01/2019 (WIT.0007.0001.0001) AND ITS IDENTIFIED ANNEXURES

MS HUTCHINS: Thank you, Commissioners. Mr Gear, you are the chief executive officer of the Older Person Advocacy Network Limited, also known as OPAN. Could you please explain what is the purpose of OPAN and what is its organisational structure.

MR GEAR: So OPAN is a member organisation of nine State and Territory organisations. These organisations have been delivering aged care advocacy support for around about 25 to 30 years. We came together in 2017 to form an incorporated company to deliver, I suppose, a consistent national approach to supports for older people in relation to navigating the aged care system and raising issues.

MS HUTCHINS: And paragraph 10 of your statement lists the nine organisations that OPAN represents. Could you please explain in broad terms what the nature of these organisations are?

MR GEAR: So these organisations are not for profit. They are listed as charities with the ACNC. They're independent of government and of aged care service providers, and they – what they do is do the frontline support, I suppose, for the older people.

MS HUTCHINS: And what is the size of these organisations?

MR GEAR: Nationally, we have around about 28 locations across the States and Territories. Mostly in metro base but with some regional offices as well, and that equates to around about 60 people, not all full-time but 60 people delivering those sorts of supports and information services.

MS HUTCHINS: Thank you. Next, I will turn to a series of questions in relation to the national aged care advocacy program which OPAN provides. Could I please explain for the Commission the history of OPANs involvement with the delivery of this program.

MR GEAR: Yes. These organisations of our members have been providing similar types of programs, as I said, over a number of decades. In 2017, the Commonwealth brought together that into a single program. What this program is really about is walking alongside older people and their families to provide them the information and advocacy support that allows them to either speak up for themselves when there's issues, to understand how the aged care system works, but also to, I suppose, step in and walk with them to provide and to raise a complaint if they need to do that.

MS HUTCHINS: Operator, please bring up document OPA.001.001.0005. This is the National Aged Care Advocacy Framework. Could you please explain what this document is?

MR GEAR: This is the framework which our organisations work under to deliver those information and advocacy services. An advocacy service is typically – starts with someone contacting us to raise a concern or issue or ask a question of us about the parameters of their aged care package or the services provided within residential aged care. We will then work with that person under these guiding principles of the framework to provide independent support to them.

MS HUTCHINS: Certainly. Operator, if you go to page 3 of this document. Under the heading – under section 4, you will see identified there a list of four activities which are provided under this program. I would like to take you to each of these in turn. Firstly, an activity provided through the program is independent and individually focused advocacy support delivered to older people which includes their families or representatives. How are advocacy support services delivered by OPAN and its member organisations?

MR GEAR: Typically, this advocacy support will mean that we are contacted by the family member or the older person themselves. That will be through our national 1800 number. And then that will go to one of our State and Territory offices who have employed the aged care advocates. That advocate will then explore with the person what their issue is and ask them about what they would like out of the process. So it's very much a consumer driven process. We're guided by the individual and we're on behalf of them, rather than working for the aged care provider. We will then work with them over a series of meetings, either face to face

or through telephone support to give them some ideas and, I suppose, skills to raise the issue themselves. If they don't feel comfortable doing that we will write on behalf of them or go with them to the aged care provider. It also means that we work with the Aged Care Quality and Safety Commission to raise complaints on behalf of the older person when they ask us to do that.

COMMISSIONER TRACEY: How do you advertise the availability of your services?

MR GEAR: Our services are noted in a number of documents that are provided by aged care providers. They're not compelled to provide those documents but we ask that they are included in information. It's on the website. It's on the Aged Care Quality and Safety Commission's website as well and we do ask aged care providers when we go out to provide education if they would like to put up a poster which talks about the benefits of our advocacy support services.

COMMISSIONER TRACEY: I don't know whether you were here yesterday but you may have, if you weren't, have heard of the, or a summary of the evidence that was given by Mrs Spriggs and Mr Spriggs.

MR GEAR: Yes.

COMMISSIONER TRACEY: Did your organisation have any role in assisting them in bringing forward their concerns about Mr Spriggs?

MR GEAR: Commissioner, I have checked with our service. We weren't involved. Mrs Spriggs had been in contact with the official visitors from the mental health service. We were aware of that and we have been providing some support during that process. Mrs Spriggs did talk about a 1800 number and that we would support what she said absolutely about a greater promotion of this – of this number.

COMMISSIONER TRACEY: Thank you.

MS HUTCHINS: Following on from Commissioner Tracey's question, in relation to consumer awareness of your programs, do you think there is a good level of community awareness?

MR GEAR: I think we can always do more on the community awareness of our program. I would like to see greater promotion. We only have limited resources for public awareness of advocacy services and it is something we are continuing to discuss around greater promotion and whether our number can be displayed in residential facilities and included in every brochure.

MS HUTCHINS: Certainly. And returning to the activities listed in the framework document, you identify at number 2 the provision of independent information to support older people and thirdly and fourthly listed is the delivery of education

sessions for promoting aged care consumer rights to older people. How is it that those sessions are delivered?

MR GEAR: The education sessions are typically face to face. They may be provided within a residential facility to a group of older people. We often ask for aged care providers to step away from those so that we can have an open discussion. It's also sometimes when we – advocacy issues come up that people will raise those with us. We also provide community-based education so that might be with Probus groups or Rotary groups or other such community gatherings. In relation to the education of aged care providers, historically we have gone and provided education in services to the staff. We have a challenge, I suppose, reaching within our resources the number of aged care providers that there are and all the staff of large – hundreds of thousands of staff. So we have been moving into more digitally provided manners of delivering that education about consumer rights and what the benefit even for aged care providers that advocacy provides.

MS HUTCHINS: Certainly. And in relation to the delivery of education sessions to aged care providers, do you have a sense of provider attitudes towards these sessions?

MR GEAR: I would have to say it's mixed. The majority would – are encouraging of their staff and themselves being educated about advocacy services. However, we do encounter some resistance to us coming in, where we will have times where people will ask us not to attend to deliver the education session and that's a concern for us.

MS HUTCHINS: How frequently would you encounter that type of response?

MR GEAR: If I think of one of our jurisdictions, one of the largest jurisdictions it has probably been around about 20 times in the last 18 months where we've been refused to come in. That then involves us raising that with higher levels of management to ask for reconsideration of that, and really it's then about us promoting the benefits of that, that this is about helping aged care providers to support their residents and service users. So that's typically how we resolve the issue.

MS HUTCHINS: In your statement, you refer to a free information support line which consumers can contact, operated by OPAN. Is that part of this program?

MR GEAR: Absolutely. So the 1800 700600 works 8 till 8 Monday to Friday and we have a person answering that or the calls coming through to our service delivery organisations in the States and Territories. And that's where, typically, a lot of our information provision – and that will be people ringing us to say, what are my rights as an aged care user, how do I actually access aged care or is the service provider right in what they are saying about what I can or cannot get in my aged care package or as a resident.

MS HUTCHINS: Certainly. And in the instances where an individual calls the support telephone line, that they're having difficulties communicating over the telephone, are there other avenues available to them to be able to access your services?

MR GEAR: Yes, there is challenges for some people. Those who are vulnerable groups who may not engage with telephone lines or online services. We are focusing on going out and engaging with those organisations. We're also looking for more, I suppose, increased opportunities to provide that community-based education where those people might come forward to us.

MS HUTCHINS: And with regards to OPANs advocacy support and provision of information is OPAN funded to negotiate on behalf of potential aged care recipients?

MR GEAR: Our role, I suppose, has typically commenced once someone is registered. We can talk to people and provide some advice around – around navigating the aged care system. However, when we have to prioritise with the people that are coming in who have those issues who are already in the system, the actual negotiation of a package and those sorts of things will more provide advice of where information is available for them.

MS HUTCHINS: This leads to a matter that's emphasised in your statement which is the difficulties people are experiencing in accessing the system. In your experience, what are some of the features of the system that are causing these difficulties?

MR GEAR: If we think along the journey, the consumer journey and where, I suppose, the potholes might be in that, it's people getting information about what aged care services are available. It is then the challenges of negotiating through the My Aged Care system, the registration, waiting for the assessment to be an ACAT or RAS assessment, so they're getting the right type of assessment. And then once someone is assessed for care is being able to access that care in a timely fashion. So the challenge of the waiting list for home care packages we hear about a lot and people ringing us to ask is there any way for them to be a higher priority because their care levels have changed. Then it's – once someone has started their packages it's those agreements and then negotiating fees and charges that they might be incurring from that package and having proper choice, I think, is one of the biggest things we hear. Is it a real choice they have in their package.

MS HUTCHINS: OPAN expresses a view that the introduction of the consumer gateway known as the My Aged Care package has not resolved a number of access issues. Please elaborate on your views in relation to the My Aged Care plan and in particular what it has helped to address and what it's still lacking in.

MR GEAR: So in addressing what it has helped, it has brought information together into one area, and has provided a consistent pathway in for all types of aged care. The challenge is it only works for people who, I suppose, have access to IT

infrastructure or can use the telephone system or can wait on the telephone system as well. So where that brings challenges is when we start to look at some of our more vulnerable Australians and we start to look at people in remote locations or people who may not have that connection to technology, and it is less functional for those people. So if you're talking about remote Aboriginal communities or homeless people or those with mental health issues it does not work well for those and we need a different approach for those types of populations.

MS HUTCHINS: Thank you. You raised one difficulty OPAN has observed in relation to the My Aged Care system is the nature of the correspondence that's being sent to users. Can you please explain your views in relation to that?

MR GEAR: Correct. The – often when someone is either allocated a package or is getting an update about their package sent out in a letter, sometimes those letters don't arrive and then – or the telephone calls that might be accompanying those don't get answered. At this stage I suppose the common practice is if they haven't answered three times, that that person is considered that they don't want their package and that's typically not the case. So that communication and the understandability of the letters and communication is really important that we focus on that in the future to make that easier to understand.

MS HUTCHINS: And is understanding this correspondence one of the services that OPAN assists consumers with?

MR GEAR: If a consumer rang us and said, "I have this letter; I don't understand it", we would step them through that letter and what it means, and then encouraging them the next steps around how you then access a service provider and establish your package or your service that you're looking for.

MS HUTCHINS: In terms of accessibility to the system, what changes would OPAN encourage to enable or encourage greater accessibility for people that want to enter the system?

MR GEAR: In relation to My Aged Care and the access system, I think the – the need to have a face-to-face or additional types of supports that supplement My Aged Care is really important. It's not something that works for everyone and we need to be targeting these other vulnerable groups which is part of what is the aged care system navigator trial and we're hoping to see how that evolves for better connections. It needs to be information that is available at different locations as well.

MS HUTCHINS: Certainly. Would you please explain for the Commission what is involved in the aged care system navigator trials?

MR GEAR: Sure. My understanding of the trials is that it was a measure from government to look at a more face-to-face or community volunteer support system that provided information to people, really about how that system works from registration through to set-up of the service. The trial is meant to be commencing

soon with national coverage of different locations and looking at volunteer models and testing volunteer models, testing paid models and also testing some virtual models as well to help people understand how that registration and access system works.

MS HUTCHINS: What's the expected timeframes for delivery of this program?

MR GEAR: My understanding is the trial works through to June 2020.

MS HUTCHINS: And do you have a view on the current breadth of the trials?

MR GEAR: I would probably refer you to the department and to the – the lead agent, COTA, on the trial. It is a trial and so it isn't in every location. It is something that could be expanded. We would hope that that would happen if the trials are a positive outcome.

MS HUTCHINS: Thank you.

COMMISSIONER TRACEY: Does your organisation have the resources to allocate an individual care worker to these vulnerable people who need to be walked through the system?

MR GEAR: Commissioner, no, at this stage. We have – we have to prioritise our services to those most in need. It is absolutely something we are focusing on. We have a target of at least 20 per cent of our services have to be delivered to people with special needs. Part of the – one element of the aged care navigator's trial is six full time equivalent specialist support workers, but when you spread those across the country that is very difficult to provide face-to-face services for those, and often with communities where there has been a lack of trust of government or a trust of the system, that is the way you need to build that level of trust to be able to do that. It's something we would like to see more resources into.

COMMISSIONER TRACEY: One hears on the radio from time to time advertisements for organisations such as Agedcare 101 and similar organisations who say that they will pilot people through the maze of - - -

MR GEAR: Yes.

COMMISSIONER TRACEY: - - - the system. Do you have any understanding of how they work? Do people have to pay for those services or - - -

MR GEAR: My understanding is that there are – they are a fee for service organisation. So where we're talking about people with lower economic supports they would not be people who would be able to access those types of services. Hence the importance of OPAN and our services which are free and independent. There are also concerns that some of those services may be connected to service

providers as well. So I suppose that's the other advantage of our service, is that it is independent of the aged care provider as well.

COMMISSIONER BRIGGS: Could I follow up on Commissioner Tracey's question about the correspondence that comes from providers or from My Aged Care to just drill a bit more about why is it that people can't understand the correspondence. Is it literacy? Is it language? Is it the letters are complex? What are the issues?

MR GEAR: I think, Commissioner, it is all of those things. It also might be that people aren't connecting that letter with the assessment that may have occurred and that assessment may have been a few months ago. So when that suddenly letter comes again there are some people also who don't like official-looking letters, and so we would like to see that there's other mechanisms of engaging people during that phase of the registration and access process to deal with some of those barriers.

COMMISSIONER BRIGGS: And that would be a form of explanation or what would it be?

MR GEAR: Absolutely. I mean, explaining and also, I suppose, educating people about how they – their rights as an aged care user and also about how to maximise the opportunity that's there as well.

COMMISSIONER BRIGGS: Thank you.

MS HUTCHINS: Thank you. Moving to the topic of challenges for isolated indigenous and marginalised communities, you raise this in your statement as an issue that has particular issues in accessing the aged care system. Could you please provide some examples of the type of challenges that these communities face in particular?

MR GEAR: So one example that was recently told to me was around, I suppose, some of the remote communities in – in the Northern Territory, places like Nhulunbuy where either weather and the tropics limits the time you can go out there and it might be that people have to fly in and fly out and hire a plane to go and talk to people in that community. And typically the communities are closed in the sense that it is a community of trust and you need to build the trust. So it needs to be people who are coming who have an acceptance of the elders and other people there. So that way takes a different model but it's a very expensive model so it does take – and there's a lot of time and travel as well. So the challenge is we haven't been resourced, I suppose, appropriately for those types of outreach-type models but they're very, very important so that all Australians understand the aged care system and their access to it.

MS HUTCHINS: And do you have any observations about what these communities generally, being remote areas, issues that they may experience in dealing with the

aged care system, both trying to get into the system and also when they're receiving some services?

MR GEAR: Sure. First of all is the element of trust. A lot of these communities have had intergenerational trauma. They have had – might have been part of the Stolen Generation, so the trust of government services is – is understandably low. That way they need, I suppose, a trusted broker to be in between. There's also the issue of workforce. So if there is a flexible aged care program which the Commonwealth does fund, there is a challenge of having appropriately skilled people and also having the same quality of care as we would get in the city. This is a challenge for rural and remote locations, not just very remote Aboriginal communities. But we need to probably look at different models which might be using Aboriginal health workers or community members to be part of that care team as well, but it's a challenge right across Australia, I think.

MS HUTCHINS: Yes. And this idea, as I understand it is, what you describe in your statement as a tailored response to the specific issues in these communities. Do you think that the current landscape of the aged care system adequately takes into account the ability to implement these types of tailored responses?

MR GEAR: I think we sort of talked yesterday that there was a little bit of information around, I suppose, even having the funding – the funding at the right levels but then having, I suppose, the systems support to build those types of models and that sometimes people aren't bidding for those types of processes. So I think we need to actually have a greater focus on what that community might need and actually consulting with the community as well and with consumers of aged care of what works for them.

MS HUTCHINS: Thank you. Moving to the topic of elder abuse, this is a issue that's raised in your statement at paragraph 28. Operator, if you could please go to paragraph 28.

MR GEAR: Yes.

MS HUTCHINS: You note here in this paragraph that:

> *OPAN identifies that elder abuse is an area where it has developed a national framework of rights-based principles, individual advocacy and preventative education.*

In broad terms could you explain what this means.

MR GEAR: A number of our organisations have been providing education to either communities, to aged care providers and to older people around the risks around elder abuse, and also about strategies to try and prevent that. So it's an awareness raising but also a prevention strategy. We received some seed funding to be able to develop that up into a national program and evaluate our current services. So now

what we're doing under a consistent framework is delivering education out to community and also telephone or face-to-face support, specifically around people who might be at risk of elder abuse, or are being, I suppose, a victim of elder abuse at this point in time and then helping them to refer on to other services as needed.

MS HUTCHINS: What are typical forms of elder abuse that OPAN has observed?

MR GEAR: It is quite broad. It could be psychological. It could be when the person is a recipient of aged care. It might be physical abuse from a family member, or from, I suppose, some of these – these occasions that we've seen. Often it's financial abuse, financial elder abuse or risk of – there's challenges around the enduring power of attorney and people understanding the appropriate role of an enduring power of attorney and that the person who also may have challenges in their capacity still has the right to make supported decisions in relation to their care.

MS HUTCHINS: Yes. And in the final sentence of this paragraph you note that this area requires ongoing Australian Government funding and support. Could you please expand on this?

MR GEAR: At the moment, the program that we have has, I suppose, a limited reach. There has been discussions around a national elder abuse plan and we look forward to that plan and the support services that are needed, but this is, I suppose, something that is – crosses organisations and needs a sort of whole of community approach to identification and prevention of this elder abuse and, really, community awareness of that which needs funding as well.

MS HUTCHINS: Thank you. In relation to home care packages and wait lists, you raise in paragraph 38 of your statement that the Australian Government investment in the home care packages is not meeting community expectations. What do you think the community expectation is in relation to these packages?

MR GEAR: So the – I suppose the difference with us from other advocacy organisations is we are having around about 230 to 240 people calling us each week around their concerns, and what they're telling us is that the wait times are just too long or the level of support that they're getting is not meeting their needs. So the capped system is not meeting the demands; the supply is not meeting demand in Australia. At the moment that is equating to 18 to 24 month waiting times and we would say that's not acceptable and older people are telling us it's not acceptable. Anything under three months would be something we were looking for.

MS HUTCHINS: You note further that while interim packages are offered to consumers, they are often not accepted. Why do you think these interim packages are not being accepted?

MR GEAR: Again, I suppose there's complex issues. There's some concerns about, "If I take this package now, I will be stuck and this is all I will receive". There's concerns around the impact on functionality and those sorts of things and

that I would be better off just keeping on doing what I'm doing. There – the – I suppose the inadequacy, I think, and the length of time that that might take to get to the proper package is the biggest concern.

MS HUTCHINS: Thank you. Operator, if we go to paragraph 42 of the statement. In this paragraph, Mr Gear, you state that:

> *In recent years OPAN member organisations have received more requests for advocacy to understand and negotiate home care packages than requests for advocacy regarding the provision of quality care.*

Why do you think this is occurring?

MR GEAR: I think it's because – well, it's not just because I think. I think we've got the callers to our services which are saying, " don't understand the fee structures. I don't understand what I'm expected to contribute, and I'm worried that this is not value for money". People are also calling in relation to negotiating the choices that they have under these packages and their ability to, I suppose, direct the care. So are these meant to be consumer-directed or consumer-driven care and at this stage people are only being given limited choice. That equates, I suppose in, practical terms where some people are saying they don't have a choice of when the person is coming to actually deliver the care or there are multiple people who come to deliver the care and it's that, rather than the actual support that is delivered in the home itself when it happens.

MS HUTCHINS: Certainly. In relation to governance of care, in your statement you mention a need for governance of care rather than just complaints and auditing which I understand you perceive to be the current focus in the system. What do you mean by this idea of governance of care?

MR GEAR: So we do work as part of, I suppose, the complaints and support ecosystem and so working with the – we're looking forward to working with the Aged Care Quality and Safety Commission but in that, we – we would like to see that it moves from just that baseline level of what we think the standard should deliver which is a minimum standard to looking at people trying to exceed those standards and to be able to have a – engagement with consumers so that their feedback around their experience of service is part of that. But that there is a system and a structure that is encouraging both good clinical care but also good social care so it's marrying those things together to help maximise the outcome for older people.

MS HUTCHINS: In relation to the new standards which you've just mentioned, which are due to take effect on 1 July 2019 do you think they go far enough?

MR GEAR: I think the standards should be seen as something that is baseline and that any good service provider will be looking to work with their care recipients to find out what exceptional service would mean for them, and that would help people, draw more people to them, but also I suppose from the consumers to be the

advocates in that sense as well, of who are a good aged care provider. We would like to see more of that. We are pleased that standard 6.3 starts to talk about the need for feedback and the need for complaints mechanisms that are free from retribution or concern and access to aged care advocates such as ours we think is really important.

MS HUTCHINS: Certainly. In your statement, you draw on the definition of quality and safety from the World Health Organisation. Operator, if you go to paragraph 88.

MR GEAR: Yes.

MS HUTCHINS: Could you provide a further explanation as to what this definition picks up and why you think it's important?

MR GEAR: So this definition, I suppose, is an adjustment from our perspective of what we saw some of the more social aspects of quality needed to be built into what has typically been, I suppose, a health or community development definition from the World Health Organisation. But we think broadly it's the same sorts of things as we expect from a quality and safety in the health care system or in other service systems. So we're starting to see that how that sort of framework might be applicable to aged care, where it has been further developed in the health system and we think there's some applicability though to where we want to go with aged care.

MS HUTCHINS: Thank you. You also raise the idea of embedding supported decision-making in all aged care service offerings. Could you please explain the rationale behind this suggestion and explain why OPAN considers it to be of importance.

MR GEAR: So at OPAN and under the aged care advocacy program we work with the assumption that the consumer has capacity. And I think too often we see that there's assumption that older people don't have the ability to make decisions, or decisions for themselves or take limited risk, and we see that there's a need to actually reframe, I suppose, the way that we engage with older people so that we assume capacity and then those who have some limitations or limitations at certain times, that we work with them about the decisions they can still make, so that we don't infantilise them or take away all their rights to make decisions, but it's a staged approach and a supported approach.

MS HUTCHINS: You raise also in your statement a concern that you've observed from your members' organisation that when there's issues with particular residential care facilities being sanctioned, that this impacts on the family more generally. Could you please explain these concerns that you've seen to the Commission.

MR GEAR: Sure. So OPAN and our service providers are supportive of what I suppose an involving and increasing audit process and an unannounced audit process. But in that, that has led to an increase in the numbers of sanctions being applied. The sanctions tend to, I suppose, impact the family and the whole

community at an aged care service and there's probably limited information that is provided to families and other residents about what does this actually mean. Our services do go to those sanctions meetings and we often ask for a chance to speak at that to explain our services that were available for people. But it does impact on, I suppose, the people's trust of the system and so there does need to be an ongoing system of support for those services, one, to help them improve, but, two, to support the families and the older people to know that they will still be provided a safe and ongoing service, and that's what we see an increased role for ourselves as part of that system.

MS HUTCHINS: Certainly. And what further work would you like to be able to provide should funding be available?

MR GEAR: If we were resourced properly I think we would be going back to those services on a number of times to make sure that the older people, we can check in with them that they are feeling safe, that they are explained what this process means, and that their rights are able to be upheld. The single charter of rights is a really important initiative in this, that we want to be out there also educating people around the charter of rights as a user of aged care services and that would be something else that we would be doing along the way.

MS HUTCHINS: Operator, please turn to paragraph 84. Mr Gear, at 84 in your statement you identify some examples of good and innovative practices based on positive feedback provided from consumers in your OPAN member organisation network. I would like to now go through a number of these with you as it's important for the Commission to get some ideas about good services as well as the poor. Could you please explain to the Commission how you have seen the use of volunteers and local supports as means of combating social isolation and loneliness work in practice?

MR GEAR: I think there's a scheme such as the Community Visitors Scheme though I would say it's under-resourced to expand to the level of need, that that idea of someone coming in and sitting with a recipient of aged care in a facility, and actually engaging with them and connecting with them and hearing about their life story and doing that on a regular basis, it's so important to reduce social isolation. And some of the models that we're seeing around younger people engaging with – with aged care recipients and looking at that as part of a social inclusion practice is really important.

MS HUTCHINS: And what is an example of the younger people engaging?

MR GEAR: I think they're talking there around the Play Up model, which they have seen examples of young people coming in and playing music or – and I think we've seen in some of the media around younger people who, even young children and connecting. So it's almost that modelling and grand-parenting connection that is taking place as well, which is great for both generations. And also, I suppose, great

for reducing the impacts of ageism where a community is understanding the value of older people which I think is something that's so important in our society.

MS HUTCHINS: You note also an example of independent living and residential aged care tailored models. What do you understand this to involve?

MR GEAR: So there are some emerging models of what's called micro-communities, those sorts of things, where it's more of a household-type environment rather than being the large facility. That is particularly important for people with dementia and it has seen some very good outcomes because the older person is still engaged around the skills of things that they like to do and are good at, are brought into that part of that care model as well. The other thing there is really around the types of models that are focused on vulnerable people who might be homeless or at risk of homelessness. So the Wintringham services in Victoria have some very flexible and open models around residential support but also supporting people to be in an environment that has good open spaces and those sorts of things, and also respects people around their dependencies on alcohol and other things that have a balanced approach to that risk and I think that's really important, that they've actually worked out a model that works with the person over time to meet them where they're at in that journey as well.

MS HUTCHINS: Are you able to provide some further detail about the form of accommodation that may take?

MR GEAR: So I actually have visited the Wintringham service in Victoria. It was amazing open design and open spaces which recognise that people who have been homeless have, I suppose, a history of trauma and that needs to be respected and worked in an environment where they still feel they're safe, but they're not constrained and I think that was a beautiful model of respectful openness and respectful risk-taking as well.

MS HUTCHINS: Thank you. Respect for the elderly and fostering a culture of respect as a nation for the elderly is a matter that the Commission is interested in. What are your views on how this challenge may be progressed?

MR GEAR: I think at OPAN we would see it as a whole of community approach that's needed. We all, I suppose, are at risk of judging people and their limitations. I think it needs to be a model that – that celebrates the achievements of older people and transmits those to younger generations as well. So we are becoming involved with the EveryAGE Counts campaign that the Benevolent Society and a number of other organisations are working on and I think as we sort of work through that – work through those sorts of volunteer models, I think it will start people to understand and respect older people right through as their generations, as people who have still got a lot of functionality and a lot of contribution to give.

MS HUTCHINS: Are you able to provide some further detail about what the EveryAGE Counts campaign involves?

MR GEAR: So the ..... have taken a pledge to commit to, I suppose, calling out ageist actions and ageist perceptions that may be out there, either in the media or in service provision. So – and they are looking, I suppose, to do a broader community awareness campaign which we hope that they will be able to find support and funding for.

MS HUTCHINS: There's no further questions from me, Commissioners.

COMMISSIONER TRACEY: We've heard some evidence about community visitors, volunteers who go to aged care facilities and give them the once over, their own audit and if they find something amiss, then they report it. Do these people work under your auspices or in conjunction with people in your organisation? How is the interaction?

MR GEAR: Yes. Commissioner, so I think yesterday we did hear some – some information about what might have been the official visitors that's connected to the mental health program. There is a community visitor scheme of volunteers who connect with older people and as I was saying before, around the discussions that they may have with them. And that time they - - -

COMMISSIONER TRACEY: Do you coordinate their function?

MR GEAR: No, that's coordinated through the Commonwealth department. Some of our services have connections with those services and a greater, I suppose, connection – coordination with that is something we would like to see.

COMMISSIONER BRIGGS: Mr Gear, in your evidence, I think you alluded to supply problems on the home and community care side, covering that whole home care sector.

MR GEAR: Yes.

COMMISSIONER BRIGGS: And you also talked about the waiting times. Are you finding that people are compelled to enter residential care because that becomes available before the home care package that they've been waiting for is delivered because they've got a similar assessment level for both, or the same assessment level for both forms of care?

MR GEAR: Correct, Commissioner. Our services are hearing cases of that, and that might be for a number of reasons. It might be, and hopefully Carers Australia will talk about it later. It might be about carer burden and caring for someone for that length of time without the right level of support coming in does impact on the family and those sorts of things. It may also be that the right level of re-ablement support and focus is not there, whether that's through physiotherapy or social engagement, therefore that means that the level of function of that person deteriorates quicker than it needs to, and therefore residential becomes, I suppose, the next option in that. I think a greater investment and earlier access would prevent some of those

things. It may also mean the person goes to hospital when that would be avoidable if those home care packages were in place to the right level at the right time.

COMMISSIONER BRIGGS: In your evidence, you also, in effect, described a quite dynamic system that needs nuanced communication to ensure trust and the provision of the right care along the stages of the process. This could become bigger than Ben Hur. How do you see that kind of system working, ideally?

MR GEAR: So ideally, yes, it would be lovely to support every single person with one-on-one support and – but unfortunately we probably can't achieve that. That means that there needs to be multiple mechanisms. That may be some online or webinar-type supports or even that sort of education about what does an aged care package mean and those sorts of things. So that there's short films or those sorts of things. The telephone support we provide, which is round about 230 calls per week can, I suppose, make it more efficient to provide some of that information. It's also working with communities and other health systems in the primary health networks probably to propagate that information out there so it's more easily accessible and understandable.

COMMISSIONER BRIGGS: Do you see a role for general practitioners in that area?

MR GEAR: Absolutely. General practitioners are key to this and also the practice nurses as well. Hence, I suppose, my connection to the primary health networks. I think some of that propagation through there and through general practice and, I suppose, with their professional associations, there's education through there as well. We would like to see that as well as, I suppose, a boosted advocacy support service as well.

COMMISSIONER BRIGGS: You also mentioned in your evidence the disempowerment of elderly people and the progressive loss of decision-making, even though many times they're quite capable of making those decisions. Have you got any suggestions about how that whole process of interaction might be helped to work better?

MR GEAR: So we have been doing some research around the supported decision-making process and so we're sort of developing a toolkit in relation to that and that is then working with the aged care workers, working with families as well though so that they take the time to actually ask the older person, "What does being in control mean to you?" Some people do want some help in those things. Other people say, "This is what that means to me" and almost having a plan around that, of what does – supported the decision, "When would you like someone to step in? When do you want to be respected and checked in that this is what you actually want?" We need that sort of model to get through all our services, I think.

COMMISSIONER BRIGGS: Do you find, Mr Gear, that it's common for people to plan for their care needs?

MR GEAR: I think in our society we have limited discussions around our future ageing needs and what our care needs. We might have a discussion around advanced care planning of what we don't want to happen. We don't have a lot of discussion about what we do want to happen in – as we – as we age and I think those discussions need to start happening with families and with society.

COMMISSIONER BRIGGS: Thank you.

MR GEAR: Thanks.

MS HUTCHINS: Just a further follow-up in relation to the Community Visitors Scheme, which you've again touched on now. Does this scheme encourage engagement by younger people?

MR GEAR: I think the focus of the Community Visitor Scheme to date has been more older people volunteering. I think that would be an exceptional strategy where we would look at younger people being able to provide some of those supports as well. We are looking to do some trials with the Community Visitor Scheme and also schemes like Meals on Wheels to look at different ways that that engagement can occur.

MS HUTCHINS: Are you aware of any schools or scout groups or similar organisations that are involved in engaging with the aged care system?

MR GEAR: I'm not aware of personally. I have, I suppose, seen some in the media. There are strategies that we would like to look at to see, can those sorts of services, as part of a community contribution or a volunteering program, be expanded and supported but they need, I suppose, the coordination services around them as well, which would be very important.

MS HUTCHINS: Thank you. No further questions.

COMMISSIONER TRACEY: Thank you. Thank you, Mr Gear, for those insights. They're going to be very useful to us in due course.

MR GEAR: Thank you.

<THE WITNESS WITHDREW [12.56 pm]

COMMISSIONER TRACEY: The Commission will adjourn until 2 o'clock.

ADJOURNED [12.56 pm]

RESUMED **[2.05 pm]**

COMMISSIONER TRACEY: Yes, Mr Gray?

MR GRAY: Thank you, Commissioner. I call Mr Paul Versteege, V-e-r-s-t-e-e-g-e.

<PAUL VERSTEEGE, AFFIRMED **[2.06 pm]**

<EXAMINATION-IN-CHIEF BY MR GRAY

MR GRAY: Might Mr Versteege be given a hard copy of document WIT.0009.0001.0001?

MR VERSTEEGE: Yes, I have.

MR GRAY: Thank you. Mr Versteege, I understand that you prepared an earlier statement in the Royal Commission dated 31 January 2019, and you've replaced that statement with a statement dated 7 February 2019; is that correct?

MR VERSTEEGE: That is correct, yes.

MR GRAY: Is this document, with the exception of paragraph 77 which has been blacked out - - -

MR VERSTEEGE: Sorry?

MR GRAY: With the exception of paragraph 77 which has been blacked out, is this document a copy of that statement of 7 February 2019 that you've made in the Commission?

MR VERSTEEGE: Sorry. Yes, it is.

MR GRAY: It is. Mr Versteege, I understand that you wish to add to paragraph – or rather footnote 18 on page 16?

MR VERSTEEGE: Yes. That's correct. In that footnote, I describe how the CPSA – the organisation I represent – contacted the office of the Minister for Aged Care to clarify the membership of the workforce council because we thought that there were only three members, being the aged care industry representative bodies. We wanted to confirm that. But we have not received a response, have not received a response by the time we made our submission – initial submission on 31 January, and have not received any response to date.

MR GRAY: And is the additional information you wish to add with respect to that footnote to the effect that you still haven't received any information.

MR VERSTEEGE: We still have not received any information.

MR GRAY: Thank you. And with that additional information, to the best of your knowledge and belief, are the contents of this, your statement, true and correct?

MR VERSTEEGE: Yes, they are.

MR GRAY: Commissioners, I tender Mr Versteege's statement, WIT.0009.0001.0001.

COMMISSIONER TRACEY: The redacted statement of Mr Versteege dated 7 February 2019 will be exhibit 1-9.

EXHIBIT #1-9 REDACTED STATEMENT OF MR VERSTEEGE DATED 07/02/2019 (WIT.0009.0001.0001)

MR GRAY: Thank you, Commissioners. Mr Versteege, I want to ask you, before we begin the process of seeking elaboration of matters in your statement, about a document that you refer to in paragraph 31.

MR VERSTEEGE: Yes.

MR GRAY: Operator, thank you, if you would bring up paragraph 31. So Mr Versteege, in paragraph 31 you refer to a document called or headed Aged Care Regulation in Quality – Activities and Actions containing certain information.

MR VERSTEEGE: Yes.

MR GRAY: I will now ask the operator to bring up a document that you've provided to the Royal Commission which bears that title. Operator, please bring up RCD.9999.0005.0001. Mr Versteege, just taking a moment to look at that document, is that the document you refer to in paragraph 31 of your statement?

MR VERSTEEGE: Yes, it is.

MR GRAY: How did you obtain it?

MR VERSTEEGE: I obtained it after vigorous inquiry. I knew a document of this nature existed because a media report had been prepared that seemed to indicate there was such a document, and I subsequently obtained a document from a Federal Government backbencher who had received it from the Minister for Aged Care's office.

MR GRAY: I tender that document.

COMMISSIONER TRACEY: Yes. The document from the Department of Health entitled Aged Care Regulation in Quality – Activity and Actions will be exhibit 1-10.

EXHIBIT #1-10 DOCUMENT FROM THE DEPARTMENT OF HEALTH ENTITLED AGED CARE REGULATION IN QUALITY – ACTIVITY AND ACTIONS (RCD.9999.0005.0001)

MR GRAY: Thank you. Mr Versteege, I want to ask you some general questions about your role and the CPSA.

MR VERSTEEGE: Okay.

MR GRAY: What's your current role?

MR VERSTEEGE: I'm policy manager for the CPSA.

MR GRAY: And that's the Combined Pensioners and Superannuants Association.

MR VERSTEEGE: That's the Combined Pensioners and Superannuants Association, a very long name.

MR GRAY: Thank you. Who are the CPSAs members, broadly speaking?

MR VERSTEEGE: Broadly speaking, we're talking – it's a New South Wales organisation so the vast majority of our membership is – lives in New South Wales. In our constitution it says that we represent low income retirees, which tends to exclude, for income security purposes – advocacy on income security, self-funded retirees but, of course, on issues such as aged care we are universal in the people we – the constituency we try to represent.

MR GRAY: When you say on issues such as aged care, do you mean any specific topics in aged care or aged care generally?

MR VERSTEEGE: Aged care generally.

MR GRAY: You mentioned some of these things in your statement but if you wouldn't mind elaborating on them and explaining on them in testimony. How does the CPSA engage with its members on the one hand and how does it present its advocacy of positions on behalf of its members to others?

MR VERSTEEGE: We are a grass roots organisation. We were created in 1931. And a lot of the work is done by volunteers, by members who sit on the executive which is the equivalent of a board. So they run CPSA, if you like, and they make

policy in the lead-up to CPSAs annual conference which is the main policy-making body, so the executive will keep an eye on things as the year rolls on. We then go to conference and after quite often vigorous debate we will make policy.

MR GRAY: And how do you present that to others or advocate it to others?

MR VERSTEEGE: Well, our advocacy is similar to what other organisations do. We make submissions to inquiries, parliamentary inquiries, departmental inquiries, this Commission and we also try to gain media exposure for the issues that we advocate on because we feel that publicity is the best form of transparency to air issues that really need addressing.

MR GRAY: Thank you. Now, I notice in your statement that you are – my word – critical of certain other bodies that are in the space of aged care policy and advocacy, and formulation of policy. I'm going to mention some of the bodies that you have – again my word – criticised and ask you to explain to the Commission what's the basis of your concerns about, say, the representative nature of those bodies or whatever other concerns you have about them.

MR VERSTEEGE: Okay.

MR GRAY: You mentioned the National Aged Care Alliance – NACA.

MR VERSTEEGE: Yes.

MR GRAY: What are your concerns about the representativeness of NACA?

MR VERSTEEGE: Well, the National Aged Care Alliance, NACA as everybody calls it in the space, was created mainly by aged care providers. Certainly, initially the membership of the National Aged Care Alliance was numerically dominated by aged care providers and we believe it still is dominated by aged care providers, even though quite a number of other organisations have joined NACA. At one point NACA was basically – had a direct line into government, to the office for the Minister for Ageing – I'm sorry, for aged care, and our concern has been and still is that an organisation, an alliance that is dominated by a certain interest group will necessarily push those interests above all others. So that even if consumer organisations like the Council on the Ageing and some others, when they join that alliance, they risk diluting the advocacy that they can do for their constituency, the consumers. That is our concerns about – concern about NACA.

MR GRAY: All right. I should also mention the other bodies that you've, in effect, singled out in your statement. You mention the Aged Care Sector Committee.

MR VERSTEEGE: Yes.

MR GRAY: Are your concerns of the same kind or is there anything you wish to add?

MR VERSTEEGE: Well, yes, it is almost identical because the Aged Care Sector Committee is there to guide government policy-making, reform, and it is, again, dominated, we feel, by aged care providers. The – there's a membership of 15 and practically all of them belong to NACA. We have three representative organisations for the industry, LASA, the Aged Care Guild and ACSA. They are also part of that; they're also part of NACA. So you have what looks like quite a variety of people all singing from the same song sheet, which is the song sheet of aged care providers in the aged care industry who will, obviously – I wouldn't do anything different – push their own interests.

MR GRAY: In your view?

MR VERSTEEGE: In my view.

MR GRAY: You've also mentioned the Aged Care Workforce Taskforce.

MR VERSTEEGE: Yes.

MR GRAY: Is it the same concern that you have, Mr Versteege?

MR VERSTEEGE: It's similar; it's not identical. The taskforce was formed and excluded unions, for example. It was a workforce task – a workforce taskforce. So it's very hard to see how that taskforce could do a proper job of consulting with staff, for example, in formulating its strategy that it was mandated to develop without talking to unions, and that's what they did. And I note – this is also in my statement – that the head of the taskforce, Professor Pollaers, who in the strategy said that, you know, the hot issue of mandatory staffing – sorry, staff-to-resident ratios that, really, we shouldn't go there, that that wasn't an appropriate policy response.

MR GRAY: That was in the report of the taskforce?

MR VERSTEEGE: In the report of the taskforce. And he has since come out – has gone on record and not just gone on record, but gone on record in a media release by the biggest union for aged care staff to say that mandatory ratios for staff should be implemented urgently. So we really welcome the fact that Professor Pollaers has changed his view but it also shows that if you can deliver a strategy at one point and six months later drastically change your view, that something somewhere in that process has gone wrong.

MR GRAY: Commissioners, before the close of the February hearing, staff of the Commission will seek comment by Professor Pollaers.

Thank you, Mr Versteege, and just finally, you mention a body formed only last month, the Aged Care Workforce Industry Council. What can you tell the Commissioners of your understanding of the composition of that council and what its role is?

MR VERSTEEGE: Well, the council's role is to implement the workforce strategy as it was delivered a few months ago. That is its role. As I mentioned when we started this conversation, the membership of that council seems to be three representative aged care industry bodies and no other organisations. We have not received any advice to the contrary and that is – that is a concern, I would say, if you're going to implement a strategy and you only have employers do that.

MR GRAY: Mr Versteege, I will go to another topic now. It's the topic that you place front and centre in your statement of aged care safety - - -

MR VERSTEEGE: Yes.

MR GRAY: - - - in particular but I will also ask you about quality and your comments about the current system. In your statement at paragraph 9 you say:

> *Of all the issues that the aged care system must resolve and manage over the next few decades none is more important and pressing than aged care safety.*

MR VERSTEEGE: Yes, that's correct.

MR GRAY: In terms of your conception of the meaning of "aged care safety" and "aged care quality", do you see them as similar concepts but on a continuum where safety are the basic minimum requirements and quality is - - -

MR VERSTEEGE: Yes.

MR GRAY: - - - what comes after that. Could you please explain your views about that.

MR VERSTEEGE: Yes. Aged care safety means all the minimum things that need to be in place on to make sure that people are housed properly, that they – that they eat properly, clothed, all the very basic stuff that must – that must be met before you start talking about the extras, although not all aspects of quality as we understand it are sort of extras, but you get my drift. It is really the basic stuff that needs to be correct first.

MR GRAY: Shall we put paragraph 21 of your statement up on the screen where you identify five areas - - -

MR VERSTEEGE: Yes.

MR GRAY: - - - where you consider there to be safety issues.

MR VERSTEEGE: Yes.

MR GRAY: Is that so? Can you speak to each of those, please.

MR VERSTEEGE: Sure. The first dot point in paragraph 21 is safety from abuse and exploitation. We've seen a lot of reports, too many reports of quite horrific abuse in residential aged care, graphic video reports and not just that. The report on the operation of the Aged Care Act each year details the number of reportable assaults. These are assaults that the Act defines as significant sexual or physical assaults. That number is published each year. It's now stands at 1.7 per cent of aged care residents can be – can expect, on the basis of the last figures to be assaulted, basically, by a member of staff.

MR GRAY: Can I just stop you there for a moment.

MR VERSTEEGE: Certainly.

MR GRAY: If the operator, please, puts up exhibit 1-10 again, and if you please zoom in on the bottom set of figures under Department of Health. Mr Versteege, are these, to the best of your knowledge and belief, taken out of the operation – the report on the operation of the Aged Care Act for the two – for the three years in question, '15/16, '16/17 and '17/18.

MR VERSTEEGE: Yes, they are.

MR GRAY: Are you speaking of the figures appearing in the top row?

MR VERSTEEGE: Yes, the reportable assault reports, that's what I'm referring to. As you can see, it's – yes.

MR GRAY: The percentage figure appearing in the right row is headed at the top of the page Percentage Change in Last Financial Year. It's not an absolute percentage by the looks of it. It's a figure which relates the last column to the preceding one, I suggest.

MR VERSTEEGE: That's right, yes.

MR GRAY: Thank you. We will now go back to the explanation that you were giving the Commissioners about safety from abuse and exploitation in paragraph 21 of your statement.

MR VERSTEEGE: Okay, so that is – those are extreme forms of abuse. I would say that there is – that there's probably a lot of abuse resident-on-resident. People with dementia – some people with dementia do become aggressive and can display that sort of behaviour to other residents. Of course, that is not reported at all.

MR GRAY: Can you explain that to the Commissioners. What's the reporting obligation?

MR VERSTEEGE: The reporting obligation is for – for – for staff assaults on residents to be reported. That's what it boils down to. It's not phrased like that but

that is what it boils down to. There are – other assaults are not counted in the reporting, and as far as I know they – in many facilities they are not even recorded. And we can assume that it happens a lot. Very recently there was an assault in the Illawarra in New South Wales - - -

MR GRAY: I would ask you not to - - -

MR VERSTEEGE: I'm sorry.

MR GRAY: - - - mention the specific – no, I just want to get in first. In this hearing we're not examining specific criticisms of any particular organisation, so perhaps if you can just bear that in mind in recounting this example to the Commissioners, I would be very grateful, Mr Versteege. Thank you.

MR VERSTEEGE: But you know there was a resident who bashed another resident to death. There are more examples of very violent attacks of residents on residents which makes the – makes facilities very unsafe. And as I said, it's not reported, it's not recorded, it's not subject to any – to any sort of administrative record-keeping that can be reported across an industry.

COMMISSIONER TRACEY: Presumably there would have to be a recording of an attack by a resident on a staff member for occupational health and safety record reasons?

MR VERSTEEGE: That could well be, but the – the resident-on-resident assaults - - -

COMMISSIONER TRACEY: Well, I understand that.

MR VERSTEEGE: Yes.

COMMISSIONER TRACEY: But there is that other category of attacks on staff members.

MR VERSTEEGE: Yes, there is. And, of course, it is very well possible that some of the reportable assaults, that is, staff to residents, are a consequence of resident to staff violence. That is – that is very – it's quite – you can empathise with somebody who, when attacked, tries to defend themselves and gets into trouble that way.

MR GRAY: Mr Versteege, can I ask you, to your knowledge, are there any reform proposals around broadening the reporting obligation?

MR VERSTEEGE: Not that I know of.

MR GRAY: All right. There will be more on that, Commissioners, in due course.

With respect to safety from abuse and exploitation, Mr Versteege, was there any other information you wanted to give the Commissioners on that point, or shall I ask you now about adequate housing?

MR VERSTEEGE: Well, perhaps that, safety from abuse and exploitation, it is also at a very low level where perhaps some residents are ignored when they ring the bell for attention because they're seen as irritants. It's that sort of low level abuse that – or neglect that happens as well. And I think it's very prevalent and it makes the lives of many residents a misery.

MR GRAY: When you say it's low level, do you mean it's low level viewed in isolation for a short time, but its cumulative effect over a long period, what do you say about that?

MR VERSTEEGE: Well, the cumulative effect would be very dispiriting and depressing for residents. When I say low level, I mean in comparison with violence.

MR GRAY: Yes. Perhaps if I can ask you now about your conception of adequate housing being part of safety in aged care.

MR VERSTEEGE: Yes. Look, you know, we're not alleging here that nursing homes are facilities in bad repair generally. There might be a few. What we are referring to here about adequate housing covers the way people are accommodated. A lot of nursing homes, residential aged care facilities still put up to four people in a single room. Those people might be strangers to – well, in most cases are strangers to each other. They may have various degrees of disability. There might be people with dementia who are disorientated and wander and disturb other people. Those are the sorts of issues that we think exist in residential aged care and is really a breach of safety for a lot of – a lot of residents.

MR GRAY: Has CPSA got data on those matters or are you referring to anecdotal reports to you?

MR VERSTEEGE: These are anecdotes but I'm not aware of – but there must be reports that refer to all types of accommodation is available from facility to facility. It is not illegal.

MR GRAY: Can I ask you about adequate nourishment in the context of safety?

MR VERSTEEGE: Yes. There is the quality of food which is subject to a lot of complaints. Again, this is anecdotal. We also refer to – in our statement, refer to studies that have been done on nutrition in aged care facilities which generally confirm that the circumstances there are not as they should be. Rates of 50 per cent of malnutrition in residential aged care facilities are very common, apparently, according to these studies. I must say that outside, amongst older people, malnutrition is a big issue as well, but, you know, we are talking about people who

have moved into care and are still malnourished. That is a very obvious breach of safety.

MR GRAY: Thank you. And next, perhaps this is obvious, certainly with respect to clinical care, but you refer to receiving adequate personal and clinical care.

MR VERSTEEGE: Yes.

MR GRAY: Would you care to elaborate?

MR VERSTEEGE: Well, we've all seen – most people have seen the reports on the ABC Four Corners program. You also hear stories. We sometimes get anonymous letters from staff who have witnessed horrendous things happening to people where personal and clinical care was basically withheld.

MR GRAY: What are the ways in which – clinical care perhaps speaks for itself because presumably clinical care is addressing a health need.

MR VERSTEEGE: Yes.

MR GRAY: And if not addressed that's a risk to the person's health.

MR VERSTEEGE: Yes.

MR GRAY: Never mind being a risk to their wellbeing as well. What about personal care, how does that become a safety issue? Can you think of any examples?

MR VERSTEEGE: Yes, I can. Look, the line between personal and clinical care in residential aged care facilities has blurred. I – I refer to, for example, medication management. Quite often the medications that people need to take are supposed to be given to them by a nurse, at least an enrolled nurse, in some cases a registered nurse. But quite often their medication is provided in what is called as a Webster-pak, what is called a Webster-pak or a blister pack and it's actually personal care workers that go around and look – well, it's Tuesday morning so Mrs Johnson gets the pills that are in that little box.

MR GRAY: Now, just to stop you there.

MR VERSTEEGE: Yes.

MR GRAY: These packs are typically a plastic container with a sliding lid; is that so? And the pills arranged by - - -

MR VERSTEEGE: Usually it's - - -

MR GRAY: - - - times of dispensing.

MR VERSTEEGE: Usually it's a plastic tray with little compartments in them covered by plastic and each compartment can be accessed separately so that you, you know, you can take your medication in the morning on the Tuesday and, you know, so you take those pills.

MR GRAY: And so are you saying that at some point responsibility for dispensing medicines, including controlled poisons under State legislation, is in the hands of care attendants who are dispensing from those packs. Is that the point?

MR VERSTEEGE: Not the latter category but – that's called normal medications. Yes, that's certainly what we hear.

MR GRAY: So ordinary – what did you call them, I'm sorry, ordinary medicines?

MR VERSTEEGE: Well, prescribed medicines but not schedule 4 or schedule 8 drugs.

COMMISSIONER TRACEY: The packs are made up by dispensing chemists, are they not?

MR VERSTEEGE: They are, yes. And that is a type of safeguard, of course, to make sure that the appropriate pills are ..... but we are talking about very frail persons in aged care facilities. So it may well be that it is not suitable for a person who normally gets – let's say a diuretic which makes you go to the toilet and dehydrates you – is given that tablet at a point where that person is dehydrated already. Now, a personal care worker does not have the knowledge or typically does not have the knowledge to say, look, you know, I know there is a diuretic in there, we will take that out. They don't have the authority to do that even. So the whole batch gets administered to the – to the resident and we have a medication failure.

MR GRAY: And finally, adequate access to care equipment and supplies.

MR VERSTEEGE: Well, yes.

MR GRAY: Do you wish to elaborate?

MR VERSTEEGE: Sure. I can give the examples that probably everybody knows. In nursing homes it's quite common for – for continence pads to be rationed, that is, the anecdotal evidence we hear from nurses that work there, and from staff. But it also happens in – in home care that people have trouble accessing very basic equipment, like a wheelchair, for example, and get stuck into a wheelchair that they have to – in which they have to be pushed, rather than that they can operate themselves. It might be the wrong size. The programs – the equipment programs that are supposed to service people in the Commonwealth Home Support Program and also in the home care packages program are not that – not working that well.

MR GRAY: Just taking those two examples, where you refer to a person being, I think you said stuck in a wheelchair, say, is that a risk to safety because of the risk of, say, pressure sores?

MR VERSTEEGE: Well, it could be one of the things but it could be – it could be that it gives you – it gives them other pains, muscular pains. There's a whole, you know, if you get the wrong wheelchair and you are really stuck in it and you depend on it for your mobility, it can also lead to – to depression because you can't get anywhere. If you are frail and you can't operate, you can't operate the push wheelchair yourself.

MR GRAY: Yes. And equally in respect of continence pads, there are real safety issues involved in not supplying - - -

MR VERSTEEGE: Absolutely.

MR GRAY: - - - a proper replacement of an incontinence pad and leaving people with their skin in contact with urine and faecal material; is that so?

MR VERSTEEGE: Yes, I'm not a medical person but obviously the skin of older people is a lot thinner than of younger people. It is compromised much more easily and, yes, if a continence pad is soaked or it has – it has faecal matter in it and it is in contact with the skin, that is – you keep that up for a while, that's life-threatening. Yes.

MR GRAY: Now, you expand on the concept of safety in the paragraphs that follow 21 by introducing the notion that you contend that getting access to aged care services is itself a safety issue. Could you explain to the Commissioners your idea and any examples you care to advance in support of that contention?

MR VERSTEEGE: Yes. Access to – to aged care is probably the first – the first – the first and foremost feature of aged care safety. If you can't get aged care and you need it, then you are even worse off than people who are in an aged care facility or in a home care package that is – that is inadequate. So it is – it is very much if you are assessed as needing aged care, particularly when you get to the point of, say, a home care package level 3, then there is really no room for delay to access that type of care because if you delay it, deterioration may be very rapid. And, of course, the aged care system is set up as an eligibility system, which – I always refer to eligibility as a euphemism for waiting list.

And I think we've heard evidence in this very room about, that it – you know, that the waiting period should be reduced to three months. I would contend that for a lot of people three months is way too long. Aged care safety depends on access and it needs to be – it needs to be provided straightaway. The Aged Care Act, if I may expand on that, the Aged Care Act has as its objectives to fund the aged care system, and it refers to safety, quality, and a whole host of things.

MR GRAY: Let's ask the operator to put up section 2.1 of the Aged Care Act. Operator, RCD.9999 – thank you very much. Do you have that there, Mr Versteege?

MR VERSTEEGE: I do, yes.

MR GRAY: And please go on. You were saying the Aged Care Act refers to a whole lot of matters.

MR VERSTEEGE: Okay. So the objects are listed in 2.1(1) as follows:

> *To provide funding for – of aged care that takes account of –*

and then it goes into quality of care, the type of care and a whole list of things, and so when you first read it you think, well, you know, aged care must be funded, we have to have regard to all these things. But then sort of the knockout punch comes in subsection (2) where it qualifies the – the availability of funding and the making available of funding by referring to:

> *the limited resources available to support services and programs under the Aged Care Act and the need to consider equity and merit.*

In other words, there is a – at the very start of the Aged Care Act there is a mechanism which has been used throughout the operation of the Aged Care Act to actually limit supply. There is a justification for supply. It makes it an eligibility program. There is always going to be a waiting list, if you use these objectives exclusively.

MR GRAY: In your statement you refer to other programs in our community which are not eligibility programs but which you refer to as entitlement programs and you, in effect, single out aged care and also oral and dental care as being in a second rate category, if I might use that expression. Would you care to elaborate on the comparison you make between certain forms of service provision - - -

MR VERSTEEGE: Yes.

MR GRAY: - - - which you call entitlement services and aged care and oral and dental hygiene on the other.

MR VERSTEEGE: Okay. Look, the Medicare system, which is a general health system, is an entitlement system. If you have a headache and you don't – you don't feel good about that you can go to a doctor and you get a Medicare rebate, no questions asked. If you have a disability, the NDIS, it's a very recent program, recently introduced program, you are entitled to help and funding under that program. But if you – if you have bad teeth in Australia and you can't afford to go to the dentist, then you have to go on a waiting list. Similarly for aged care, if you – if you need aged care, you will probably have to wait for it.

And in respect of aged care in those other systems, when you look at the NDIS which is for people up to the age of 65, so if you have a disability up to the age of 65, you fall under an entitlement program and you will continue to do so after you've passed the age of 65, but if you are over 65 and you develop a disability which can be a mobility issue and it can be – it can be dementia and a range of other things, of course, you have to rely on the aged care system and that is a waiting list system. So it is – it is very much age-based, the difference between disability at the age of 65 and less and disability 65 and over. It is a clear case of age discrimination which is only validated by the fact that it is in legislation and therefore not caught by antidiscrimination legislation.

MR GRAY: Thank you. I do want to go back and ask you about what you seem to see as the consequences of perceptions about safety and residential care because – and I would ask the operator to put up paragraphs 26 to 29 of Mr Versteege's statement. In these paragraphs you seem to make linkages between concerns about safety leading to a reluctance to enter residential care, leading to what you identify as quite a lengthy – I beg your pardon, quite a – quite an extensive number of people approved for residential care who have not taken it up.

MR VERSTEEGE: Yes.

MR GRAY: Is that the chain of causation you're identifying here?

MR VERSTEEGE: Yes. We – as part of the reports that are provided quarterly on the operation of the home care packages program, the most recent report also reports on the number of people who have been approved for a home care package but have dual approval, that is they are also approved for residential care. And that number is 90,000 or almost 90,000 in the latest report. And people are waiting around in lower – excuse me – in lower level home care packages or even without a home care package, rather than going to residential aged care. I have to say that even though the – the waiting list – because the waiting list is 90,000, the residential aged care system could - - -

MR GRAY: When you say "waiting list" do you mean - - -

MR VERSTEEGE: Yes.

MR GRAY: Yes.

MR VERSTEEGE: Yes, it's not a waiting list as such. It's a dual approval, so all those 90,000 people are basically on the list for a home care package. It's just that we now also know that if they have a dual – a dual approval for residential aged care, so among those people 90,000, if they wanted to – to go into residential aged care and some are eventually forced to, not all of them could be accommodated because the occupancy rate in residential aged care is currently stands at 90.3 per cent, and I think the – the capacity of the residential aged care sector is about 217,000 places.

So there is no way that you can accommodate 90,000 people in – in nursing homes just to relieve the pressure on the home care package program. There is - - -

MR GRAY: Can we go to paragraph 16, please. Is that the point you're making there and the figures?

MR VERSTEEGE: Absolutely, yes, there are 127,000 people on the home care packages waiting list. Some of them have lower level – a lower level than – for which they have been assessed, another package, but the entire waiting list is 127,000 people are waiting for adequate care, and of those 127,000, 90,000 have approval for residential aged care as well. So that would cover the home care package level 3 and 4, I would imagine.

MR GRAY: Thank you. And if we now go to your paragraph 27 again, and in – you refer there to declining occupancy rates in residential care. There seems to be – the gist of your evidence here seems to be that there is an enormous queue for home care.

MR VERSTEEGE: Yes.

MR GRAY: There's significant overlap with people who have been approved for residential care but there's a good deal of reluctance on the part of those people to take up their residential care places, if I can put it that way, because of the sort of sentiment referred to in the survey that you conducted in 2015 which you refer to in paragraph 28. Is that the gist of your evidence on this point?

MR VERSTEEGE: It is. It's very well put, yes.

MR GRAY: And you identify safety as central to this distortion, if I could put it that way; is that correct?

MR VERSTEEGE: Yes, that is correct.

MR GRAY: In paragraph 30, if the operator would be so kind, you identify, amongst other things, you just mention in passing that home care is not monitored for safety. Is that just the Commonwealth Home Support Program that's not monitored for safety?

MR VERSTEEGE: Yes.

MR GRAY: Or is that – right.

MR VERSTEEGE: Yes.

MR GRAY: So home care packages are monitored for safety, are they?

MR VERSTEEGE: Yes, they are. There is a program and there have recently been some non-compliances so it is – it is active and it's working.

MR GRAY: Thank you. I want to take you to exhibit 1-10 again. You've identified in your statement some conclusions you draw from this document as to possible reasons for the uptick or increase in what might loosely be called compliance activity or action in 2017/18. Let's just take that a step at a time. If we look at the 2017/18 column, I think every figure is higher, some markedly higher than the year before and the percentages appear in the column on the right. There's one that is not higher than before which is notice of intent to issue directions but apart from that every single metric is higher. You've made some observations about this and drawn some conclusions in your view about what the causes are. What are those?

MR VERSTEEGE: Well, the question, of course, is when you have a year on year increase in noncompliances, reportable assaults, missing residents report, referrals to – to the regulator, you ask yourself the question why is this such a sudden dramatic increase? Has the aged care industry undergone some catastrophic event or what is the cause of the quite astronomical increases in – that are shown in this document? It is – it is my view that there has not been a specific event that – or a string of events that have caused this sudden increase in noncompliance. The reason for this is that the Aged Care Quality Agency, as it was then called, started to do things differently when they went out to assess residential aged care facilities.

One example that I mention in my statement is how it assessed the nutrition requirement or a standard where previously they would refer to documents, they look at menus, they look at what the nursing home might have ordered in the way of food and would then conclude that everything was okay. And that happened assessment after assessment after assessment and people got used to the agency coming in and looking at that so that was always in order. But suddenly the agency changed tack and actually observed what was happening in the dining room of a – of facilities and what they found was that people were served a meal but were unable to get to it, not everybody obviously but quite a few people were unable to actually eat that meal. And because staff were rushed, they would not be able to assist them. Staff would come round and collect the uneaten meal and a person would basically not eat – not eat.

That way, they were able to – to dole out quite a few noncompliances on that particular part of the standard on nutrition. They started to do things differently and that has led to the – to the sudden increases. Facilities were used to being assessed in one way; they were suddenly assessed in a different way, and the result was massive noncompliances. Of course, this happened in one year and I think part of one year and I think the increases you would – you would have seen if – if – because in one year not every facility is going to be assessed. If all facilities had been assessed in that single year, you would have seen even higher figures than that.

MR GRAY: Thank you.

COMMISSIONER BRIGGS: If I might ask, are you suggesting that the regulatory regime was a kind of tick and flick approach to regulation, with people looking at what had been provided in reports and so on, rather than actually checking seriously what was occurring?

MR VERSTEEGE: Well, it's very difficult to – to measure compliance. It's not an easy job at all. I guess the people who actually did the assessments got set in their ways, that there was a certain way of doing things and they did it, with the best of intentions, we must assume. But as part of that process, everybody got so used to doing it in a certain way and getting a certain outcome, that when, you know, a fresh light was shone on performance, that performance was found to be wanting and, yes, tick and flick, that is probably a good – a good description. That's how it ended up. The processes of assessment are to talk to residents, to talk to staff and to look at documents. The guide for assessors is quite clear on that. So that's what they have been doing. Of course, they were also at liberty to look around and do things a little bit differently and that is actually what is – that is what is happening now and this is why we are seeing, in my belief, such a huge increase in noncompliance.

COMMISSIONER TRACEY: Thank you.

MR GRAY: Mr Versteege, I want to return now to one of the ideas that you develop when discussing the eligibility characteristics of the aged care system. And in particular, I would like you to turn to paragraph 25 of your statement where you refer to something called the aged care provision ratio, ACPR.

MR VERSTEEGE: Yes.

MR GRAY: What is the ACPR?

MR VERSTEEGE: The ACPR is a ratio which is calculated – estimated by the Department of Health to determine how many places – aged care places there should be available to – to the people that need them, and they – the ratio is usually set as – as a number of 1000 residents over a certain age. That – that – historically it has been over the age of 70. I think they are going to use over the age of 75 soon in recognition of the fact that people live longer and enter residential aged care or enter care later.

MR GRAY: Just stopping there.

MR VERSTEEGE: Yes.

MR GRAY: Is it a particular number which is currently 125 people, for each 1000 people in a particular age cohort currently above 70?

MR VERSTEEGE: Yes, that's correct.

MR GRAY: Soon there will be presumably some sort of recalibration exercise based on the age cohort being some ratio of that cohort of the population who are over 75?

MR VERSTEEGE: Yes, that's how it works. You have - - -

MR GRAY: And it's only currently that 125 - - -

MR VERSTEEGE: Yes.

MR GRAY: - - - out of 1000 - - -

MR VERSTEEGE: Yes.

MR GRAY: - - - who are funded. Is that how it works?

MR VERSTEEGE: Yes, well, they make that available as a place so there will be – residential aged care services can apply for a place that is – that is made available as a result of the recalibration of the – the aged care provision ratio. So each year there are a number of places that – that are made available and residential aged care facilities can put people in those places and then apply for subsidies from – from the government to fund the care of those people.

MR GRAY: Can you express some views about the ratio?

MR VERSTEEGE: Yes.

MR GRAY: Would you care to explain those views?

MR VERSTEEGE: Yes, I've used the term that it's really a smoke and mirrors approach. Because the ratio goes up continuously, the illusion is created that the supply of aged care places is adequate, and that, you know, each year is reviewed and it goes up, so it's still adequate. That has always been sort of how the – how the aged care provision ratio has been projected by – by the regulator. And as we now have seen from the home care packages report, quarterly reports, supply is anything but adequate, either in residential aged care or in the home care packages program.

MR GRAY: So if we just go to the last sentence of paragraph 25, just that last phrase:

> *ACPR targets are set to keep pace with the increases in the number of people aged 70 and over.*

Are you saying there that because it's 125 places, be they a mix of residential and home care and perhaps flexible care, because it's 125 per 1000 people in the age cohort over 70, then to the extent that that age cohort increases, the gross number of places will increase. Is that the illusion that you're referring to?

MR VERSTEEGE: Yes, well, the overall number of places is increased but not sufficiently to – to actually abolish the undersupply that has existed for a long time.

MR GRAY: Thank you. I want to ask you now about a different topic which is assessment methodology and compliance, and you've made some comments about the 2018 single framework for quality, and I will give it its correct name, it's the single aged care quality framework which is to commence in operation on 1 July 2019. Mr Versteege, you've included in your statement reference back to the current accreditation standards which will come to an end mid-year.

MR VERSTEEGE: Yes.

MR GRAY: And you've identified two documents, the Quality Surveyor Handbook and Results and Processes Guide which actually, as I understand your statement, give a fair bit of guidance as to the meaning of or the application of the current 44 residential care accreditation standard expected outcomes.

MR VERSTEEGE: Yes.

MR GRAY: Are you saying there's no such guide available in respect of the new principles, the new single framework quality principles which are about to apply; is that right?

MR VERSTEEGE: Well, to my knowledge it doesn't. You know, we're still a way off from the actual introduction of – of the new – the new regime, but I think – and I think, you know, they might be working on a document. It's not a point of criticism. It just doesn't exist at the moment so I can't comment on whether there's actually a change of tack or not in how this new framework is going to be used in the assessment of residential aged care performance.

MR GRAY: Thank you. You do express some other criticisms about the new framework I think. What are those?

MR VERSTEEGE: Well, to me it seems that the single aged care quality framework is – is a rewrite of the – of the old accreditation standards and common home care, where home care – common standards. It's probably a good idea to merge them, but I don't really see a change of approach to – to setting standards. I think they're very similar. I think there's basically a one-on-one relationship between the requirements of the new system, as they are called, and the expected outcomes of the old system.

MR GRAY: Is it the case that you wish to see greater detail around objective and uniform compliance measures? Is that the gist of your criticism?

MR VERSTEEGE: Yes, it is. I think that if you are going to assess performance you can only do so in a way that is uniform and objective across the – across the industry. That is fair to the industry and it is fair to consumers. I think that both the

regime we've got at the moment of accreditation standards and home care common standards and the new framework does not touch the level of – this is a difficult word.

MR GRAY: Specificity.

MR VERSTEEGE: Yes, that is required.

MR GRAY: Thank you, and you mentioned three standards in particular when we're looking at the new quality framework.

MR VERSTEEGE: Yes.

MR GRAY: Standard 3 personal and clinical care, standard 5 service environment and standard 7 human resources, and you suggest to the Commission in your statement that these can and perhaps should be made the subject of more objectively measurable uniform compliance criteria; is that right?

MR VERSTEEGE: That is correct, yes.

MR GRAY: Can you give the Commission any examples as to how that could be done in respect of any of these three standards, personal, clinical care, personal environment or human resources?

MR VERSTEEGE: Okay. Perhaps I can take the example of – of – of CCTV footage in combination with documents that have been produced as part of providing care, records of when people have been turned, you know, skin care and medical examinations which are completely lacking from assessments at the moment of residents. If you introduce those elements – introduce those elements in – as part of the standards and you reference them to – perhaps be referenced to external protocols on how to manage wounds, skin – compromised skin, you would have a much – a much better idea of the performance of a particular facility on the score of personal and clinical care. I also think that if you do that across those three – three standards that you've mentioned, that that gives – that probably sums up the performance of – of the particular facility so that you don't have to go into a lot of the other stuff which is basically checking whether people do do continuous improvement and have strategies in that regard. If you – if you actually check how well people are in a facility, that captures the performance of that facility.

MR GRAY: Thank you. I want to now ask the operator to put up page 17 of your statement where you have a list of recommendations. And I just want to cover off the matters that lead to a number of these suggestions. In effect, the suggestion at paragraph 82, it explained your contentions in respect of an entitlement approach to aged care being more appropriate than an eligibility approach and you've given examples of waiting lists and other matters, and is that what lies behind paragraph 82?

MR VERSTEEGE: Yes, it is.

MR GRAY: And when we come to 84, in effect, is this a conclusion you draw from the concerns you expressed around safety, or are there any other matters you wish to advance to the Commissioners in respect of your recommendation at 84?

MR VERSTEEGE: We think that aged care safety is compromised, and particularly in residential aged care to the degree that we have seen these horrific reports which are often dealt with as, you know, this is just a – an instance of – of something rather than, you know, it's the rotten apple approach. If you remove the rotten apple the rest will be fine. We take the tip of the iceberg approach, not necessarily that the, you know, the horrific assaults that we have seen on the ABC Four Corners program happened as a matter of routine, but it is indicative of – of almost everything that is – that is wrong with the residential aged care sector. If you had more staff in residential aged care sectors there wouldn't be as many assaults. There wouldn't be a stress, there would be more social control. That is the sort of stuff we are talking about to achieve basic aged care safety. Once that has been achieved, let's talk about quality.

MR GRAY: Thank you. With respect to safety and the point you made to the Commissioners about access itself being a safety issue, is that what underlies the recommendation at paragraph 85?

MR VERSTEEGE: Yes.

MR GRAY: Yes. 87, you've already advanced your views in respect of the waiting lists for the home care packages.

MR VERSTEEGE: Yes.

MR GRAY: And that seems to be the topic that's squarely the subject of the recommendation in 87.

MR VERSTEEGE: Yes, it is.

MR GRAY: 88, I don't think you've elaborated on compliance monitoring – yes you have, I'm sorry. You've mentioned there's no compliance monitoring for CHSP as opposed to home care packages.

MR VERSTEEGE: That's right, yes.

MR GRAY: And you say there should be?

MR VERSTEEGE: There should be because performance in the CHSP is very much dependent on the quality and the – and the work ethic of individual workers. You know, we are talking about personal care workers who are lowly paid and their performance is not checked.

MR GRAY: Thank you. 89, that's actually the topic that you were addressing most recently, only a few minutes ago, concerning objectively measurable standards and indicators and the need for uniform application including under the new single quality framework.

MR VERSTEEGE: Yes.

MR GRAY: Are there any additional matters or have you covered off on the reasons for that recommendation at 89?

MR VERSTEEGE: Well, I haven't talked about indicators.

MR GRAY: Please do.

MR VERSTEEGE: There are three indicators at the moment of aged care.

MR GRAY: Aged care quality and safety, is this the quality – the national quality indicators - - -

MR VERSTEEGE: Yes, it is.

MR GRAY: - - - program.

MR VERSTEEGE: Yes, it is, yes. That program is voluntary at the moment which effectively means that it's not in operation because the industry is a bit concerned. I can understand that but, you know, if you start making data available to make you look bad, that is not a good idea. I also note that the Minister for Aged Care, only a couple of days ago has announced that he's going to introduce mandatory indicators, so it will move from voluntary to mandatory and that's a good thing.

MR GRAY: Thank you. And so that's what lies behind recommendation 89. Could I ask you about 94. I didn't give you an opportunity to explain your concept for an official visitors scheme.

MR VERSTEEGE: Yes, official visitors schemes are used extensively in other areas of health care and it would be a good addition to – to the – to the aged care system. It would basically introduce people who have a fair idea about aged care and what should happen in aged care and who are able to advocate on behalf of – of residents. We envisage – it doesn't say that here but we envisage the official visitors scheme for residential aged care only. There are many, many people – I think the Minister quoted something like 40 per cent of people who never, in residential aged care who never see anybody because they don't have anybody or they're totally isolated. An official visitor scheme would be – would be a godsend for those people.

MR GRAY: Now, in respect of eligibility and entitlement and funding constraints, you also refer to the need to review the staffing component of care subsidies. This is

at paragraph 90. It's also repeated at 92 but it's the one recommendation as I understand it, Mr Versteege:

Aged care funding through the Aged Care Funding Instrument should be reviewed and the staffing component of care subsidies identified and published.

What's the basis of that recommendation?

MR VERSTEEGE: The Aged Care Funding Instrument is used to determine the subsidies an aged care provider receives for residential aged care. And that is to fund the care component of – of the expenses a provider has. Now, the vast majority of the care component is made up of staffing costs, costs of direct care staff. So what we would like to see is how much is set aside as part of the Aged Care Funding Instrument for each resident to actually provide them with direct care from a person. That is important because that would identify what the effective staff to residents ratio are in residential aged care at the moment if that was done. I'm not sure that the Aged Care Funding Instrument actually considers staffing costs. It almost looks as though they pluck a figure out of the air. And perhaps I'm in agreement – a very rare agreement with aged care providers that the Aged Care Funding Instrument needs to be urgently reviewed.

MR GRAY: You address that issue and the question of adequate staffing more generally and staffing ratios in your statement in a number of places, beginning at paragraph 56.

MR VERSTEEGE: Yes.

MR GRAY: In respect of staffing ratios, you've adverted to this a number of times but in the passage at 56 to 62, is it the case that you're critiquing the current requirements in relation to staffing levels as not being prescriptive enough?

MR VERSTEEGE: Yes, that's correct. I don't think they are prescriptive at all really. It's – it's open slather. A facility can determine by itself how many people – how many staff they're going to put on at any given time and that's where the – that's borne out by reports from nurses that they're sometimes looking after 100 or even more people in a nursing home at night. And, yes, it enables inadequate staffing in residential aged care facilities who are minded to cut costs that way.

MR GRAY: And there's quite a lot in that passage from 56 onwards but you conclude at 65 that CPSA supports minimum staffing ratios as a step in the process to rectifying staffing issues.

MR VERSTEEGE: Yes, that's right.

MR GRAY: How are those staffing ratios, including skills mixes for different types of settings, to be determined, in your view?

MR VERSTEEGE: Well, it's – I mentioned the Aged Care Funding Instrument review. Obviously when you sit down to determine how much subsidy should be given in respect of a – of a care recipient, you consider all the costs that that care will incur and a large part of that is – is staffing. We feel that staffing in residential aged care facilities is inadequate and that is – that is a community feeling that there is – there's not enough staff. So as part of – part of the determination of care subsidies we could actually mandate that certain types of care require certain levels and skill mixes of staff to deliver adequate care.

MR GRAY: Thank you. And it's that analysis, is it, that underpins the group of three recommendations. They really should be read together, is that the case, at 90, 91 and 92 of your statement?

MR VERSTEEGE: Yes.

MR GRAY: Yes. Thank you. Now, there's two other recommendations I need to ask you about, and that will conclude the examination. One is an idea you develop at paragraphs 70 to 73, where you say:

> *A current feature of accreditation in residential care is that it covers, in the hands of the one organisation, the accommodation function and the care function.*

MR VERSTEEGE: Yes.

MR GRAY: And you have a proposal that that shouldn't be the case and that there are good reasons for separating them; is that so?

MR VERSTEEGE: Yes, I think there's a good reason to apply split accreditation to residential aged care facilities. There are two very different businesses that are conducted in the residential aged care facility. One is a real estate business and the other is a care business. So it makes sense not to accredit them together but to accredit them separately. And the advantages of that – I could see two main advantages – is one, that where there is serious noncompliance and the regulator might be tempted or might consider really that this is a case where accreditation should be withdrawn or revoked, that that is easier to do because you don't – you only revoke the accreditation for the care provision, that is, the residents all stay put in the same facility which is operated by the same – the same provider, but a different care provider can be brought in to – to address the problems that existed in care provision. It is important because the regulator might be reluctant to go to revocation of accreditation because it will displace so many people.

MR GRAY: Accreditation of the accommodation?

MR VERSTEEGE: Sorry, of the accommodation, yes, well, together in the current circumstances. If you have a facility of 100 people, those 100 people will have to be rehoused somewhere, and in a place like Sydney or even Adelaide, that might be –

that might be not too hard, although it is displacing elderly people, very distressing for them. But when you go to a regional area, it's simply not an option because in many regional areas there's one – there's one facility for, you know, a vast catchment. And there is no possibility, really, of taking the ultimate compliance action of withdrawing accreditation. The other example is – I mean, we have introduced consumer direct care in – for the home care packages program which means that if you're not happy with your provider you can choose a different one, one hopefully that is better.

In residential aged care though it has always been considered something very difficult because, you know, if you have consumer direct care in a residential aged care facility it would mean that the person has to move to a different nursing home and some people do. It would be far easier if – if – if a population of a residential aged care facility decided that they were not happy with the care they were given, they would be able to vote out the care provider and get a new one.

MR GRAY: Thank you. And these are the examples and the analysis that underlies recommendation 93; is that right?

MR VERSTEEGE: Yes.

MR GRAY: Thank you. And there's one final recommendation I will ask you about that's a very big topic. At 83 you talk about the integration of the disability care system, the general health care system and the public oral health care system with the aged care system.

MR VERSTEEGE: Yes.

MR GRAY: And by integration, do you mean that they should be regarded as one monolithic system or do you have in mind a more nuanced approach where you're giving consideration to the way those four systems interface with each other?

MR VERSTEEGE: Well, the word "monolithic" is a bit – suggests that it's not such a good idea. This may sound like a pipedream but it's actually in operation in countries like Holland and Germany where there is a care system. It's not – there's no talk about disability care or aged care. It's – it's all together. I mean, the funding systems that support that, of course, are very different from what we use in Australia. There is a social insurance approach to all these things, which ensures there is funding. It's a hypothecated approach to funding of care where people pay social insurance premiums that ensure that if something goes wrong, they enter the care system and that – that means that if they have a disability it's treated as a disability, not as something that happens to you when you're old or when you're young.

MR GRAY: Thank you, Mr Versteege. Unless the Commissioners have any further questions, that concludes Mr Versteege's evidence for today.

COMMISSIONER TRACEY: Thank you, Mr Versteege. Your practical knowledge of this industry has been of great assistance to the Commission, and we thank you for your evidence.

MR VERSTEEGE: Thank you.

<THE WITNESS WITHDREW [3.28 pm]

COMMISSIONER TRACEY: Yes, Dr McEvoy.

DR McEVOY: Commissioner, I call Ms Sue Elderton.

<SUSAN TRACY ELDERTON, AFFIRMED [3.28 pm]

<EXAMINATION-IN-CHIEF BY DR McEVOY

DR McEVOY: Now, operator, could you please bring up document WIT.0003.0001.0001. Ms Elderton, do you recognise this document as a statement that you've made to the Commission?

MS ELDERTON: I do.

DR McEVOY: Do you wish to make any amendments to the statement?

MS ELDERTON: Except for one or two typos, no.

DR McEVOY: I take it from that that its contents are true and correct to the best of your - - -

MS ELDERTON: It is true and correct.

DR McEVOY: - - - knowledge and belief. Commissioners, I tender Ms Elderton's statement with that document number that I've just read.

COMMISSIONER TRACEY: The witness statement of Susan Tracy Elderton dated 2 February 2019 will be exhibit 1-11.

EXHIBIT #1-11 WITNESS STATEMENT OF SUSAN TRACY ELDERTON DATED 02/02/2019 (WIT.0003.0001.0001)

DR McEVOY: Ms Elderton, you're the national policy manager of Carers Australia; is that correct?

MS ELDERTON: It is correct, yes.

DR McEVOY: And could you tell the Commission what Carers Australia does.

MS ELDERTON: So Carers Australia is the national peak body which represents and advocates for the diversity of Australians who provide unpaid care, so they're family and friend carers, and they provide support to family members and friends with a disability, a chronic condition, mental illness or disorder, drug or alcohol problem, terminal illness or who are frail aged, regardless of the – so they provide care regardless of the age of the person they care for or their own age.

DR McEVOY: When you say Carers Australia is a peak body, what do you mean by that?

MS ELDERTON: So Carers Australia's members are State and Territory associations. There's one in each State and Territory. And we are the national body that they support and - - -

DR McEVOY: So how do you engage with the State and Territory organisations?

MS ELDERTON: So each State and Territory organisation mirrors, if you like, to some extent, Carers Australia and we have both formal and informal contact, very frequently. The one difference between us and the State and Territory associations is we don't deliver any services except for something called the Young Carer Bursary; they do. So they tend to have much more direct contact with carers and they pass the lessons on to us. Having said that, we do have a very big social media presence, so in 2018 we achieved a collective reach of about 1.5 million and in this mix we had – we have about 13,000 active users, so we do have a lot of contact with carers. But not quite as much face-to-face contact as the State and Territory associations.

DR McEVOY: And so how does Carers Australia advocate on behalf of carers?

MS ELDERTON: Well, in much the same way that most peak bodies do. So we lobby, if you wish, politicians, parliamentarians, we work with the public service with the same end in view. We try and lift our media presence, talking about carers and their needs as much as possible. We have events for carers. We – including Parliamentary events which carers are invited to so that politicians can hear from them themselves. We put in submissions to Parliamentary inquiries.

DR McEVOY: If you have a look at the bottom of – if you have a look at the bottom of the first page of your statements, paragraph 6, you say that:

Carers should be able to enjoy optimum health, social and economic wellbeing and participate in family, social and community life, employment and education.

In making that observation, do you mean to suggest that carers are not always able to enjoy those things?

MS ELDERTON: Carers are definitely not always able to enjoy those things, and very detailed statistics on that came out of the survey of disability, ageing and carers which the ABS talked about this morning and the Australian Institute of Health and Welfare. So I don't have the figures in front of me but carers are much less likely to be unemployed if you compare them – and especially primary carers and I want to distinguish here. Primary carers are carers who provide a substantial amount of care and there are about 860,000 of them but all in all our stats shows there are 2.7 million carers. So that incorporates carers who share care with other people, I suppose you would say.

But primary carers, in particular, have very low levels of employment, very high dependence on social security. Because of their caring activities, aren't able to participate as much in normal family life as somebody without those responsibilities would. Similarly social and community life because they are at home caring. Young carers in particular tend to miss out on education – and that's very well researched – because of their caring responsibilities. Carers suffer much higher levels of stress when you compare them to the population of non-carers. And actually quite a lot of carers have a disability themselves.

DR McEVOY: At about page 6 of your report, Ms Elderton, you refer to a 2015 Deloitte Access Economics report. Operator, if you could bring up RCD.9999.0003.0001. Ms Elderton, I think you have a copy of that report.

MS ELDERTON: I've got the front page, not the paragraph – the front page of the report. I just had the paragraph you were referring to.

DR McEVOY: Yes. Is that the report that Carers Australia commissioned Deloitte Access Economics to produce in June 2015.

MS ELDERTON: Yes, we did. It was the second report we commissioned. The first was in 2010 and there will be a third, yes.

DR McEVOY: Commissioners, I would seek to tender that report.

COMMISSIONER TRACEY: Yes. The Deloitte Access Economics report entitled The Economic Value of Informal Care in Australia in 2015 dated June 2015 will be exhibit 1-12.

EXHIBIT #1-12 DELOITTE ACCESS ECONOMICS REPORT ENTITLED THE ECONOMIC VALUE OF INFORMAL CARE IN AUSTRALIA IN 2015 DATED JUNE 2015 (RCD.9999.0003.0001)

DR McEVOY: So Ms Elderton, you were involved as the national policy manager in the commissioning of that report, I think.

MS ELDERTON: I was, yes.

DR McEVOY: And what does that report tell you about the dollar value of informal carers in Australia?

MS ELDERTON: So what the report identifies is what would happen if you had to replace family and friend carers with paid care, so what they're valuing is the replacement value of that unpaid care. And in 2015 they valued it at $60.3 billion. In 2010 they valued it at $40.9 billion. And the – they made the assessment against a formula for what paid carers doing the same sort of work would cost. But it's much more complicated than I can comment on beyond that.

DR McEVOY: And are you able to, on the basis of that report, say anything about the value of informal aged care, having regard to that overall figure?

MS ELDERTON: Well, we know that, again on the basis of SDAC, that about 49 per cent of primary carers care for the aged. But you couldn't simply divide that number into the 60.3 billion and say that was their contribution because what is calculated again on the basis of SDAC is the hours of care that were put in which may vary from cohort to cohort, depending on the age and disability which Deloittes does take into account of the people being cared for. What you can say is that they provide a substantial amount of that 60.3 billion.

DR McEVOY: Well, what sorts of challenges do you identify these unpaid carers as facing?

MS ELDERTON: I mentioned some of them earlier. I didn't include social isolation which is one of the biggies. Caring for somebody 24/7 sometimes – and I can later if you like give an indication of the hours that carers care – keeps you pretty housebound, especially if you can't take the person you're caring for out with you. But I mean, among the other things I identified earlier is if they're working age carers they may have to give up employment to care that much. If, as we know, a lot of carers – a lot of carers generally but including carers of the aged are between the ages of about 40 and 55, 55/60, if they give up work – and they're women especially – they're unlikely to get another job if they've given up work for long enough and that has lifelong consequences for them, obviously, including on things like superannuation.

Consequences for older carers, so people over the 65 – over the age of 65, not working age, is they're ageing themselves. Providing high care needs is a real challenge to them, and it's likely to affect their own health, their ability to cope and quite frankly in some cases their capacity to provide the right level of care. But they will continue doing it because they and the person they care for don't want to go the residential care path.

DR McEVOY: Well, what sort of services exist to help these sorts of carers?

MS ELDERTON: Well, in terms of carers in their own right – services for carers in their own right, there's a suite of – first of all, there are some State services which I don't know enough to talk about, but certainly from the Commonwealth point of view there's a suite of services that are provided by the department, or funded by the Department of Social Services and they include things like counselling, coaching, helping people to develop plans to keep on caring and to look to the future of their caring, peer support, which is – addresses very much the isolation issue, if carers either online or in person can have the opportunity to mix with other carers in a similar situation. Some training but it's patchy, so that training in caring.

And then there's information, advice and referral, so carers contact carers associations on all sorts of issues and they will include pensions, carer payments, legal issues, wills, powers of attorney, housing issues, but also access to aged care, access to disability care, you know, where do I go, it's not working out for me, how can I get help. And in that case they will be referred to mainstream services out there. So if it's a legal issue they may be referred to Legal Aid, for example, plus giving a bit of background information on the legal issue at stake.

DR McEVOY: Let me just take you back to - - -

MS ELDERTON: But not respite and I will get to that in a minute.

DR McEVOY: We will come to respite. Let me just take you back to training which you mentioned a moment ago and you said it was patchy. What – can you just expand upon that a bit. What sorts of training opportunities are there for carers?

MS ELDERTON: I know some of our own carers associations – and I'm assuming organisations out there that aren't part of our membership – will run short courses for carers on particular ways of, you know, lifting, peg feeding. Actually it's care for the – how they need to care for the person they're caring for. Carers Queensland runs an RTO for carers so that they can get a certificate – a relevant certificate III so they might be able to transfer later on, once they cease caring, into aged care or disability care. Not everyone will but, you know, if you've got no job and you're on Newstart at the end of your caring period it is a job and it's not exactly the same job. You get holidays, you get weekends, you get superannuation if you're permanent – yes, if you're permanent. So it is attractive to some carers, ex-carers.

DR McEVOY: So are there training programs outside the auspices of the State Carers Australia bodies, or are they on the whole confined to the extent they exist, confined to those bodies?

MS ELDERTON: I only know about the ones I know about. I can't cover the whole, you know, Baptist Care, Catholic Care, the Red Cross, other organisations of that kind may also offer training programs, but I don't know about them. Bearing in mind that this will all change in November, but DSS has been funding over 100 organisations across Australia out of its carer support funding. We don't know about all 100 organisations, yes.

DR McEVOY: Well, perhaps let us move to the subject of respite. When we talk about respite, what are we talking about?

MS ELDERTON: Well, there are different kinds of respite and – and they cover different periods of time. So community respite may be available if the person being cared for goes into a day activity program, for example, or into a day program. There's replacement care in the home which you can get through a home care package and that can constitute respite. And there's something called cottage respite, which I wouldn't mind coming back to but that's where people are cared for in home-like environments in houses, much preferable to an institutional setting for everybody and in some cases it's possible to have somebody cared for so that a carer can actually go to work, but that's very, very few cases.

Then there's more long-term respite, like somebody might want to get respite on a Friday or the occasional weekend so that's overnight and during the day. And that is available through these cottages, but it's very hard to get in residential care, who – they normally only want somebody for two weeks. It's too much of an effort to take somebody in for a night or over a weekend. And then there is residential respite where you get the opportunity – you get the opportunity to take a break for a week, normally a minimum of two weeks, sometimes longer, and that gives you the opportunity to actually go away to – well, not necessarily even go away, to spend some time recovering if you're burnt out by yourself at home.

But also to visit friends and relatives who live elsewhere, to have a little bit of a holiday, to attend to important family events or friend events and – in the aged care space unfortunately that's often funerals but it's really, you know, in another State perhaps, in another locality but it's very important for people when they get to that age where it's their last opportunity actually to – to pay tribute to the person who has died but also to be again with their old friends and relatives and, you know, important events in anyone's life, but very hard to do if you can't find replacement care.

DR McEVOY: You said you wanted to say a bit more about cottage respite. Do you want to say any more about that?

MS ELDERTON: Well, just that it is a preferred form of respite. And it has actually been recommended in a report on respite that was done by the Aged Care Financing Authority.

DR McEVOY: Yes, I wanted to ask you about that, but go on.

MS ELDERTON: Yes, there should be more out there. But the reality – the reality is, it is expensive. It becomes available in different ways like some of our carers associations have had buildings – houses donated by State Governments or Territory Governments but they still need to be modified for the purpose and you still need to – you know, they will have a paid carer in them all the time. The – the thing about cottage respite is it's funded under CHSP, the Commonwealth Home Support Program and there's no allowance for capital investment subsidy out of CHSP. And that's one of the things that makes it expensive to provide. It's actually acquiring the property and modifying it.

So I think – I have to look at my stats cheat sheet. I think – no, I haven't got it here. I think there are about 68 cottages across Australia or there were in 2017/18, compared to – and I haven't got it here but, you know, a much, much, much larger number of residential care places.

DR McEVOY: So I take it from what you're saying that Carers Australia hold significant concerns about the general availability of respite?

MS ELDERTON: Yes, we do, and particularly residential respite in recent years. So a couple of years ago or a bit more, we started hearing that it was getting harder and harder to get, and there are two forms of respite too, I should point out. There's emergency respite which is actually paid for by DSF, not out of aged care, which is for when carers have a health emergency or a major life event which they have to attend to, or some other, you know, critical event in their lives so they can't continue providing care for a period or maybe they're just totally burnt out. They just don't feel like they can go on another day. And that's – that can be provided in the home but as I said, it's hard to get – it's hard to get that subsidised, or it can be provided in a resi care facility.

And then there's planned respite where you know something is coming up and you want to have a break or you want to have a regular break every few months or whatever it might be. And again, a lot of that happens in residential care. So we conducted a survey to see if it was really true that it was getting very hard to access it in residential care and we approached organisations across Australia whose job it is to try and get that access for carers. And the results came back and it turned out that both emergency – actually more emergency than planned respite was extraordinarily hard to get. In fact, only three per cent of the 112 respondents said that it was easy to get and nobody said emergency respite was easy to get.

And we wondered why because according to the Department of Health's data the incidence of people taking respite beds in residential care facilities has kept rising,

not dramatically but it has kept rising. So one thing we posited – and this came out of conversations with providers and people in the sector – was that actually those beds weren't being used for people who wanted short-term respite. They're increasingly being used by people who wanted to have a try before you buy experience. Go in – go into a respite bed, see if you like the facility, you know, road test it if you like and then if you like, you go straight into permanent care, which is much more attractive to a provider than taking in people short term from time to time. And the second reason that tended to happen was people being put in those beds while they waited, you know, sometimes for a considerable time for all the paperwork that's necessary before you go into permanent care. So ACFA found that in - - -

DR McEVOY: You're talking about the Aged Care Finance Authority now.

MS ELDERTON: Yes, sorry, Aged Care Financial Authority found that in 2015/16, '16/17 and '17/18 more than a third of people who went into respite beds almost immediately transferred into permanent aged care. Now, that had always happened to some extent. The figure they had against that was in 2012/14, 25 per cent did, but it's growing. It's growing a lot. And one of the reasons why – there are many reasons why residential care providers may not want to provide respite. One of the reasons is first of all the effort of taking someone in is big, you know, for a very short term. There's a whole lot of administrative work that needs to be done. An ACAT needs to be done, even if there's another ACAT that exists out there somewhere. And the subsidies are really low for respite compared to permanent care and the disruption, actually in the facility is high, too. You take in a new person, you don't know their needs. You've got to adapt to them. It takes much more effort than someone who's a familiar presence.

DR McEVOY: So what options are there available if you want a shorter period and you can't access the sorts of programs you've been talking about?

MS ELDERTON: Not many. I mean, there are options like if you can get a friend or somebody else in the family to come in and help out while you get a rest. But that's not always available and something that carers say they want most but frequently complain they can't get is support from other members of the family. The other option is to get replacement care in the home but there are barriers to that because of the cost and, as I said, under home care packages it's not – it's not a service, so if you're on a home care package you can get access to subsidised respite but only when all the other funds have been – for other purposes have been expended from the package and if there's some left over that can be used to pay for the cost of respite.

DR McEVOY: And is it your position – Carers Australia's position, is it, that that should change?

MS ELDERTON: Yes, yes, it definitely is. We do think it should be factored in as a service. One complication, too, is that respite is not officially a service for carers;

it's a service for the person being cared for. We – and we do acknowledge that there are people without carers who will benefit from a period of rest that they need for themselves, a short-term residential care – home care, whatever. But for the most part it is so carers can take a rest.

DR McEVOY: And so you've been pursuing that, have you, with the Commonwealth?

MS ELDERTON: We've been pursuing that – I joined Carers Australia in 2012 and it wasn't new then. We've been pursuing that for about 15 years, if not more, yes, but things did change with the aged care reforms too. So that many of those services formerly before aged care became nationalised, if you like, were provided by State Governments but all that funding went into the Commonwealth programs.

DR McEVOY: Can I take you to the question or the issue of staffing considerations in both residential care and home care? What does Carers Australia say about the quality and adequacy of the aged care workforce in residential care?

MS ELDERTON: Well, we're concerned about it and, again, if you go back to our submissions and those of our State and Territory colleagues over the years, there always has been a concern. In fact, there has been a concern before the recent aged care reforms. It sounds like it was always something of a problem in residential care. But I mean, what's come to our attention – and actually I have to say particularly through this Royal Commission where we've had more bad stories coming in than ever before and the Four Corners program and so forth, and Oakden and the like, that yes, they feel that they're understaffed both with personal carers.

We hear more about being understaffed with personal carers actually than being understaffed with registered nurses, although we take on board that there probably aren't enough registered nurses either, always in the facility and especially when you get one registered nurse over weekends and Friday nights for 80, 100 residents, I mean, that's ridiculous. But the way the story emerges – and it's not always about abuse either. Sometimes it's people being so rushed off their feet that it's casual neglect, if you like. So, you know, we've heard – you heard yesterday from Ian Yates from COTA, the importance of carers – paid carers being able to take a bit of time to be with – be with the aged person that they're madly running around washing and feeding and sticking into wheelchairs and putting into bed at night, and that time just isn't available to them. And they don't really regard it as part of their job.

Many may – would probably like to, but when you're working under those sorts of conditions it's hard to. It's hard to even think of it. And if I'm talking about casual neglect, it could be something as simple as putting somebody to bed very early in the evening, who can't move, facing them to a wall and they're there for hours and hours and hours. It's daylight until nine maybe. The television could have been on. They may have a nice window view to look out on, but there they are, plonked, facing a wall, just seeing a blank surface. Or people – carers rushing, putting people in chairs, turning on the television, the only problem is the chair is facing this way and

the television is over here. It's those sort of really little things that can make somebody's life a total misery, when all they can do is sit in that chair all day.

DR McEVOY: Much of what you've just said comings back to understaffing. Can you just outline - - -

MS ELDERTON: Maybe understaffing, also I think maybe lack of empathy, too.

DR McEVOY: Other – would you identify other causes?

MS ELDERTON: I think those are two, carers are rushed off their feet and just not having the sensitivity or the training or the induction or anything much to make them more sensitive. Particularly in cases where they are very – personal carers are very poorly paid and that's something that came out of the aged care workforce strategy that – and I think Ian Yates mentioned yesterday, the sort 15 per cent below what they probably should be paid. So what that means is it attracts people who take on the job because they can't get another job. They've got no – you know, they're not proud to be there. They have no mission about being there. They have no particular feeling about being there. They're there because they get paid. And that's not good for a care industry.

DR McEVOY: Do you have a position on what might be a range of appropriate responses to that fundamental problem?

MS ELDERTON: Well, first of all, I think probably they need to get paid better, and they – and they need more training and they may have to have that training as soon as they come into that facility, not at some time during the year, you know, if ever.

DR McEVOY: What about the imposition of staff-to-resident ratios? That's something that you deal with in your - - -

MS ELDERTON: Yes.

DR McEVOY: - - - statement. What's Carers Australia's position there?

MS ELDERTON: We used to be very strong on ratios, bearing in mind that it seems to me a lot of the conversation about ratios goes to nurses, not necessarily personal carers. But we – and we heard the arguments that if you can do it in child care, why can't you do it in aged care. And I think the reality is that aged care is a much more complex beast than child care. And we did read the – the taskforce review of the aged care workforce and we were persuaded by their recommendations that ratios were just too blunt an instrument, given the variety of circumstances including the mix of consumers and you can't just say, well, if this is a high care facility they need X and if this is a low care facility they need Y and if they're, you know, if 50 people with dementia in that facility they need Z. Because you will get different mixes in different places.

You may have an aged care facility with 20 people in it, and you will have another one with 100 people in it. That will make a difference. It kind of – it can go to business models where I don't think so much for nurses and personal carers but when other staff, occupational therapists or whatever are actually contracted in as needed, as opposed to having a ratio of them in place all the time. So – so as I said, it really was the taskforce report which was very considered report, had lots of submissions which persuaded us, that maybe ratios is not the right way to go, but the taskforce did also recommend that there does have to be some standard industry practice out there, at least a standard of what constitutes good practice in different situations.

And also we agreed with the – with the view that at the local level, providers should have a workforce plan in place and that should be public and that should be made available to consumers and carers, both within the facility but also if they're thinking of going into that facility, so it gives them an opportunity – a better opportunity to choose between providers than just the grounds are lovely, the building's lovely, the food's looking okay, good place, yes.

COMMISSIONER BRIGGS: The question for me, Ms Elderton, in working through that taskforce report and your evidence is it's pretty hard to establish staff ratios but is that a good enough excuse for not doing so?

MS ELDERTON: Because it's not my area of expertise, and I will be persuaded by people who do have that expertise, I'm not absolutely sure. And I notice the Minister moved back a bit and said it's still – it's still under consideration, it's still a possibility. But I also take on other things that I've read in researching actually for this inquiry, that there's no – there appears to be no evidence out there from other countries or even from the Victoria public residential care sector where they do have ratios, that it has made a big difference to the quality of care, so that's one thing. Another thing I would worry about, ratios can work two ways. I mean, if it's the minimum standard, nobody has to rise above that minimum standard. So, you know, good places could get sort of dumbed down, I guess, in terms of staff to consumer ratios, but – but I have to admit it's not my area of expertise. I can only go on what I'm hearing from people who know more than I do, yes.

DR McEVOY: Can I just take you back to the challenges in staffing in the home care dimension. Do you want to just elaborate on the nature of those challenges?

MS ELDERTON: First of all, most of the complaints we get are about residential care, not home care, and most of the complaints the Aged Care Complaints Commissioner got were about residential care, not aged care. In fact, I think it went that – maybe it was 75 per cent or something. Yes, 75 per cent were about resi care, 18 per cent were about home care packages and seven per cent were about CHSP, Commonwealth. And that would reflect our experience, too. You do hear complaints but for us they're anecdotal. Again, I can't find a body of evidence. So the complaints you hear first of all is the high turnover of home care staff, which makes a real difference, I think, to the – to people who are by themselves and that's the only person they may ever see in their lives and they tend to become – they may

become friends, you know, they become familiar faces. If they're changed every two or three or four months, they lose that. They haven't even built up the relationship yet.

But having – having said that, I don't quite know what you do about it because it is a highly casualised industry. We do hear concerns that they're not properly trained. We do hear concerns that they're unreliable and it makes a huge difference if someone is due to turn up and they don't. So they do go – those complaints go to quality of service but the most complaints are about the waits for home care packages. And you will hear that particularly from carers because if someone hasn't got a package at all or they've been assessed for a level 4 package and they're on a level 2 and 18 months later nothing has happened – or less than 18 months later nothing has happened and the person being cared for is getting worse and worse and worse.

They may have had a fall which has made all the difference or they were partially blind and now they're heading towards fully blind in the short period of time, or they did have, you know, early dementia and it's – it has got much, much worse in a short period of time. Then carers have to – family carers have to step in, or there's a residential care option. And as I've said before, if you – if you're going to step in full time, and you're of working age, that may be the loss of your job for good even in some cases. If – if the carer themselves is aged – and so 76 per cent of carers who are partners of the person they care for, care for somebody over the age of 65, so most will be partners. And yes, it will impact their own health.

DR McEVOY: Well, just probably two - - -

MS ELDERTON: Can I just do one more thing?

DR McEVOY: Yes, of course.

MS ELDERTON: Because this is one of my – a statistic that really gets to me. In the – if I can find it – in the 70 to 79 age group for carers, 40 per cent care – sorry, just over a third care between 40 and 60 hours a week and just under a third care for more than 60 hours a week. That's enormous for – you know, for somebody between 70 and 79 and over – over 80, the figures are very similar.

DR McEVOY: So what does Carers Australia say about how we can better support carers who are caring to that extent?

MS ELDERTON: Well, there are two things I suppose. One thing is address the problem with capped home care packages, people not getting the level of support they need and the enormous wait times. National Aged Care Alliance has supported no more than a three months wait. The gentleman before me said no wait. I don't know that that's reasonable, but that – we should be aiming for that at least.

DR McEVOY: Aiming for three months, you mean?

MS ELDERTON: Yes, and an increased number of packages, particularly at the higher levels. For – in other senses, to help carers caring at home, one is actually better access to carer services in their own right, the ones I mentioned before, including respite. And I actually think respite is one of the more important ones. I mean one thing that – one of the problems carers face, particularly dementia carers is totally interrupted sleep, sometimes for years and years and years. That can have an enormous impact on your capacity to cope, really. And one way you can deal with that is having more overnight replacement care available a few nights a week so that it's not just a constant thing. We would like to see that.

DR McEVOY: Perhaps just one final question, or couple of questions on the subject of future challenges to aged care, and Carers Australia's view about that, in particular you identify in your statement that we're reaching a tipping point here. Can you just explain to the Commission what you mean by that?

MS ELDERTON: Well, we saw the diagram that I think it was the Institute of Health and Welfare or ABS showed this morning about the shape of our population today. And it's – it's really not difficult, you know, it's quite easy to understand. Baby boomers have a lot more children and the generations before them had a lot more children, too. So there are actually fewer physical bods on the ground below that baby boomer level to provide the care. Plus other changes in the demographic so that many families under the age of, you know, if they're not in the aged care bracket themselves need two jobs to survive. Women are having children later in life so they may be caring for their own children at the same time that they're expected to care for an older parent.

Divorces, more and more divorces, particularly in later life than there have ever been before, which means that the person who – the people who are potentially there to care no longer have any interest, if you want to put it that way. Mobility of families. Families move to far-flung places to work and, you know, are just not available in the locality to provide care. So all those kind of things get – and also, you know, just people having to work for longer. All those things coming together.

DR McEVOY: And do you say that the consequence of this is cataclysmic for the provision of care.

MS ELDERTON: Cataclysmic is a big word but, yes, it's certainly extremely worrying and – and theoretically they're going to have to be replaced by paid workers, care workers, or they will have to go into resi care. They won't be able to age at home as they want to. There are some things that could make a change and one of the things that we think is needed is more carer-friendly workplaces, more flexible workplaces so that people can work, even if they work at home, if they work different hours, if they share work so that they can continue to provide some level of care, and continue to work. So that's one of our big causes.

And, you know, if we get a cure for dementia that could make an enormous difference. Early intervention for consumers may mean that they're able to remain

healthy and care for themselves for longer. But they're all very iffy things. The one thing that is sure is that you're going to get a declining population of family and friend carers.

DR McEVOY: Commissioners, I don't have any further questions of Ms Elderton so subjected to anything you may wish to ask.

COMMISSIONER TRACEY: Thank you. There are so many selfless unsung heroes out there in the community and I don't think it's appreciated just quite how many there are, and the depth of their commitment and you've been most helpful to us in understanding that and what might be done to provide them with greater assistance in the time that lies ahead, and it's one of our terms of reference, as you know. And we therefore are more than grateful for your evidence this afternoon. Thank you very much.

MS ELDERTON: Thank you.

<THE WITNESS WITHDREW [4.17 pm]

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

MATTER ADJOURNED at 4.18 pm UNTIL WEDNESDAY, 13 FEBRUARY 2019

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