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TRANSCRIPT OF PROCEEDINGS

O/N H-985233

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

10.09 AM, WEDNESDAY, 20 FEBRUARY 2019

Continued from 19.2.19

DAY 7

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, the Australian Institute of Health and Welfare, the Commonwealth Department of Health and the Aged Care Quality and Safety Commission.
MS C. HAMILTON-JEWELL appears for Ms C. Little

COMMISSIONER TRACEY: Please open the Commission.

DR McEVOY: Commissioners - - -

COMMISSIONER TRACEY: Dr McEvoy.

DR McEVOY: The first witness, Commissioners, is Ms Little but there are some appearances before that, and then Ms Hutchins will lead Ms Little through her evidence. If the Commissioners please.

COMMISSIONER TRACEY: Yes.

MS C. HAMILTON-JEWELL: May it please the Commission, Hamilton-Jewell, I appear for Ms Little.

COMMISSIONER TRACEY: Thank you.

MS HUTCHINS: Commissioners, I call Ms Claerwen Little.

COMMISSIONER TRACEY: Thank you.

<CLAERWEN ELEANOR LITTLE, SWORN [10.10 am]

<EXAMINATION-IN-CHIEF BY MS HUTCHINS

MS HUTCHINS: Operator, please bring up document number WIT.0010.0001.0001. Is your full name Claerwen Eleanor Little?

MS LITTLE: It is.

MS HUTCHINS: And this is your statement?

MS LITTLE: It is.

MS HUTCHINS: Do you wish to make any amendments to the statement?

MS LITTLE: No, I don't.

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

MS LITTLE: They are.

MS HUTCHINS: I tender Ms Little's witness statement number WIT.0010.0001.0001 and the identified annexures.

COMMISSIONER TRACEY: Yes, the witness statement of Claerwen Eleanor Little dated 31 January 2019 will be exhibit 1-51.

EXHIBIT #1-51 WITNESS STATEMENT OF CLAERWEN ELEANOR LITTLE DATED 31/01/2019 AND THE IDENTIFIED ANNEXURES (WIT.0010.0001.0001)

MS HUTCHINS: Thank you. Ms Little, you're the national director of UnitingCare Australia. Could you please explain to the Commission what the role involves?

MS LITTLE: UnitingCare Australia is the national body for the Uniting Church's community services work and it's an agency of the assembly of the Uniting Church in Australia. My role as national director is to lead the work of advocacy and of strengthening our service provision across our church.

MS HUTCHINS: Thank you. You note in your statement that you don't personally have any managerial responsibility nor operational oversight, but you do consult with the members of the UnitingCare network.

MS LITTLE: Yes, I do. So I don't have any oversight but, yes, we have a consultative network.

MS HUTCHINS: Can you explain what it is that the UnitingCare Australia network does?

MS LITTLE: We come together over issues of mutual concern. Most of those issues are also to do with the mission of our church which is about a reconciled and healed world and so we take the issues that are seen in the services that we provide across the country and then we are a voice into the policy settings and to the Parliament and to other decision-makers to try and make the world a better place.

MS HUTCHINS: And in relation to the UnitingCare network, I understand there's a number of providers within the network. Could you explain a little further about what it is that the network – who the members are and what it's comprised of?

MS LITTLE: Sure. So the network is comprised of the Uniting church's community services activities, so a number of organisations. They are incorporated differently across each State and Territory depending upon their kind of relationship within the church. So some are incorporated under the Uniting Church Act, some are companies limited by guarantee, some are corporations. So each of those organisations delivers services at the State or Territory level; we haven't got

agencies that go right across the country. And they provide a range of community services right across the life course.

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

MS LITTLE: Essentially, they are public benevolent institutions that are there to do – to ameliorate poverty, disadvantage, to provide services of the highest quality to people right across the country, aged care, children's services, financial counselling services. You name it, we do it. Mostly in areas where most other people won't go necessarily: major capital cities, rural remote areas. So a very large network of services all providing amelioration of some sort and meeting needs at the local level.

MS HUTCHINS: Yes, because the network members operate on a not-for-profit basis?

MS LITTLE: They do.

MS HUTCHINS: Yes. And how many people does the network provide aged care services for?

MS LITTLE: We are approved providers to over 100,000 people through our residential aged care, home care and community home support program. And then across the network through our financial counselling, our Lifeline services and many of the other more generalist community services, we see older people every day.

MS HUTCHINS: I would like to discuss with you the topic of rights of people as they age because we saw throughout your statement that this was a key focus of how you addressed the question to the Commissioners. At paragraph 19 of your statement you say:

> *The lens through which UnitingCare Australia has considered each of the Commissioners' questions is the right of people as they age and how a national culture of respect for the ageing and older people may be fostered.*

Can you please explain why it is that you've adopted this approach?

MS LITTLE: As the Uniting Church organisation we have a fundamental belief that every human being has certain rights and we believe that older people are no different and that they have human rights. And we don't believe at the moment that the aged care system necessarily is working in the best interests of the rights of older Australians, so that's really the lens in which we look at all of our work. We don't just provide a service for the sake of it but it's really about making sure that people's rights are upheld and also their needs are met.

MS HUTCHINS: And what are the types of rights you have in mind when you say that rights are not being met?

MS LITTLE: Essentially – so basic human rights, access, equity, the right to have food, the right to have shelter, the right to have their choices and their own dignity upheld. Their rights for civility, their rights to be treated well, their rights to have their own needs and aspirations met. So they're some – just a few.

MS HUTCHINS: And throughout your statement, you adopt the term "consumer" when you're referring to older people accessing the system. Why is it that you prefer this term?

MS LITTLE: Terminology is a very interesting subject. We chose the term "consumer" because it has a more empowering nature to it than a "client" or a "service user" so there's something about a consumer that is empowered to actually hopefully make decisions for themselves. So if you're a consumer then you have certain rights in what you can expect from a service that you are – that is being provided to you. So we use that word. I mean, you know, prefer the word "elder" because I think elder is a very respectful term but we used that term so we could particularly have some way of seeing that people should be, within a system, empowered and have certain rights attributed to them.

MS HUTCHINS: Certainly. Because a common theme in your statement as well is the advocacy for a rights-based approach for consumers or elderly. What do you understand this approach to mean?

MS LITTLE: Essentially a rights-based approach means that a person within a system has certain choice and they have their dignity and their own sense of humanity and their own story and their sense of who they are actually upheld within that system.

MS HUTCHINS: And is it your view that a client-centred model of care works towards achieving this goal?

MS LITTLE: Yes, it does. Yes, it does. A person-centred approach means that the system is built around the person and not the other way round.

MS HUTCHINS: Yes. The Commissioners heard much during the last week or so of hearings about the tension between affording people the dignity of choice and the risks that might be associated with the exercise of choices. In your statement, you suggest in this regard that more pragmatic regulations ought to be adopted. What do you have in mind when you refer to "pragmatic regulations" in this regard?

MS LITTLE: When it comes to – sorry, did you mean about consumer choice - - -

MS HUTCHINS: Yes.

MS LITTLE: - - - and risk or - - -

MS HUTCHINS: Yes.

MS LITTLE: Yes. Essentially, the regulations as they stand at the moment are very rigid. They don't necessarily take into account the fact that an individual might have certain wishes and aspirations in their care setting for example. That means that they want to take some risks; that they might want to have some choice. At the moment the regulations really bind up a system and the service so they can't – they can't necessarily provide that choice for the individual. So, for example, if somebody wants to get out of bed, they want to have a choice about what they wear in the morning. They have – they want to have a choice about what they eat for breakfast. At the moment we have a regulatory environment which is incredibly hard in which to create an environment where choices can be exercised in that way, mainly because it is a regulatory environment that is essentially about punishment and not about a flexibility within the care setting, especially residential care.

MS HUTCHINS: What type of reform do you envisage could occur to help accord elderly more rights of choice in this regard?

MS LITTLE: I think the regulatory environment needs to be much more flexible. It must – it needs to be a continuous improvement process that is based on outcomes and based on the needs of the individual, rather than the needs of the system. And it needs to be something that is much more – of course, it has safeguards built within it but it really has to have much more flexibility so that a care provider can actually really and truly meet the needs of the individual within that setting.

MS HUTCHINS: Certainly. Now, in your statement you mention some research which UnitingCare commissioned by Newgate to understand community perceptions of aged care and understand people's vision for good aged care moving into the future. Operator, could you please bring up document UCH.500.001.0101. So this document, I understand, is a summary report of the Newgate research.

MS LITTLE: Yes, it is.

MS HUTCHINS: Could you explain the nature of the research that was undertaken as part of this project?

MS LITTLE: We really wanted to know what the community was thinking about aged care. There was a lot of – there is and there was at the time at the end of last year, of course, much media attention and much anecdotal evidence that people were very unhappy with the aged care system and so we really wanted to test that with some market research. It wasn't a huge piece of research but we wanted to – to just see, to get some rigor into that to see what – what people were expecting and what people were thinking about aged care so that we could look at the aged care that we provide across our network and improve that in whatever way we can, but also so that we in our policy work could be as constructive as we can be in the reform process.

MS HUTCHINS: Certainly. And how was the research undertaken?

MS LITTLE: There were two focus groups and an online community and an online survey.

MS HUTCHINS: Operator, please go to page 5 of this document which is entitled Executive Summary. You will see towards the bottom of the first column it states:

> *The research showed that aged care is on people's radar but it is not currently seen as one of the most critical issues for the government to address.*

Could you explain what were some of the findings of the research which led to this conclusion?

MS LITTLE: Essentially on – there's a – on page 12, essentially the questions were asked, what is top of mind for you, what do you think are the most important things in your life that you need to be focusing on and also what the government's attention should be on. So those questions were asked and there were no surprises in that; the cost of living, health and hospitals and employment were the top three for people. Aged care sort of came down – it was on the radar but not something – essentially not something that people really thought about until they had to.

MS HUTCHINS: Certainly. Because one of the other findings of the research, as I understand it, was that the participants did not have a good understanding of the aged care system and there were a number of common misconceptions - - -

MS LITTLE: Yes.

MS HUTCHINS: - - - about the aged care system. What were some of those misconceptions that people held?

MS LITTLE: Basically, people thought that it was dominated by the for profit sector, that people were making that – the big for profits were making a lot of money out of aged care. That it was mostly residential care. Home care wasn't really – and the sort of nuances of community home support program and home care program really weren't part of their kind of understanding of the aged care system and sector; that it was really predominantly residential aged care and for profit.

MS HUTCHINS: Certainly. And Operator, if you could please turn to page 20. Could you please explain the findings on this page.

MS LITTLE: Well, essentially, people – basically five per cent of the people in – in the research thought they were very likely to need aged care in the next 10 years. 11 per cent thought they were quite likely. But mostly that was obviously significantly higher in the 65 plus. So no surprises, really, to say that if you're in the older age group you think you might need aged care or someone that you're caring for might need some aged care. I think – I think the important thing that we learned from that as well is that where we're seeking to address the issues in aged care, we need to talk to families as well as the individual. So, really, aged care is something for the

family; it's not just for that individual person and that's an important piece of finding.

MS HUTCHINS: Certainly. What did these findings say to you as well about how participants viewed their future needs in relation to aged care?

MS LITTLE: Sadly, some people suggested they would rather die than go into a residential aged care facility. They would rather poke their eye with a pencil than have to enter a home. So I think that was one of the findings, that it really does have – the expectations of people are that residential aged care is not a good place to be.

MS HUTCHINS: And did you have a sense, generally, as to whether people are considering what their future needs are going to be in relation to aged care, generally?

MS LITTLE: Generally, people only think about that when it's the time.

MS HUTCHINS: Thank you. Operator, please turn also to page 29 of this document headed Understanding of Aged Care Funding and Willingness to Pay. Can you please explain in broad terms what the findings were in relation to both people's understandings regarding how aged care is funding and also their willingness to contribute to funding?

MS LITTLE: Sure. Basically, people don't have a good understanding of how the system is funded. They think that more money is needed from government. And I think one of the – the other key findings is that people don't believe that they should be paying for aged care. They do believe they've paid their taxes and they've contributed to the community all their life and that they should be supported in old age.

MS HUTCHINS: Thank you. And the idea of individual contributions towards the cost of aged care, what's your view in relation to this?

MS LITTLE: I think that given the size of the need for care for our ageing population which is growing considerably over the next decade, we need to think of some creative solutions to that. We have said that we think we need to explore how consumers can pay if they can pay more, and also we believe that we need to look at other ways of funding the system into the future and we're starting to look at that as a network, how we can contribute some other ideas to that.

MS HUTCHINS: Yes. And what type of work have you done as a network in relation to that?

MS LITTLE: Just talking at this point; so watch this space.

MS HUTCHINS: Okay. Now, I will turn to some further system issues shortly but first I would like to discuss with you UnitingCare's observations in relation to remote

communities, and access in remote communities, because I understand this is an area in which you have particular involvement; is that correct?

MS LITTLE: Yes, we do.

MS HUTCHINS: And can you please explain the type of work you do in remote communities, and perhaps go through some of the challenges which are experienced in these communities as opposed to in the aged care services areas generally.

MS LITTLE: Sure. Yes. The Uniting Church has had a particular interest and involvement in and commitment to remote Australia for a very long time, through its derivative churches, through the work they've done through their missions, etcetera, and so that has built up over a long period of time to today where we have a number of residential aged care, disability services, home care program, community home support program right across the top end of the country through Juniper and Australian Rural and Remote Community Services. We have around 14 residential aged care facilities in places like Docker River and Mutitjulu and Tennant Creek and Halls Creek, etcetera. And then quite a significant number of home care packages as well.

So the commitment we've had as a church and as community services has been a long one and what we're seeing in those remote communities is that over – particularly over the last couple of decades a real decline in the ability of communities to look after themselves and a great challenge in providing services to the older members of those communities because of the lack of ability to bring good staff in. It costs money to build services that need refurbishment. There are significant health and other issues in remote communities, and particularly in indigenous communities through compulsory income management and other interventions, there has been often a decline in the economy of those communities. So they're small and fragile.

So some of the challenges are just how do you do that in very small groups but people who are incredibly precious and – so as providers, deeply committed. There's no market out there, so you don't have competition as such, but there is a great challenge in retaining and – in recruiting and retaining staff. The travel and other allied health services are not available, so if you are providing home care, much of the home care package may be spent on transport and travel a long way away, and if there are particular health services such as dialysis that are needed then people need to go – if they are indigenous communities they might need to go off country to do that which is incredibly difficult.

MS HUTCHINS: Are these providers independently financially viable or do they need to be propped up from resources from elsewhere in the network?

MS LITTLE: We have – there is government funding, clearly, for remote service delivery and we welcome the – some of the more flexible arrangements that the government has provided out there which has been terrific through NATSIFACP,

etcetera. What we find is that we do need to subsidise the work that's being done out there through our own resources and the costs are quite significant.

MS HUTCHINS: And a matter that you raise in your statement is that quite often in these remote communities, providers are receiving funding or individuals are receiving funding from many different sources, which you say can create inefficiencies and siloing of the service delivery. Can you please expand on this issue for us.

MS LITTLE: In some communities you might have a disability service, a health service, some State funding coming in, federal funding coming in through a variety of different funding arrangements. That does create inefficiencies. The multipurpose services that have been created in some communities across the country where State and federal governments have come together and pooled funding means that you actually – you really get better – better resource allocation because you can have some efficiencies in back of house functions, in transport arrangements, in all sorts of things. So essentially, for us a pooled arrangement in a small community is a much better way, an efficient use of government funds particularly than each government funding program siloing its finding source into – sometimes in some communities you have, you know, 15, 20 more funding programs all funding small amounts.

If you put all that money together and had a buy-in from your local community to really understand what the goals are that you want to achieve there, we've seen that work incredibly well in other places.

MS HUTCHINS: What's an example of where you've seen it work?

MS LITTLE: A long time ago – long time ago – 10 years ago in Looma in WA that approach was tested. It was evaluated by the University of Western Australia and it was found to be incredibly effective. The disability and the aged care services and health all came together. So it's just those three. I think that it can be expanded in a lot of other places, but that was evaluated by UWA and it was found to be effective and my understanding is that we haven't actually done it since.

MS HUTCHINS: And is it continuing there or has it stopped?

MS LITTLE: Because the – it was a pilot. Often with pilots, once they're over and the lens is off, it does take – and people move and often what happens in remote communities is people come and go. Unless you have the same commitment and you've got a structure in place, often it will fall away.

MS HUTCHINS: Okay. Thank you. So moving away from access issues for remote communities specifically, more generally, noting that your network deals with a range of disadvantaged people throughout the community, what are some other issues experienced by this broader population?

MS LITTLE: One of the – the ones that comes top of mind are older people in insecure rental accommodation, particularly women. We know that the homeless population at the moment is – is alarmingly growing in older women, single women, and the accessibility for a home care package is predicated on secure accommodation and we know there is a housing crisis across the country in affordable housing and that is having an impact on women entering residential aged care prematurely, or they don't want to, because they cannot access a home care package because their accommodation is not secure. They might have, you know, a week-by-week rental. So that is one issue. The other issues, of course, of accessibility which is the one that most people here have spoken about is the wait list for home care packages, that the access to home care is – is for 3 and 4 packages is at crisis point. Other accessibilities based on gender, based on CALD background, culturally and linguistically diverse backgrounds, also mean that languages can be a barrier for people if they are trying to access a service that's not in their first language.

MS HUTCHINS: Certainly. In your statement you refer to a research which UnitingCare Australia commissioned by Ansell Strategic which I understand addressed accessibility in supply of aged care places across planning regions. Can you explain in broad terms what this research involved and what the main findings were?

MS LITTLE: Essentially, we again, being the curious folk that we are we engaged Ansell Strategic to do a piece of work to find out if there were some other ways, if you were to change the allocations and change the ratios of home care packages and residential aged care packages, whether that would free up any – and possibly make a level 5 package, if that would free up any funding which could then go to make up the deficit that we're seeing in residential aged care. So the analysis was to look at all of the planning regions, to look at the allocation of home care packages, to look at the use of home care packages and then to map that and then to do some modelling around changing the allocation ratios per 1000 for residential aged care, home care, etcetera.

What we found was that if you did, indeed, put in a level 5 package, change the ratio slightly so that you've got less – you've got more home care – more home care choice and less residential beds, that you would actually have a significant saving within the system over 10 years which could then be reinvested back into residential aged care to make up for some of the deficits.

MS HUTCHINS: Yes. Thank you. I would like to now turn to some specific issues within the system. During the course of these hearings the Commission has heard a range of issues with the existing system and a number of these are identified at paragraph 15 of your statement. Rather than repeating the issues again, I would like to turn to paragraph 16 of your statement where you identify some key reasons for these problems, and we can discuss some potential solutions. Firstly, at paragraph 16(a) you raise the issue of an absence of leadership around dialogue, respecting the rights of elderly and adjusting inequities. What type of leadership initiatives would you like to see in this regard?

MS LITTLE: We believe that the country is at a point where we need a Cabinet Minister – so we need somebody right within the cabinet at the heart of power to lead any of the – particularly the recommendations that come out of the Royal Commission but to really lead us so a Minister for Longevity – I think Susan Ryan actually asked for that back in 2014, suggested that. So we believe that, firstly, we need leadership from our politicians to help us as a country understand that we are ageing. We have a national anthem that says we are young and free, and we need to understand that we are young in age as in maturity possibly as a country but we are an ageing population and we have not come to terms with that, we believe.

So firstly, we need some political leadership. And then we need our champions across the corporate sector and all other parts of the sector to have a national conversation about what it means to be ageing, what it means for us all as individuals and as communities, as families to get old, and to understand that and to embrace that and then to build a system of care that is based on respect and dignity.

MS HUTCHINS: Certainly. In relation to some champions in the corporate sector, have you seen any examples of corporations taking steps of the type you may be envisaging?

MS LITTLE: I can't think of any just at the moment.

MS HUTCHINS: Sure. The next matter that you raise at 16(b) is the lack of government funding and an unwillingness to discuss funding options involving greater consumer contribution. We touched earlier on community perceptions in this regard. What do you think would be appropriate reform in relation to community contributions to funding?

MS LITTLE: Like I said, I think for us it's early days to think about how best those consumer contributions might be made. It is a very low contribution at the moment in residential aged care. There's a cap on that so some of the immediate sorts of things that come to mind could be an uncapping on some of the means testing in aged – in residential aged care, but again that's early days for us, so I wouldn't want to kind of speculate on that. But we do believe that in order for us to afford the system we do need to have a conversation about a greater consumer contribution.

MS HUTCHINS: Thank you. And moving down to 16(d) you note funding and regulatory regimes that maintain the status quo and discourage innovation is a problem. Now, later in your statement you set out UnitingCare's proposal to develop a broader range of models of care so that consumers can make a meaningful choice from a continuum of options. What are some inflexibilities in the current system you have in mind in making this suggestion?

MS LITTLE: Essentially, if one is looking at a care for their relative or for themselves, you have three options: you have a Commonwealth home support package which isn't really in the scope here but it's, you know, your kind of low level. You have a home care package of which at the moment if you have high needs

to need a wait a significant period of time for, unless you're fortunate. And then you have residential aged care. There's nothing in between those; a home care package and a residential aged care. So we believe that there are many other options that can be developed between that smaller settings. The residential aged care settings at the moment are predominantly large institutional settings.

So for us, we think the flexibility should come in looking at many, many different sorts of settings within those three and outside of those three. So that's the sort of flexibility we're looking for. The aged care system, and particularly residential aged care is an institution and we believe that there are probably two institutions left, aged care and prisons in our country, possibly more but essentially they're the two big ones and we believe it's time that the aged care institution is – is really unpacked and brought into much – a much broader range of smaller and more flexible options for people than just the three that exist at the moment.

MS HUTCHINS: Certainly. And so in your statement when you say that we need to deinstitutionalise aged care, are these the types of steps that you have in mind?

MS LITTLE: Yes. Yes. Much more flexibility and a system that's built around the needs of the individual.

MS HUTCHINS: Certainly. In relation to the innovation element of 16(d)d, UnitingCare proposes the establishment of an innovation fund, saying – and you say that this could be done so that Australia can lead the world in innovative new models of aged care and support. Can you expand on what you have in mind in relation to an innovation fund and why you think it's important in light of the current landscape?

MS LITTLE: There are some innovations that are happening at the moment but they are pretty small scale and often they relate to technology. The innovation we're talking about is your kind of big hairy audacious ideas and it's a fund that would – quantum could be 200 million, just off the cuff, and it's something that really helps us to think beyond the current construct that we have. That's not just about innovation in technology or in individual kind of transaction but it's really an innovation in the system that we currently have. It is obvious that it is not meeting the expectations of our current community and also for the future. So we do need to think differently and so this was really to say there's an investment that's needed in doing that. We are a country that has been renowned over the decades and centuries for its innovation and I think that we have the opportunity now, given the crisis we've got, to actually change the paradigm.

MS HUTCHINS: And are you able to provide some examples of the type of innovation that you have in mind?

MS LITTLE: Well, on a small scale, there are some great innovative ways in which people can stay in their own home, be cared for differently through things like the Home Share model, which is a Belgian model which matches up people with

students or those who need accommodation with the older person in their home. That's a very small-scale kind of innovation, small settings for flexible options for people. But the innovations I'm talking about is how do you move a system from where we are now with a very large investment in pretty big residential aged care facilities that clearly the community doesn't want now and probably won't want for the future to one where we can provide high quality care for people with really, really complex needs at one end but the care needs of others, that is with – outside that current construct.

MS HUTCHINS: Thank you. And turning to 16(e) which identifies as an issue the absence of agreed outcomes and how they are measured. Is this statement referring to, I guess, the assessment of providers within the industry? Or is this going towards something else?

MS LITTLE: Essentially, we welcome the single quality framework and the new standards that have been developed because they have – they're developing an outcomes focus. So a focus on outcomes means a focus on the individual. It's not a focus on kind of ticking a box, making sure that you've got all those kind of – those, you know, technical aspects right, although they are important but if the outcome is – the outcome is actually at the end of the day the most – the thing that's most important. So an outcomes measurement framework that is very clear, that's right across the board, that everyone understands, this is what we're aiming towards, I think is a better way of actually achieving good quality outcomes and good quality care than one that is a regime that at the moment is built around sanctioning and built around trying to catch people out for doing the wrong thing.

MS HUTCHINS: Certainly. So we've heard much evidence during the course of these hearings that the standards that are due to be coming into effect in July are outcome driven. Do you think that that's the case and do you think they go far enough?

MS LITTLE: They are – they will be outcome driven. We need to understand what we mean by that. So there is a conversation with the government with providers and with consumers, in fact, around what the outcome is that we're trying to achieve because if you're not clear about that, then you usually don't make the mark. I think they do go – they do go far enough at the moment. Because it's early days, we need to get some outcome measures in place, tested and probably refine it along the way.

MS HUTCHINS: And are there further steps that you would say should be taken in order to push this outcome driven approach?

MS LITTLE: The – the way in which those outcomes are achieved will require culture change from providers in understanding what it really means to provide care that's based on the individual and based on the outcomes as expressed by them, their family, and the community. And so there is a very large piece of work really I think for some providers in understanding outcomes, understanding that care is a relational activity, not a transactional one. And changing the culture of an organisation can

take time and it has to happen from the board right through to the care staff and the cleaners and the – everyone. So there's a cultural – there's a cultural change that is required in order for us to have an outcomes focus in aged care.

MS HUTCHINS: Certainly. And do you think further regulatory change is required to help effect this cultural change?

MS LITTLE: Yes. I think the regulations then need to follow what that – how those outcomes are going to be achieved. The current assessment process, the current visiting process is problematic. We're hearing a lot of stories from the frontline that it's becoming more punitive. It's becoming an aggressive process rather than a helpful one. That – that there are some – there's a need for some understanding of expectations that's not being met at the moment. So there's some work to be done there.

MS HUTCHINS: Yes. And from a consumer's perspective, do you think there's sufficient information available regarding provider performance for them to be able to make an informed decision?

MS LITTLE: I think that some organisations are better than others in doing that. So there's information out there at the local level, at the service level, but what you say you do, not necessarily, you know, may not be what you end up getting. So I think that you do – we do need to have transparency around expectations for the consumer, absolutely, not just by the individuals but what is it that we actually want to see happen within our services right across the board. And that's attached to funding and attached to making sure that services are meeting the standards. So, you know, they are usually attached to standards but we do need some more transparency around that.

MS HUTCHINS: Thank you. And finally, at 16(g), you raise the issue of significant gaps in the interface between aged care and other health systems. What impact do you think the separation of the aged care services from general health services has on the perception of the elderly and on the effectiveness of the delivery of the services?

MS LITTLE: I think aged care has – and I was here the other day when I – when the GPs were talking. I think aged care has become – it's almost like we've kind of – we need to put away our older citizens, that we need to put them into a home and – and then leave them there. So that interface between the rest of the system means that it's often a closed system in residential – particularly residential aged care. And that means that the interface is hard and the interface is often built upon the relationship between the other allied health services and the hospital and the GPs, and that residential system. So I think we need to open up the system a lot more.

MS HUTCHINS: Certainly. And how do you think the system could be opened up more?

MS LITTLE: The interface that we are hearing from our network members with the local hospitals, for example, is a difficult one. So we have examples where the hospital will ring in the middle of the night and say we're going to discharge a patient back to the residential facility because they know that someone's there 24/7. It's incredibly disrespectful to the individual and to the other people who are living in that place, given that it is their home. So the ways in which we need to – we need to create some much better interfaces where, really, basically you've got expectations, what are those expectations of both parties? We need to have a conversation around what are – what are those interfaces that we want to see happen well, and then make sure that they do happen. It's really problematic because hospitals often have, you know, staff turnovers, they have different people on shifts.

The communication is really poor. If we were to have an electronic system that was easily accessible by both the residential facility and the hospital, for example, people's notes would go with them electronically. You could access it back at that end because it has been put in at that end. The medication management, all of those aspects that are really, really important to good quality care can be managed much, much better by a much better interface either both relationally and, I think, electronically. We need to look at whether we can put some sort of a system in place that means that information about that person and their care is much better managed.

MS HUTCHINS: Thank you. Just as a final matter, I would like to clarify something you said earlier in relation to regulation of outcome driven care for consumers when we were discussing 16(e), the absence of agreed outcomes and how they are measured. One of the things that you said was that you felt the regulatory function is becoming aggressive and we would like to understand further what you meant by that.

MS LITTLE: What we're hearing from our network is that when they have unannounced visits, the assessors are aggressive. They are often incredibly negative and they say, quite openly, that they're there to find something wrong, they're there to find them – to catch them out. We had one last weekend that came on a Sunday, which was the first of its kind, wasn't expecting that, fine, but – and then demanding – and others who say demanding lists of phone numbers of home care clients and then ringing them on the spot. So what we're really seeing is a real shift in the dynamic between our providers who are doing their absolute very best on the ground and those people who are coming in, some of whom know nothing about the system that they are assessing, and it has become – it has become something that – that is requiring advocacy through our – through our other peak organisations at the moment and something that we're really, really concerned about.

What we're seeing is that – we had two examples where absolutely had a great review of home care at the end of last year, a whole week – a full three year review, and then within two months – and met everything – within two months come back because there's a complaint, they want to review the entire system all over again. So we're really seeing a shift and I think that's a real worry because for us and for most providers we're wanting to continuously improve our services but it is not a helpful

way if they're just there to, you know, to basically find you out and to try and find something that is wrong.

MS HUTCHINS: Because presumably you wouldn't have an issue of more attention in itself being paid to ensure that the quality of standards in the aged care homes are appropriate?

MS LITTLE: Absolutely not.

MS HUTCHINS: And the issue is more with the manner in which it is occurring.

MS LITTLE: It's the manner in which that is occurring. Yes.

MS HUTCHINS: What would you suggest would be a more desirable manner than that which you just described?

MS LITTLE: I've seen the letters that are sent out to providers. I think one helpful thing would be some sort of a sheet of expectations about what you can expect from us, a bit like, you know, you get from some of the commercial world. This is the way that we will behave. So some behaviour codes would be useful. One of our services was – basically the staff were in tears and she essentially showed the assessors their own behaviour code of conduct and said this is how we expect anyone to behave who comes into our service and so I will have to ask you to leave if you don't. So I think that would be a helpful way in understanding truly expectations of both parties, yes.

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

COMMISSIONER TRACEY: Do you find that following these visits, that you get, or your institutions get some useful feedback as to both positive and negative aspects of what's being reported on?

MS LITTLE: They get the – from my understanding, they get the – what has been met and what hasn't been met. So, essentially, mostly it's about what hasn't been done rather than what has been done well. The worrying aspect is also that some are waiting a couple of weeks before they get the report. So if they have got unmets, they would like to do what they are straightaway so they can put some things in place and make some changes to that. But, essentially, I think from what I'm hearing from my network most of the feedback is about what's not happening rather than what is.

COMMISSIONER TRACEY: And is this the sort of regulation that you say inhibits innovation, or were you speaking more broadly about other forms of regulation that have that effect?

MS LITTLE: The compliance regime that is on aged care at the moment does take away any ability for time to be spent on thinking about new ideas. So, essentially,

the focus is very much about the compliance. So I think that does detract from a sense and a culture that says we might be able to do things differently, raise our head above the parapet and actually have a look at what might be out there. So, essentially, I think it's the time that these things take, not necessarily for a productive outcome that – that takes away from innovation.

COMMISSIONER TRACEY: And on another issue, do you – you were talking about the interface between the aged care residential facilities and hospitals, GPs and others in the medical community. I know it's early days but have you got a sense as to whether these new individual records that are available to the medical profession nationally have had any beneficial impact on the problems associated with keeping track of what has been done for patient in hospitals and other institutions?

MS LITTLE: I – I would have to take that one – very happy to go back and check that. I haven't heard anything so far.

COMMISSIONER TRACEY: Yes. Thank you.

COMMISSIONER BRIGGS: Thank you. Ms Little, would you agree that the regulatory framework up to a few years ago needed a bit of attention?

MS LITTLE: Yes, absolutely.

COMMISSIONER BRIGGS: So what you're talking about at the moment is not so much an improvement in the compliance arrangements but the manner in which they're done and an understanding on both sides about how it will be done; is that right?

MS LITTLE: Yes, and I – I also believe that the regulatory framework is also very inflexible, and there are many compliances at both State, local and federal level, particularly in residential care that need to be – that all need to be – often are duplicating such as food, safety, etcetera. So there are – there are a number of regimes at play all at once which do create an inflexible service.

COMMISSIONER BRIGGS: Okay. The example you gave about the regulator demanding the names and contacts of consumers of the home care services, I think this is not new in the residential care area. My understanding of the way the audits or reviews or whatever they're called work is that the first thing the auditors do is to ask to speak to elderly people in the home, and they spend some time on that because that is an important signaller for where the issues might be. So would you agree that that makes sense in the home care environment as well, because it can shed light in a non-compromised way by the consumers having a say about what's going right or wrong?

MS LITTLE: Absolutely. I think, you know, with our own focus on the consumer being at the centre of any – any good system, that would be really important. I think,

again, it's about the manner in which that was – these are demanded and of the way in which it happens.

COMMISSIONER BRIGGS: I hear what you're saying. And then we go, as Commissioner Tracey did, to the issue of the interfaces and we've got a similar issue here about expectations and a who did this, they did that, why didn't you do that, so we've heard in evidence a series of stories about that. So the GPs complain that you folks don't necessarily tell them what has gone on with the patient or support them in the work with the person in their care. We've heard that the hospitals don't give discharge summaries to either you or the GP about the person. We've heard that the aged care service doesn't provide advice about the condition of the person and their medications and so on to a hospital. And there is confusion all round. It just strikes me that this confusion has been existing for years, right, and it is absolutely one of the reasons for the My Health Record to try and reduce some of this.

MS LITTLE: That's right.

COMMISSIONER BRIGGS: Are there any protocols that are operating at the local level which would sort – which should have sorted this stuff out before now, because these are fundamentals about the care of some very frail people?

MS LITTLE: Absolutely. We have a number of examples that have been created at a local level because at the end of the day it's often about relationships, and who – and if you have a great relationship, I know in my own delivery of human services for many years, if you have a great relationship with the local department, with the local hospital, etcetera, you really do get the job done. So we have some great examples of being able to have arrangements with the local ambulance service, arrangements with the local health service so that these things don't happen. I think it's the larger the institutions, the harder it is to kind of get those relationships happening and, as I say, staff come and go so you're constantly trying to kind of create that. So I do believe, I agree, absolutely, that protocols and arrangements in place that need to be revisited quite regularly could actually help to ameliorate some of this sort of, the pain points that are happening between the institutions essentially.

COMMISSIONER BRIGGS: We might take that up with the States and some of the private hospital people.

MS LITTLE: Yes, I think that would be a good idea.

COMMISSIONER BRIGGS: Thank you.

COMMISSIONER TRACEY: There was one matter I overlooked that I did want to raise with you. When you were discussing models that were alternatives to the residential care on the one hand and home care on the other, you mentioned one of the intermediary options might be what you described as the Belgian model. Could you elaborate on that and just tell us what that model involves?

MS LITTLE: Yes. Home Share is the name of the model. Essentially, it's a broker program which – there was one running in the ACT and also down in – in our services in Victoria, whereby a – essentially a matching up young people, or anyone, really, who needs somewhere to live with an older person who has a home and who needs somebody to live with them. It's quite a simple model but the funding requirement comes through the good matching process. So it's very successful in Belgium. We have had a round table with the Minister and others the year before last with the Home Share model to try and get it as one of the options in the My Aged Care system. So far we haven't been quite successful but we're still trying on doing that because it is essentially a way in which – and there have been some wonderful outcomes where families have actually engaged with not just the two people who live together but essentially their families have become family.

So it overcomes issues of loneliness for older people. It means they can stay in their own home longer. There are some very clear expectations about, you know, what's required, what the person who's coming in, how much they pay, what they're expected to do as far as housework, etcetera. But if properly constructed it's a wonderful way in which people can stay in their own home, be well supported but also tick that other boxes of other people needing – who need accommodation having it. I'm very happy to provide – provide that to – to the Commission.

COMMISSIONER TRACEY: Well, I would be grateful if you would because it sounds like a very useful tool to assist people and avoid the need to go into residential care if that can be avoided.

MS LITTLE: Yes. It's great.

COMMISSIONER TRACEY: Thank you very much for that and all your other evidence, Ms Little. I think in due course you will be hearing from us a bit more to invite you to a round table or two to develop some of these matters a bit further. But thank you for today's evidence. Was there anything arising, Ms Hutchins?

MS HUTCHINS: Nothing further.

MS LITTLE: Thank you so much.

COMMISSIONER TRACEY: Thank you. The Commission will adjourn until 11.30.

<THE WITNESS WITHDREW [11.07 am]

ADJOURNED [11.07 am]

RESUMED [11.33 am]

COMMISSIONER TRACEY: Yes, Ms Hill.

MS HILL: If the Commission pleases, I call Melissa Coad.

<MELISSA COAD, AFFIRMED [11.33 am]

<EXAMINATION-IN-CHIEF BY MS HILL

MS HILL: Ms Coad, could you please state your full name.

MS COAD: Melissa Coad.

MS HILL: And what is your role?

MS COAD: My role is in the national office of United Voice which is a trade union and I work as a national coordinator for aged care.

MS HILL: How long have you held that position for?

MS COAD: Since about 2012.

MS HILL: Did you prepare a statement dated 6 February 2019?

MS COAD: Yes, I did.

MS HILL: Operator, could the document with ID WIT.0018.0001.0001 be displayed. Ms Coad, do you see a copy of your statement on the monitor before you?

MS COAD: Yes, I do.

MS HILL: And to the best of your knowledge are the contents of that statement true and correct?

MS COAD: Yes, they are.

MS HILL: Commissioners, I tender that.

COMMISSIONER TRACEY: Yes. The witness statement of Melissa Coad dated 6 February 2019 will be exhibit 1-52.

EXHIBIT #1-52 WITNESS STATEMENT OF MELISSA COAD DATED 06/02/2019 (WIT.0018.0001.0001)

MS HILL: As the Commission pleases.

Ms Coad, what is United Voice?

MS COAD: United Voice is a union. We represent a whole range of members working across a whole lot of industries and sectors but, obviously, specifically for our purpose today, our members working in aged care.

MS HILL: How many of your members would you say are working in the aged care sector?

MS COAD: We have about 12,000 members in aged care.

MS HILL: What sort of work are they doing?

MS COAD: It varies but predominantly the work that our members do is the work of direct care so personal care workers, if you will, in both residential care and in home settings. Additionally, we have members who work in residential aged care in roles such as catering, cleaning, gardening.

MS HILL: And do you have contact with your members?

MS COAD: I do. I am in the national office of United Voice but I do have contact with our State branches and with their members so I will travel to branches and meet with members when they're having groups of members coming together. If we're involved in any kind of consultation around reforms in aged care often I will try and bring a member with me to those events as well.

MS HILL: Do your members describe to you a single issue as facing them?

MS COAD: I guess to sum up, I mean, there's lots of aspects to the issues that they describe to me, but the single issue that they would say in relation to aged care is that they don't feel that they can do the jobs to the best of their ability.

MS HILL: And is that in respect of a particular role or the roles across the board?

MS COAD: That's particularly in respect of the personal care workers.

MS HILL: You've just told the Commissioners that your organisation is affiliated with State branches such as the New South Wales branch.

MS COAD: That's right.

MS HILL: And your New South Wales branch has drafted a survey entitled Home Care Member Survey 2017, hasn't it?

MS COAD: That's correct.

MS HILL: How was that survey obtained?

MS COAD: That particular survey was, I believe, emailed to members to – for them to respond to that survey.

MS HILL: And how many responses, are you aware?

MS COAD: There was 182 responses.

MS HILL: And what was the purpose of that survey for United Voice?

MS COAD: The purpose of that survey was really an internal purpose for our branch to gather information from the members about the specific issues facing them so that the branch could then use that in interactions with members and for other purposes.

MS HILL: Operator, can I please ask you to display the document ID UVH.0002.001.0001. Do you see the cover page of that survey on the monitor before you?

MS COAD: Yes, I do.

MS HILL: And I see there that it has got a draft watermark on it. Why is that, Ms Coad?

MS COAD: The draft watermark is still there because it is an internal document and often with these things there's plans to potentially go back down the track and do further work on them, but it is just for use as a sort of a working document – internal working document.

MS HILL: I tender that, your Honour.

COMMISSIONER TRACEY: Yes, the United Voice home care member survey 2017 will be exhibit 1-53.

EXHIBIT #1-53 UNITED VOICE HOME CARE MEMBER SURVEY 2017 (UVH.0002.0001.0001)

MS HILL: Ms Coad, are you able to describe, in your experience, what a typical aged care worker looks like?

MS COAD: In terms of our membership I guess a typical aged care worker looks like a woman who is in her 50s.

MS HILL: And in paragraph 17 of the statement that you've made you consider the 2016 workforce census and you set out the features of the aged care workforce in Australia. Is your evidence that paragraph 17 broadly sets out the conditions of aged care workers in Australia?

MS COAD: Yes, that's right. So that census is the most recent data that we have on the demographics of the workforce.

MS HILL: And what are those conditions that are basically that the aged care worker has?

MS COAD: Sorry, do you mean the conditions of their work or the – yes.

MS HILL: Of the demographics.

MS COAD: So the demographics of the workforce are that they are predominantly older than the average Australian workforce, predominantly female. That they are most likely to be part-time employees, or casual employees. There's very little full-time employment among the direct care workforce. And most of them – the wages, hourly wage rates are particularly low and so most – there is a high number of workers that would like additional hours. There's also a high number of workers that work more than one job.

MS HILL: And those key demographics were considered in the New South Wales survey, weren't they?

MS COAD: Yes, they were.

MS HILL: Operator, if I could please ask you to turn to UVH.0002.001.002. Now, being mindful of the fact that it's a relatively small survey size, you see there on the display before you the key demographics as have come out of that survey.

MS COAD: Yes.

MS HILL: In respect of the wages of workers, that's something that you address at paragraph 49 of your statement and at paragraph 49 your evidence is that the wages of workers does not amount to a living wage. What do you mean by that?

MS COAD: Yes, so I'm not necessarily referring there to any technical definition of what a living wage is but the hourly rate of pay is quite low – we're talking about $21 an hour – and that is compounded by the fact that most of the work is part time. So people really do struggle to amass enough money to live adequately. Additionally – sorry, additionally I think the issue for our members is that that really impacts them in their prospects of retiring because they're not able to have savings or significant superannuation balances, for example.

MS HILL: What does that tell you about the value that's placed in aged care workers?

MS COAD: That it's not valued to the level that it should be for the work that it is.

MS HILL: If nothing changes, what in your experience do you say that this means for aged care work in the future?

MS COAD: I think if nothing change we have a significant challenge into the future of growing the aged care workforce. There are predictions that the workforce would need to reach a million people by 2050. I think if wages and other working conditions don't change we're going to have significant problems in attracting and retaining people to that workforce.

MS HILL: How can the aged sector retain workers?

MS COAD: I think it can retain workers by improving the quality of the job so wages is definitely one significant aspect of that as is the inadequacy and unpredictability of hours. There are certainly other working conditions that would go to that as well. The thing that our members tell me repeatedly is that they feel stressed in their work, pressured in their work, that they don't have enough time to do their job properly. So I think those workload issues would also significantly improve that.

MS HILL: Is United Voice doing anything to address those issues?

MS COAD: Yes. So we address those issues individually when we bargain with employers around the terms and conditions of the work in that particular employer but more broadly we do work at the policy level to try and effect those conditions.

MS HILL: Does United Voice have a view as to how the aged care sector can attract new workers into the future?

MS COAD: Yes, I think certainly by addressing some of those issues. So we have a very strong view that there should be, for example, in residential aged care a minimum staffing model. Exactly what that looks like, we do not have an opinion on but we think there's some really important underlying principles when developing that sort of model, number one of which is that residential aged care facilities are the homes of people residing in them and when looking at the requirements of those people it goes much more broadly than just their physical needs such as showering, dressing, things like that but, really, encapsulating the social and emotional needs of people in those facilities as well. And there's some other characteristics of the work that certainly would need to be looked at.

MS HILL: At paragraph 50 of your statement you refer to the need for an appropriate staffing and skill mix in residential care. Is that what you're referring to?

MS COAD: That is what I'm referring to, yes.

MS HILL: And what are your members telling you they need in respect to that?

MS COAD: Particularly they're telling us they need more time. So what we would really be looking to is a model that allowed workers to spend appropriate amounts of time in residential aged care specifically with residents. So our members tell us that a lack of staffing leads to quite high workloads for them and leads to them being rushed through things. One member described it to me as a conveyor belt of tasks that they have to undertake. Members feel particularly upset that they don't get to spend quality time with people, that they don't get to do things at a pace that is dignified and appropriate for the individual person. So, certainly, we would say that some sort of mandated staffing level should address those workload issues.

MS HILL: Operator, could I ask you to please display document ID UVH.0002.0001.003. The priority issues for your members were canvassed in a New South Wales survey, weren't they?

MS COAD: Yes, they were.

MS HILL: And you can see the result of that before you.

MS COAD: Yes.

MS HILL: Can I ask you to take the Commissioners to those findings, please.

MS COAD: Yes. So, certainly, this question was asked of respondents to the survey about their top three priorities in terms of addressing issues for their work. As can be seen from that, better wages was their number one priority. There are also a number of issues that went to the workload aspect that I was talking about previously so, obviously, I was referring to residential aged care when I was talking about that particular staffing model but workloads is also an issue in home care. So things like less stress, obviously, go to that – those workload issues, less physical demand. More respect and acknowledgement for the work is a big issue for members as well, and that's beyond just the results of this survey. Certainly other members that I deal with mention that as well, that they don't think that the work they do is valued and respected.

MS HILL: Operator, could I please ask you to display document ID UVH.0002.001.0005 and the following document, page 6, side by side. If I could draw your attention to the bottom of that first page on your left there where it says the heading Unpaid Overtime and the body of text that follows that is over the page on the right-hand side. The New South Wales members were surveyed about unpaid overtime - - -

MS COAD: Yes, they were.

MS HILL: - - - in terms of their roles. Could I ask you to take the Commissioners to those findings.

MS COAD: So the findings of this survey was that about 30 per cent of respondents did report doing unpaid overtime and you can see at the bottom of that park there that unpaid overtime was more likely to be reported by casual workers and less likely to be reported by workers that had higher hours. But I can also say beyond this survey that that is a common thing that members report to us, is that they do do work in their own time.

MS HILL: What are the members telling you about that?

MS COAD: So, certainly I have heard members say things like that in home care, for example, if they know that a particular person doesn't have any family or other supports they come up with their own rosters in their own time to check in on those people. I have spoken to members who work in residential aged care who have told me that they have finished their shift, gone home and had a shower and got changed and come back to the facility to sit with someone who's dying in their own time. I have also heard members tell me that they have, in addition to spending time outside of paid hours, that they have also purchased things for recipients of care as well – that might be clothes or toiletries or other personal items – out of their own funds.

MS HILL: Towards the bottom of page 6 which is the document on the right-hand side there's a heading Sufficient Time Scheduled. You've given evidence to the Commissioners in respect of members describing to you the feeling of being rushed in their work. Could I ask you to take the Commissioners to the results of the New South Wales survey in respect of that.

MS COAD: Yes. So there was a – the majority of respondents believe they were – they did have enough time but almost 30 per cent disagreed, and I think that's a significant number there. Even though 58 per cent of the respondents thought they were scheduled with enough time, 70 per cent did report being rushed. So there might – there's a bit of an anomaly there but I think people are used to having to do that work in a really rushed fashion which is probably what is reflected in that result.

MS HILL: Bearing these matters in mind does United Voice say there should be a ratio in home care or residential care?

MS COAD: We certainly think there should be some – obviously it's different than residential aged care where there's a kind of – you could have a number because the people are all in one location. But we certainly think there should be some regulation around minimum visit times, for example, for particular people so that people are not, as I said, rushed in doing their work. We have heard reports from members that they've been scheduled 15 minute visits sometimes to people's homes and they say that is simply not adequate. Even if those visits are to do things like a medication check to check that people had taken their medication, members have said to us for some people 15 minutes is not enough time to do that. Where the

person has dementia or other challenges it can sometimes take 15 minutes to get in the door let alone go through a process of checking anything.

MS HILL: In respect of home care, have your members seen a change in their circumstance of work in respect of the change to or the introduction of individualised funding?

MS COAD: Yes. So members have reported to us that they feel since the changing to the – change to the funding regime in home care, they feel that they have less time to do things like staff meetings or team meetings in paid time. They feel that those things have really dropped off.

MS HILL: And why is that, Ms Coad?

MS COAD: Their perception is that because providers are now given an individual bucket of money per client, they can't pool their resources in any way. They have to acquit that individual bucket of money against that person, and that that gives less flexibility for people to kind of, you know, spend more money in places where they need to and less in places where they may not need to and that's the perception of our members is what's causing that.

MS HILL: Is there a current training regime in place for personal care attendants as far as you're aware?

MS COAD: There's no mandated training regime. There are qualifications at the certificate level available to workers and there's quite high levels of holding of those qualifications in the sector so quite a lot of people do have relevant qualifications.

MS HILL: And when you're talking about relevant qualification what are you referring to?

MS COAD: Certificate III – they've changed names recently so I think it's currently an individual support is the title of the certificate III.

MS HILL: If I could ask the operator to please display document ID UVH.0002.0001.0002. The New South Wales survey, specifically considered that issue, and do you see that before you under the heading Industry Qualifications?

MS COAD: Yes.

MS HILL: Could you take the Commissioners to the finding of the New South Wales survey as set out in that table.

MS COAD: Yes, so as I mentioned there is quite a high – despite there being no mandatory requirement for holding a qualification, there are quite high levels of qualifications amongst workers in the sector as can be seen by some of those, so for example, the certificate III in aged care, 53 per cent in home and community care, 49

per cent. So there are quite large numbers of people that do hold relevant qualifications. Some of these qualifications – the breadth of these qualifications reflect name changes over time in some of the qualifications.

MS HILL: Mr Rooney, the chief executive officer of Leading Age Services Australia, gave evidence yesterday to the Commissioner that there is has been a upskilling of personal care workers by providers that his organisation represents – that members of his organisations would have personal care workers that have been trained in certificate III and certificate IV qualifications over time. Commissioners, for your reference that exchange is at pages 457 and 458 of yesterday's transcript. Ms Coad, are you aware of any of your members being trained in certificate III or certificate IV by their provider?

MS COAD: I'm not personally aware of that, no. That's not to say that it doesn't happen but I'm not personally aware of it. But what I would say about these qualifications of certificate III is that they are – in our opinion, they should be mandated entry level qualifications. But what our members tell us beyond holding those qualifications is they are desperate for additional training in a range of specific areas that goes above and beyond what they might obtain in that certificate III.

MS HILL: Can I take the Commission then to your evidence in respect of the United Voice recommendation that training should be mandated. You address that at paragraph 54 of your statement. What sort of training needs to be mandated in the view of United Voice?

MS COAD: We believe that the – there should be an entry level qualification mandated at the certificate III level. There is a lot of discussion about the quality of the delivery of some of that training. We don't think that potential poor quality of a delivery of training should mean that that shouldn't be mandated. We think that that should be mandated and that the quality should be addressed as a separate issue. Additionally to that entry level qualification we really think there should be additional training provided to people, and being guided by what our members want training in, things like dementia care, palliative care, mental health and a range of other specific health conditions.

Our members say to us if they had ongoing training in those areas that would give them a better understanding and allow them to provide a better quality of care. They are aware that research and things move in those areas regularly and they would really like to maintain a currency in some of those areas. I think for us as well as providing better care if people were able to be trained in some of those areas that might open up potential for career pathways in this area as well.

MS HILL: Operator, could I please ask you to display the document ID number UVH.0002.0001.0005. Do you see that document in front of you?

MS COAD: Yes, I do.

MS HILL: And that's the desired training area table that has been set out in the New South Wales survey.

MS COAD: Yes.

MS HILL: And what could you take the Commissioners to what that sets out.

MS COAD: Yes, so some of those things that I just mentioned are obviously reflected there – and this is in conversations that I had with our membership more broadly than just New South Wales home care but you can see the consistency there. Most people would really appreciate additional training in dementia, other specific conditions, mental health and palliative care as well as then some of the other areas around management, managing clients and medication.

MS HILL: If I could ask the operator to please display document ID UVH.002.001.0007. In particular, the heading on that page, Training for Service Provision, do you see that there before you, Ms Coad?

MS COAD: Yes, I do.

MS HILL: Could I ask you to take the Commissioners to the results of the New South Wales survey in that respect.

MS COAD: Yes, so 23 per cent of members who responded to this survey reported carrying out medical procedures or giving medicines without training. Again, this is something that we hear commonly from our members is that they are put in positions where they are sometimes involved with medical – administration of medicines where they're not comfortable with being involved in that.

MS HILL: Do you have a view as to why they are placed in those situations?

MS COAD: I believe it would – well, they report to me that it would be mainly due to understaffing and the unavailability of someone else to do that work.

MS HILL: Should everyone that's engaged in aged care work receive training, so, for example, if someone has come round to mow the lawns?

MS COAD: I think everyone should receive training. The levels of training may be different depending on the roles that you undertake so, obviously, where people are providing direct care to people that might be a higher level of training but I think that people who are engaged in aged care more broadly should have some understanding of the people for whom they're working or working with.

MS HILL: Would mandated training be an obstacle to future workers looking to enter the aged care sector?

MS COAD: We don't think it has to be. We think there are a range of ways that you can make mandated training accessible for people. For example, making that training free, available publicly and free to people wanting to enter the sector. We think that you can put in place things like – that people can start working whilst they're working towards gaining that qualification so they don't have to have completed the qualification before they start working. There are a range of initiatives you might look at such as recognition of prior learning if people have been working in the sector or a similar sector already. So there's a whole lot of things that can be put in place that mean that that sort of mandated qualification shouldn't be a barrier to entry.

MS HILL: If workers in aged have a complaint about an aspect of their work what can they do about it, Ms Coad?

MS COAD: If the complaint is about sort of an industrial matter relating to their work obviously they can come to the union or pursue it through different avenues. If it's in relation to an aspect of care that they're seeing, they can report that up the management within their own facility or externally through the aged care complaints service. I would say, though, that – particularly with that latter example around instances of care – members say to us that either they don't know how they would go about raising those issues or they say that in the past they have raised or they have seen other people raise those issues and that has had negative consequences for that person in relation to their employment.

MS HILL: What are those negative consequences, in your experience?

MS COAD: Things like a reduction in hours. Members have reported bullying and harassment in services where people are seen to rock the boat or make trouble.

MS HILL: In paragraph 41 of your statement you describe the Aged Care Quality and Safety Commission as not being relevant. What do you mean by that?

MS COAD: Yes, I probably could have worded that better. What I mean is it doesn't currently have in its remit the role to look at workforce issues. United Voice doesn't have a position on whether that would be the right place but at this point in time that's not part of its role.

MS HILL: Does United Voice have a position in respect of how those workforce issues can be addressed?

MS COAD: Yes, certainly. So as I mentioned, the staffing models that should be looked at to mandate staffing models, introductions of training – mandated training, introductions of career pathways in aged care, a system of regulation that would fold into that the minimum entry qualifications and the capacity for ongoing training as well as the specific workforce conditions around wages and inadequate hours.

MS HILL: Do people working in aged care currently have to undergo any pre-employment screening?

MS COAD: They have to do a police check. That's the extent of it at this stage.

MS HILL: What would United Voice like to see as far as pre-employment screening processes go?

MS COAD: So we would like to see an overarching regulation system that included in the first instance a pre-employment screening check that was slightly broader than purely a police check.

MS HILL: What are you referring to when you say "slightly broader"?

MS COAD: It could include employment history and things like that as well. The broader regulation system would then also mean that people would have that minimum qualification and then have access to ongoing training and development whilst they hold that registration, and that that would result in a registration system, effectively, for that workforce. Members also say to us for them, from their perspective, such a system would help to increase the value or the perceived value of the work that they do.

MS HILL: Are you aware of any current arrangements in place for recording personal care attendants within the aged care sector?

MS COAD: No, I'm not.

MS HILL: Mr Rooney in his statement of 31 January this year gave evidence to the Royal Commission that regulatory changes may be needed in relation to the screening and accreditation of personal care workers. If I could ask the operator to please display document ID, WIT.0013.0001.0001. Do you see Mr Rooney's statement on the screen before you?

MS COAD: Yes, I do.

MS HILL: If I could then ask the operator to turn to paragraph 90 which is on page 11 of that document. Do you see paragraph 90 on the monitor before you?

MS COAD: Yes, I can.

MS HILL: Could I ask you to read that to yourself, please, Ms Coad.

MS COAD: Certainly.

MS HILL: Do you agree that a national register for the aged care workforce is appropriate?

MS COAD: Yes, we do and it would be part of that broader scheme that I was talking about earlier.

MS HILL: Do you agree that there is a need for regulatory change to the screening and accreditation along those lines in respect to personal care workers?

MS COAD: Yes, we do because there is currently no system in place so we believe that one should be introduced.

MS HILL: You've told the Commissioners you expect that that would improve how personal care workers – how aged care workers would feel about their role. What does your experience tell you about that?

MS COAD: So members – so as well as giving members the opportunity for that ongoing training and development that I mentioned that they tell us that they really want and is evidenced in the results of the survey that we've spoken about, they do feel that that would increase a perceived value of the work that they do, if there is a mechanism that recognises people who are working in that – in the system.

MS HILL: And what would United Voice like that registration to look like?

MS COAD: We believe it should be what we refer to as a positive registration system rather than a negative one so we wouldn't want to see, for example, a publicly available banned list. We think it should be a positive system where – whereby people who have gone through all those processes have registration to work in aged care and that that is something that they hold. That if they move between employer to employer, for example, it is something that the worker themselves holds so it's transferable for them.

MS HILL: If I could ask you to consider the role of personal care attendants, what are your members telling you about their interactions for the people they're caring for?

MS COAD: Our members by and large say to us that they are incredibly – they do this work because they are incredibly passionate about doing this work. They really value and enjoy the interactions with the people that they're caring for. They think that – or they report to me that having those quality interactions with people can really improve the quality of service provision that they give to those people. I mean, we are talking about a system that is based on human interactions. This is not work that's delivered at arm's length. It is delivered by people to people and so those relationships and interactions are pivotal in that.

MS HILL: Are personal care workers able to do their jobs properly and to satisfaction in the current environment?

MS COAD: They tell us they're not, particularly, as I mentioned to you earlier, related around that workload issue that they feel pressured to do things in limited time.

MS HILL: In paragraph 27 you refer to a worker in home care experiencing a feedback loop. Could I ask you to expand on that for the Commissioners.

MS COAD: Yes, certainly. This comes from the research that I have referenced there where the researchers found that the stress experienced by home care workers in not – in feeling that they weren't able to do their job to their best extent added to their inability to do their job to their best extent so that it was a bit of a vicious cycle.

MS HILL: In evidence, the secretary of the Health Department, Ms Beauchamp was asked a question about the current quality standards. I would ask the operator to bring up day 5 of the transcript, page 342. Do you see a page of transcript in front of you, Ms Coad?

MS COAD: Yes, I can.

MS HILL: If I could ask you to go to line 40 on the page that's on the left-hand side, and read that to yourself, through to line 10 on the following page. Do you agree with Ms Beauchamp's evidence in that respect?

MS COAD: I agree it's important but I think this is the aspect of care that our members say to us they currently are not always able to deliver. I would say that my experience with our members is that they do have empathy and compassion. That's why they're working in this job, but then what they say to us is they don't feel that they have the time to really adequately develop those relationships with people.

MS HILL: Commissioners, they are the questions I seek to take Ms Coad to.

COMMISSIONER TRACEY: Thank you. Ms Coad, we've received evidence in the course of the inquiry that suggests that there are a significant proportion of workers in this industry who are overseas citizens holding working visas here in Australia. Is that reflected in your membership?

MS COAD: It is to a certain extent. I can't give you an exact figure but I could certainly come back with that.

COMMISSIONER TRACEY: It is suggestive of the fact that employers in this industry are having difficulty recruiting locals to do the work that your members are doing. And that may reflect the sorts of concerns that you've been giving evidence about, that the industry is simply not sufficiently attractive to Australian workers so that it would be helpful to know the extent to which the industry is dependent upon foreign workers. Could I ask you about training because, again, there seems to be some disparity in the evidence. We've heard some evidence that the large proportion of the workforce is unqualified beyond 120 hours of in-service training to do their

work, and I must say I was most impressed by the table in your statement that indicated a very high proportion of your members are qualified. Are you able to tell us whether those qualifications have been achieved whilst they have been working in the industry with the support of their employers, or whether they've obtained those qualifications in order to get work in the industry?

MS COAD: I think there would be a mix. I couldn't tell you the exact proportion but there would certainly be a mix of those arrangements so people obtaining those qualifications prior entering and people undertaking those qualifications whilst working in the sector, and that may be with or without the support of their employer.

COMMISSIONER TRACEY: And do these people have to do – the ones who are obtaining qualifications whilst they're working, have to obtain those qualifications by attending classes outside their normal working hours, or do the employers encourage them as part of their paid employment to attend classes and develop their skills?

MS COAD: Certainly in my conversations with members I would say that the latter, that doing – undertaking studies during paid time is fairly rare. I'm just trying to think if I've – recall an example of that and I can't. So I suspect that mostly people would be undertaking this in their own time.

COMMISSIONER TRACEY: Yes. And when they do that, and when they obtain these qualifications, is that then reflected in their wage levels on the pay scales provided for in the agreements?

MS COAD: It would be – if there was an enterprise agreement with an individual provider that might be different but in terms of the award, the difference between the pay rates and the award are minimal.

COMMISSIONER TRACEY: And do you seek to negotiate wherever you can into individual agreements, workplace agreements, provisions such that there is encouragement by way of increments in salary achievable by obtaining these qualifications?

MS COAD: Absolutely. So where our State branches will be negotiating with individual employers around agreements those are definitely things that we would seek to put in there. The difficulty that we face in a lot of instances is that people will say that they are constrained in what they can do because of the funding arrangements so that if they don't have the money coming in, that they are unable to provide those sorts of wage increases. So certainly it's something that we seek to do. Our experience is that it is fairly constrained in the aged care system because of the nature of the funding.

COMMISSIONER TRACEY: Thank you.

COMMISSIONER BRIGGS: Let's pick up on that, if we could, please, Ms Coad. I think you alluded to earlier on in your evidence that because in adopting the person-centred approach to home care packages, that has affected the level of training that might be provided by providers to personal care workers; is that right?

MS COAD: It's not so much the adoption of person-centred care. It's the nature of the individualised funding. So the way that the home care packages are funded has, in our members' experience, reduced some of those paid time activities, not the nature of the – construction of the package, if you will. So it's not the person-centred care in and of itself; it's the way that that has been funded.

COMMISSIONER BRIGGS: Can you explain to us a little more about that, so we can understand it properly.

MS COAD: Certainly. And this is obviously the views of our members and not the views of a provider administering these packages. So what – what we understand or what members have said in conversations with employers is that previously they would be allocated a number of home care packages which would give them a pool of money from which they then had some flexibility if people's needs increased or decreased to sort of move that money around a little bit and that they had some efficiencies in using that pool of money. Now that they have individual budgets for each person receiving a package they have to acquit that money against that individual budget which gives them some – less flexibility in moving things around where it's appropriate.

COMMISSIONER TRACEY: Okay.

MS COAD: But I'm certainly not an expert in that funding so it's - - -

COMMISSIONER BRIGGS: That makes sense to me. Can I ask you another question about the flow of personal care workers from caring for a partner or a family member into formal employment in this sector. Do you see much of that?

MS COAD: We do. I'm not sure how widespread it is but certainly in our experience we do have members who have come to this work because they have cared for a family member.

COMMISSIONER BRIGGS: And the information that you've collected about the age of personal care workers is pretty significant, and one of the things this Royal Commission will consider is the supply of workers in the sector and I suppose the age of the workers, the gender mix, these are all important things and we would like to see people of all ages and genders moving into the sector. Have you got any counsel for us on attracting new members or new workers to the sector?

MS COAD: I think the only counsel that we would give really goes to the quality of the jobs in aged care. I think people will be attracted to this work because of the nature of work that it is, but I also think that beyond that, if people can see

opportunities for them in this work, if they can see that they will be remunerated appropriately for the value of the work they do, if they can see opportunities for career progression, for continued learning, for things like that, that they will be more attracted to this sector. Certainly, it is our view that quality jobs are inextricably linked to the delivery of quality care and that you can't have one without the other.

COMMISSIONER BRIGGS: Thank you.

MS HILL: Ms Coad, in your experience with your members, are workers receiving ongoing training in their roles within the aged care sector at the moment?

MS COAD: I would say are. I don't know how widespread that is, so certainly some employers do provide ongoing training to their workforce and some don't. But what we would like to see is a broader system of ongoing training such that that was transferable for people so sometimes if people have received specific training from one employer and they might move to another employer who then won't recognise that training that has been provided by other employer. So we're certainly keen to see a more formalised system of ongoing training that is transferable for people.

MS HILL: Thank you, Commissioners.

COMMISSIONER TRACEY: Ms Coad, thank you very much for your evidence. It has been very helpful to know how your members are travelling at the moment, and what can be done to improve their lot and that of the industry and your evidence has been very helpful in that regard.

MS COAD: Thank you.

COMMISSIONER TRACEY: Thank you very much.

MS COAD: Thank you.

<THE WITNESS WITHDREW [12.14 pm]

COMMISSIONER TRACEY: Dr McEvoy.

DR McEVOY: Commissioners, I call Matthew Graham Richter.

MR SILVER: Commissioners, may I announce my appearance on behalf of Mr Richter and The Aged Care Guild. The name is Silver.

COMMISSIONER TRACEY: Thank you.

MR SILVER: Thank you.

<MATTHEW GRAHAM RICHTER, AFFIRMED [12.15 pm]

<EXAMINATION-IN-CHIEF BY DR McEVOY

DR McEVOY: And Operator could you bring up, please, WIT.0012.001.0001, and perhaps also on the same screen WIT.0029.0001.0001. Mr Richter, do you recognise these as statements that you've made to the Royal Commission?

MR RICHTER: Yes, I do.

DR McEVOY: Do you wish to make any amendments to them?

MR RICHTER: No, I don't.

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

MR RICHTER: Yes. That's correct.

DR McEVOY: Commissioners, I tender both statements separately.

COMMISSIONER TRACEY: Yes. The witness statement of Matthew Graham Richter dated 31 January 2019 will be exhibit 1-54.

EXHIBIT #1-54 WITNESS STATEMENT OF MATTHEW GRAHAM RICHTER DATED 31/01/2019 (WIT.0012.001.0001)

COMMISSIONER TRACEY: And the supplementary witness statement of Mr Richter dated 15 February 2019 will be exhibit 1-55.

EXHIBIT #1-55 SUPPLEMENTARY WITNESS STATEMENT OF MR RICHTER DATED 15/02/2019 (WIT.0029.0001.0001)

DR McEVOY: Mr Richter, would you please give the Commission your full name.

MR RICHTER: Matthew Graham Richter.

DR McEVOY: And what organisation do you represent?

MR RICHTER: I am the chief executive officer of The Aged Care Guild.

DR McEVOY: And what precisely is The Aged Care Guild; who are its members?

MR RICHTER: So The Aged Care Guild is a small group of privately held providers who have come together to form an association to advocate for policy for – forward policy settings that are positive for this industry. And what I mean by that is we would like to see policy settings where the key drivers for this industry come from consumers, not from the government or the providers. We think that a policy setting that enables that would enable good providers to do well which is ultimately good for the Guild members. The Guild members are listed in my supplementary exhibit and include Allity Aged Care, Ourcare Proprietary Limited, Bupa Care Services Proprietary Limited, BlueCross Sapphire Care, Japara Holdings Proprietary Limited, Regis Aged Care and McKenzie Aged Care Group Proprietary Limited.

DR McEVOY: Mr Richter, you say that you would like to see policy settings where the key drivers for this industry come from the consumers and not from the government or the providers. If you have a look at the first page of your statement down at the very bottom, you will see you make reference to the constitution of the Guild, the first object of which is to promote the interests of the aged care industry throughout Australia by any means thought desirable by the company. You've also made reference in your statement at various points to the Guild's advocacy role in supporting or opposing views likely to affect the interests of members. Can I suggest to you that that's your primary focus as an organisation, rather than having a focus on the protection of consumers of aged care services?

MR RICHTER: Yes, Counsel, I accept that that's my primary focus and we execute that primary focus trying to get a focus in this industry on consumers.

DR McEVOY: So one of the things that you've also said – and I think this is at about paragraph 1.1 on page 2 of your statement – is that the Guild is of the view that Australia's aged care system meets the current needs of most ageing Australians who rely on it. That's your view, is it, that it is meeting needs?

MR RICHTER: Yes. And my statement does need to be read as a whole, Counsel, because this industry is very complicated and based on the evidence that is available to me and based on my experience and current government policy settings, which I think is very important to consider, the system is meeting the needs of many senior Australians. I'm not saying that the system is perfect, nor am I saying that I agree with the current policy settings. My statement does go on to identify a number of areas where we think – and I think the system can be improved, and I can draw your attention to those areas if you would like to discuss that.

DR McEVOY: We will come to some of those areas. One of the things your statement says – and this is at about paragraph 2.2 – is that:

> *The Guild does not accept that there is a systemic risk to the community by the quality of care provided today.*

Does that remain your view, having regard to some of the evidence that you will have heard over recent days?

MR RICHTER: What we're trying – what I'm trying to say there – "systemic" could have been not the best word to use. What we're trying to say there is I don't believe that all providers are doing the wrong thing or all providers are bad or certainly that all staff are not doing the right thing or are no good or anything like that. The staff are incredibly dedicated in this industry. They're in the industry because they care and I want to reflect on that as an important basis and I don't think everybody is failing. So I may have not got those words exactly right but that's the intent of what I'm trying to convey.

DR McEVOY: Operator, could you please bring up exhibit 1-10 which is RCD.9999.005.0001. I'm not sure whether you're familiar with this document, Mr Richter, but if you take a moment to have a look at it, I would suggest to you that what it indicates is that there has been an increasing number of issues identified relating to the quality of care that's being provided today. And you will see perhaps that there has been a substantial increase in the number of serious risks found: revocations of accreditation, sanctions imposed, notices of noncompliance and referrals to the former quality agency. Can you tell me what the Guild's position is in relation to this consistent increase in the list of issues relating to the quality of care provided in aged care?

MR RICHTER: Certainly. And it is a difficult question and one of the reasons obviously why we're here right now. It could be potentially a function of one of two things or both these things at the same time, in my view. It could be that we're getting a better underlying picture of what the aged care system actually is looking like, in which case we're getting a clearer picture of operations on the ground through better processes. Or quality is decreasing in the system so there's more – more findings. Or it could be a combination of both and I'm uncertain which is – which is happening.

DR McEVOY: Well, whether it's one or the other or both, would you regard these as symptoms of a systematic – a systemic, rather, a systemic risk?

MR RICHTER: Yes, I do. I think there are a number of symptoms that this system is approaching a tipping point and we need to refocus it and I think, as has been mentioned by some others, rebalance it.

DR McEVOY: So where you say at paragraph 2.2 that the Guild doesn't accept that there is a systemic risk to the community, is that the Guild's view or are you now saying that, in fact, the Guild has a view that perhaps there may be some systemic risk?

MR RICHTER: Yes. As I mentioned before, I probably worded that statement not quite as succinctly as possible and I was trying to say that we don't think that all providers and all staff are not doing their best out there. Excuse me. But we do

think that there are warning signs – clear warning signs, including these quality numbers, of issues in this industry and there are other warning signs which require urgent attention.

DR McEVOY: Well, you said at the outset I think that you regard yourselves as being driven by consumers. What's the Guild doing to address some of these systemic problems?

MR RICHTER: Sure, so I can talk about a few initiatives that we've been trying to do at the Guild. One of the biggest things that I think is an issue in this system is a lack of information for consumers almost at any point on what is a very complex and complicated journey. It has been one of the first things I have noticed. I have noticed it in health care prior to moving here as well, and it's one of the first things that we have talked about in my leadership at the Guild. What we're doing about that, we have started publishing our consumer experience reports on aggregate but they're only done every three years. We are in the process right now of building a prototype model that could online aggregate a whole range of consumer experience feedback, including things like net promoter scores which is something like would you recommend this service to a family member or a friend. It could even include clinical indicators; it could benchmark them across the industry. And we're developing that and I can't make anyone use it, because I have no mandate over any providers in this industry, but we're developing that to try and push forward on the front of both transparency and information for consumers, as one example.

DR McEVOY: Well, that's one example. Are your members on board with that initiative?

MR RICHTER: Yes, they are.

DR McEVOY: All of them?

MR RICHTER: They're on board with us developing this prototype, yes.

DR McEVOY: And how much have you spent developing that initiative?

MR RICHTER: At the moment, we've got $100,000 allocated to that initiative.

DR McEVOY: And has that got staff being allocated to it, that sort of thing?

MR RICHTER: We're working with a partner in the industry to help develop it and it's being developed with myself and some of my key staff internally.

DR McEVOY: When you say a partner in the industry, who is that?

MR RICHTER: They're a small organisation called CarePage who have expertise in consumer feedback.

DR McEVOY: And so what do you contemplate that this program may tangibly, practically result in for consumers?

MR RICHTER: What I would like to see is a place where you could go as a consumer and find information out about what you're looking for. So not everyone wants the same thing out of their residential aged care or other aged care. So that's the first challenge, that everybody's different and maybe you have certain preferences about how you might want to live and that you could find out more information about how different organisations and different homes run their services. I would like people to be able to find out about how those services perform. So quality indicators would be important; quality indicators that mean something to consumers as well.

So what I mean by that is, we can have clinical quality indicators measuring falls and those kind of things but consumer outcome quality indicators as well; what has your experience been like, what has your family's experience been like, would you recommend this facility to someone else that you care about are really important measures. And then to have benchmarks across the industry that are visible so the industry can see what's good, what's not so good, what's great, what's terrible. We don't have that at the moment.

DR McEVOY: And that's indeed so. Does the Guild contemplate a rating system as a part of this?

MR RICHTER: That's – that's a possibility. It has – it would bring this concept, this prototype is being developed deliberately with the flexibility to enable those kind of things that can really incorporate most things. As I said, it's a prototype. It's not a final product and it is something that we would be very close to even being able to demonstrate to the Royal Commission at some stage if that would be of benefit.

DR McEVOY: And what sort of timing does this program have in mind?

MR RICHTER: Ideally, we would like to move it from prototype to something active very quickly this year, if we could. We've got to finish the prototype, test it and then determine what early data we might start to pick up from the ground. It picks data up at the facility level through things like iPads. So where we might start, who we might engage with in a trial sense and get it operating as quickly as possible is our goal.

DR McEVOY: And it's your present thinking that that might well include some sort of rating system?

MR RICHTER: It could.

DR McEVOY: How many of your members are participating in the National Quality Indicators Program?

MR RICHTER: I'm unsure. I would have to take that on notice, but yes.

DR McEVOY: Are you aware of any of them that are participating in it or you have no knowledge about that?

MR RICHTER: Yes, I'm aware of both the program and I think there may be one or two that are participating but I'm unsure of that answer. I would have to clarify that.

DR McEVOY: Only one or two of your members. I wonder what that says about their commitment to the sort of transparency and rating system that you've just been speaking to the Royal Commission about?

MR RICHTER: When you have a look at their operations, most of these organisations have fairly extensive clinical systems in place already. I think the motivation wasn't there to join up to a trial that collects a minor amount of clinical indicators that they're already collecting that was quite – and I'm told, this was some time ago – an administrative burden and quite a difficult system to operate. But many providers are already collecting clinical indicators but what we don't have is any central repository of those indicators in the system.

DR McEVOY: Do your members – does the Guild have a view about whether the mandatory quality indicators which are to commence on 1 July this year should be published?

MR RICHTER: We're fine with them being published.

DR McEVOY: All of your members are supportive of that, are they?

MR RICHTER: Yes.

DR McEVOY: When I asked you, I think, several questions ago now, what were you doing and what we've been talking about probably for the last five minutes is this issue of transparency and ratings, and you've told the Commission that that's a project which you think will come to fruition this year and that it may well include ratings and that your members are on board with that. What other initiatives is the Guild taking?

MR RICHTER: So we've provided examples of good robust consumer feedback systems. So one of the major shifts and one of the most positive things I see in the new quality standards is a functional move to focus in on consumers. In my earlier statement when I said I don't necessarily agree with the current policy settings, I said that because I think at the moment they focus on cost control and illness.

DR McEVOY: Cost control and?

MR RICHTER: And illness.

DR McEVOY: Illness, yes.

MR RICHTER: Whereas that's not ageing. And that focus doesn't support positive ageing. These standards start to change that focus to what a consumer wants, what they might aspire to be in their old age and how we support that.

DR McEVOY: I'm not quite sure that in answer to my question you've said what further initiative you have in mind.

MR RICHTER: My apologies, I got myself a little bit lost there. So in that regard, bringing some experience that I have from my previous career, we've done a lot of work on talking about what best practice consumer engagement might look like. All these organisations engage with consumers. They have different levels of feedback systems and different levels of complaint systems but we've really tried to make sure that that is – that is really pushed hard and escalated to, you know, a really high level of best practice level across the board where possible, if they didn't have that already. I think that's really important because there's a very different way of working coming up.
We need to work with the consumer and this is how we should be working. It seems to make sense but the system hasn't worked like that so we need to plan our services, thinking about the consumer, taking their feedback. So these systems need to be robust, they need to be multifaceted so that's another area where we've been doing a lot of talking so we're focused on that transparency area and feedback area mostly.

DR McEVOY: Where you talk about consumer engagement and you talk about feedback and you talk about these systems being robust, all of which is no doubt tremendous, what does that mean though in a practical sense? What is the initiative that you are referring to here and how is that being rolled out or how has that been rolled out?

MR RICHTER: Well, it's up to, obviously, each individual provider but, for example, one provider has just rolled out an independent hotline for complaints or whistle-blowing, if you like. It's stronger than the previous system they had in place. It's completely independent from the organisation. Anybody can use it, including families, consumers, staff, contractors who come on-site, someone who walks by. Anybody can use it and it's completely independent of the firm. That's a very important thing. There is a – there is a complaints system nationally in the regulatory regime but the more avenues we have for people to be able to provide feedback – and I think we need to think of complaints as feedback as well, to act on them and make the system better – the better. So I can't make providers do that but that's an example of a provider taking some advice and implementing something a bit better than they had before.

DR McEVOY: Are you able to say which provider that is?

MR RICHTER: That's Allity Aged Care.

DR McEVOY: How does this work. There's a telephone number that people are able to call. Who runs the telephone service? Do they run it themselves?

MR RICHTER: No, they don't. It's completely independent of them. I'm just trying to remember the name, it's Whispli, I think it's called, the company that runs that service.

DR McEVOY: That's a - - -

MR RICHTER: I didn't identify deliberate services for them. What I did was provide examples of good services that I had seen in practice in health care and other places before for them to have a look at and talk about why it's of benefit to their organisation and their consumers to have as strong as possible feedback lines in place if they did not already.

DR McEVOY: All right. Well, that's a second initiative which you say has been taken by one of your members. Are there other initiatives that there may be utility in you sharing with the Royal Commission?

MR RICHTER: I think in terms of specific initiatives, I don't have – any other funded specific initiatives that would draw to – draw attention to at the moment. We have done a fair bit of work on looking at the value of aged care in Australia and commissioned some research on that and we have also done work on looking at how we might answer the future funding problem and come up with some ideas on that. Now, we're not proposing that the ideas that the Guild come up with should be implemented or adopted or even anything. It's – the point is that it's a conversation starter about something this country really needs to talk about at some stage soon. It shows that industry can participate in that conversation with good ideas and the modelling that sits within that – the long-term modelling that sits within that project does demonstrate the really big financial problem we have facing the country coming up.

DR McEVOY: Perhaps I will come to funding in a few minutes, Mr Richter. What I might do before that, though, is take you to paragraph 1.15 of your first statement which is on page 5, where you say, at the start of that paragraph:

> *It is my expectation that regulatory action taken in relation to providers will continue to rise in the near future.*

Why is it that you think that regulatory action is going to rise? Is it just because there's an improved capacity to make complaints? Or are there other reasons in play here?

MR RICHTER: There are a couple of reasons why I think we would expect to see this happen. Firstly, I think with any new system like this, what you see is people getting the administration side of it a little bit wrong at the start and you should get some kind of little blip there but hopefully not too much. But this system ultimately

is, in my view, and hopefully better than the previous system. If it undertakes a risk-based approach like it's talking about and a consumer-based approach, it should be better and it should be different. And this industry doesn't have a history of changing quickly, so there will be a period where there will be some overlap between regulatory activity and how quickly this industry moves, in my view, to a true consumer focus. I could be completely wrong about that and I hope I am.

DR McEVOY: Well, is there a sense, Mr Richter, in fact – is there a sense that the more you investigate matters of this kind, the more you're going to find?

MR RICHTER: That's entirely possible. As I said at the start, that's one of the possibilities that explain those previous figures.

DR McEVOY: So in paragraph 3.5 of your statement on page 8, you say:

> *The Guild is concerned that restrictive regulatory arrangements and the lack of articulated policy direction from government is impacting development and stability in the sector.*

What do you mean by that in circumstances where you've just accepted that there's going to be a rise in regulatory action and that this is partly a function of the fact that the more you investigate, the more you find?

MR RICHTER: So paragraph 3.5 is referring to a different component of the regulatory system, not the quality and safety system, but the regulatory arm that deals with – with funding and fees and means and all those kind of issues. So at the moment we have a system which is out of balance, in my view, from a financial perspective, in that one side of the system – the revenue side – is mandated by the regulatory environment in terms of how income comes in. The other side, the expense side is exposed to market-based costs like wage rises, energy rises, those kind of things, and the two don't seem to be very well linked and I think it's out of balance and one side restricts the other, if that makes sense, Counsel.

DR McEVOY: Are members of the Guild expressing concerns to you in relation to financial viability?

MR RICHTER: The primary concern is policy and regulatory instability and then financial vulnerability of the sector overall is a concern as well. The sector isn't performing very well from a financial perspective and that has material implications, I believe. When you have any industry that is returning on its assets a negative return, you don't tend to see broad-based innovation. You don't tend to see broad-based training and development. And these are some of the problems that we're seeing. So this issue of finances is important from an industry perspective.

DR McEVOY: Well, when you say the industry is measuring negative return, what's your basis for that observation?

MR RICHTER: The StewartBrown four year 2018 industry survey reported a negative .5 per cent return on assets for the industry.

DR McEVOY: For the industry but what about your members?

MR RICHTER: So my members return a positive, on average, return on assets. I don't have the overall measure right now but last time we did it it was somewhere between two and three and a half but we would have to do that again for you – per cent return on assets.

DR McEVOY: Yes. And when was that, Mr Richter, that that return - - -

MR RICHTER: That calculation, we did last year based on the previous financial year results. So we would need to go and redo a calculation.

DR McEVOY: And is that an average, is it, of members of the Guild?

MR RICHTER: That's an average, yes.

DR McEVOY: So some of them will be - - -

MR RICHTER: Some will be higher.

DR McEVOY: - - - a bit better. Some will be a bit lower.

MR RICHTER: That's correct.

DR McEVOY: Yes. Can I ask you, Operator, to bring up RCD.9999.0011.0746. This, of course, is the Tune review, Mr Richter, that you're well aware of and have referred to in your statement. Operator, if I could ask you to go to the recommendations which are a couple of pages in, and in particular recommendations 13, 14 and 15. Just bear with us, Mr Richter. You're familiar with these recommendations, Mr Richter, aren't you? You've referred to them, recommendation 15 you see there:

> *That the government abolish the annual and lifetime caps on income tested care fees in home care and means tested care fees in residential care.*

You've urged in your statement that 13, 14, 15 and 19 be taken up. Can I ask you to elaborate on why it is that the Guild takes that position?

MR RICHTER: Certainly. We highlighted these recommendations to illustrate how the previous issue that we were referring to about balance could be addressed. It's important to note that we support the entirety of the Tune review and Mr Tune undertook the review as a holistic exercise. So I wouldn't say that you would implement any of these without implementing other measures in the Tune review that balanced them. So there are a number of recommendations that go to better

information for consumers and transparency, for example, that need to come along with any of these recommendations. So it is a package. We highlighted these recommendations because what they do in Mr Tune's view is they – we said that we had a restrictive regulatory environment on the income side previously. This works to free that up a little bit, to try and balance that income expense equation, so we highlighted them as an example of how something like that can be managed. But the entire package should be implemented.

DR McEVOY: And this would – this would include what is there set out in 14:

> *Providers charge the minimum basic daily fee. The cap be retained, providers be able to charge a higher basic fee, the maximum daily fee be published –*

Etcetera, etcetera. Are you having members who are saying to you that they might leave the market because of some of the financial pressures you've mentioned?

MR RICHTER: We don't entertain those kind of discussions because we maintain careful – careful anticompetitive rules in our meetings. So people's market activities – people's – excuse me – company's market activities, intents or plans, we don't allow discussion at in our meetings. What has been conveyed to me is that there is significant uncertainty about the future in aged care and from an investment point of view uncertainty always makes it harder to attract funds.

DR McEVOY: What about expansion on the part of your members? Are you aware of planned expansions?

MR RICHTER: Yes, I am.

DR McEVOY: Can you say something about that?

MR RICHTER: Yes. We provided some additional data in our supplementary statement on - - -

DR McEVOY: On beds.

MR RICHTER: On expansion, yes.

DR McEVOY: That's about paragraph 8.10 of your second statement, I think.

MR RICHTER: That's correct, so to my knowledge, we – we as – the members of the Guild intend to live around 2644 beds. The question was over the next 18 months. I would expect that the majority of them would be delivered in that time. I did caveat my statement that there are various things that can happen in a building and construction plan that can change those timelines, so it might not be exact.

DR McEVOY: What was the outcome of the Guild's research in relation to a funding model with the assistance of Swiss Re and Rice Warner? You talk about

that in your first statement. I think that's about paragraph 7.6. Are you able to say something – a little more about that?

MR RICHTER: Certainly. Firstly, it reinforces, I think, what we should already know, is that there is a big issue from a purely fiscal perspective for this country to deal with. It looks like it might be a long way in the future, but experience in other countries when you look around the world says the longer you wait, the harder it is to deal with this issue. That's one of the big things that I see from it. This model provides an example of how we might go about finding more funds for a social service like aged care. As I said previously, it's – we're not saying it should be the model or that it should be taken up but we would like a discussion, sooner rather than later, about what we want from an aged care system in Australia and how much we're willing to pay for that and how we're going to pay for that.

These questions are fundamental, I think, to the future of aged care in Australia and they're not easy questions. We're not alone in this. We're not alone. Other countries are facing similar issues. The UK is – is stalled on this issue at the moment. They are struggling to grapple with it politically and it is having devastating consequences in their health system and in other areas. So we're not alone. The World Health Organisation has tried to call to arms its member organisations to look at ageing and Australia hasn't responded strategically. They've called for a strategic plan from their member organisations to start to look at ageing as a strategic issue, to start to look at how ageing can better intersect with the health system and other factors.

Having a plan for ageing sounds like something that might be a little bit bureaucratic but I believe we can't rely on being the lucky country to move through the demographic bubble that's ahead of us. We need a plan to navigate this country through that demographic bubble to turn it from an issue to a success. And the World Health Organisation at the centre of their intent is exactly that; that we move away from this being a big scary problem and start to see it as the opportunity it could be.

DR McEVOY: Well, let's look at one aspect of the strategic problem, and that's the issue of the workforce challenges, and I might take you to paragraph 7.4 of your second statement which is to say your 15 February 2019 statement. You've set out there a table which includes total new graduate nurses and total graduate nurses to leave an organisation for the financial years 2013/14 to 2017/18. So these figures, I take it, are coming from all of the members of the Guild?

MR RICHTER: No, there's – they're coming from a majority of members. There's one member that did not submit to this.

DR McEVOY: Okay, which member was that?

MR RICHTER: That was Bupa.

DR McEVOY: Bupa didn't. So these figures have to be read without Bupa. What approximate size does Bupa have relative to other members of the Guild?

MR RICHTER: Bupa is very large. They're one of the largest organisations in the industry. So that's material.

DR McEVOY: All right. Well, we might have to ask Bupa about the equivalent figures. But focusing just on these figures without Bupa, the numbers are somewhat striking, aren't they? If you have a look at the total new graduate nurses in the year '15/16, it's 148, 141 the next year and 163. In each of those years, more than – in 2015/16 and '16/17 more than two-thirds of nurses were leaving, and it's not terribly dissimilar in 2017/18. Do you regard that as a disturbing sort of set of figures?

MR RICHTER: Yes, I do. And this is something that John Pollaers in his work reflected on and it's one of the signs that I see of the – a warning sign that we need to have a look at resetting this industry, that there's high turnover of its workforce. That's not a good thing.

DR McEVOY: Well, and that's the case, you see that in 7.5 as well, where you've got a table providing the average employment period for new graduate nurses in '13/14 through until 2017/18. That reference, I take it, in each of those columns, 2.35 and '13/14, that's a reference to the number of years they stay?

MR RICHTER: That's correct.

DR McEVOY: So 2.35 falling to 1.99, falling to 1.69, falling to 1.48, falling to 1.31. It's a pretty striking trajectory, isn't it?

MR RICHTER: It is.

DR McEVOY: And what actions are your members taking to deal with this sort of attrition rate amongst nurses?

MR RICHTER: I would have to ask them specifically for their programs. They have a range of programs that they do have in place, training and development to try and put in structured career pathways.

DR McEVOY: Well, Mr Richter, can we try and deal with this other than as a matter of generality. Are you able to give me any information about what particular members are doing in this regard or, indeed, what the Guild is doing about this?

MR RICHTER: I could take a question away to generate a list of activities for you, if that would be of assistance, from the members.

DR McEVOY: Well, I'm sure it would, but does the fact that you can't indicate any at the moment indicate that none spring to mind?

MR RICHTER: That's right.

DR McEVOY: Have a look at paragraph 6.3 of your second statement. That table sets out workforce movements and you've got nurses, carers and others. Just focusing on nurses and carers, you're seeing very substantial turnover there in the personal carer ranks as well. You've got about just under a third, I think, leaving each year. What about that? Has the Guild sponsored any initiatives or is it doing any work on the question of how that's to be arrested?

MR RICHTER: From a Guild perspective, one of our primary objectives is to try and get the workforce industry council, which is proposed John Pollaers' workforce strategy, established and operational to try and get an active mechanism in this industry to try and address some of these broad issues.

DR McEVOY: What does that mean in practical terms, Mr Richter?

MR RICHTER: It means we've been working to help John Pollaers try and get that council formed and working as quickly as possible so that strategy doesn't sit idle any longer.

DR McEVOY: Does that include initiatives like paying personal carers a living wage?

MR RICHTER: The work – are you referring to the workforce strategy that John Pollaers delivered?

DR McEVOY: Yes. And your involvement with it, which was really what my question was directed to.

MR RICHTER: So we had some members involved in the formulation phase of it in terms of the strategy now. My view is I would like to get an industry council established. My view is that it should be a robust council of providers who are doing well from a workforce perspective and there needs to be some criteria around that. Our union colleagues and consumers to determine - - -

DR McEVOY: Mr Richter, I'm sorry to interrupt your answer but my question was directed to whether some of these initiatives might contemplate paying carers a living wage?

MR RICHTER: Yes, the workforce strategy does consider wages amongst a number of other things.

DR McEVOY: Yes, but my question was directed to whether your members had that in contemplation as something that they might do?

MR RICHTER: I can't answer that. I'm not sure.

DR McEVOY: One of the things that figure 6.3 also shows, Mr Richter is that carers are growing at a faster rate than nurses. Would that be fair?

MR RICHTER: I think that's fair, yes.

DR McEVOY: And are you able to say something about the Guild's position on that?

MR RICHTER: On the rate of growth of carers versus nurses? Well, my position is that it's very unclear at an industry level exactly what is happening with workforce. So we've got these numbers in front of us which is a start. But you can't get this everywhere and at an industry level. I think we need to be able to make clear what's happening from a workforce perspective to make some decisions through, hopefully, the workforce strategy that John Pollaers has written about how to enhance the workforce. My view in terms of the growth in carers is that that has got to be looked at against the context of the care that's being delivered at the moment, and make sure that that's appropriate.

DR McEVOY: Commissioners, I've probably got another 10 or 15 minutes, but I'm very content if it's convenient to continue with Mr Richter now before the luncheon adjournment?

COMMISSIONER TRACEY: If you're confident you can stay within those bounds we will sit on. If not, we will adjourn until 2 o'clock.

COMMISSIONER BRIGGS: Yes, I've got a couple of questions to follow up, too.

DR McEVOY: Perhaps in those circumstances, Commissioner, we should adjourn for lunch.

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

ADJOURNED **[1.02 pm]**

RESUMED **[2.06 pm]**

COMMISSIONER TRACEY: Yes, Dr McEvoy.

DR McEVOY: Thank you, Commissioner.

Mr Richter, before we rose for lunch we were talking about workforce and labour issues, you might recall. I want to ask you about the recruitment of foreign workers,

whether within Australia or overseas by members of the Guild. Are you able to give the Commission any information about that?

MR RICHTER: I don't have specific numbers, if that's what you're looking for, but certainly foreign workers are a significant component of the workforce, and for the Guild.

DR McEVOY: And by what mechanisms do Guild members recruit foreign workers?

MR RICHTER: The Guild members – they would use a range of mechanisms. I can't discuss them specifically but it's something that, again, I can survey our members and collect for you if you would like to know the different mechanisms.

DR McEVOY: Are you saying, Mr Richter, that you're simply not aware of what the position is there, or not?

MR RICHTER: I'm not aware of the exact recruitment mechanisms that each firm uses to recruit workers.

DR McEVOY: Would it be the case, to your knowledge, that providers identify and employ particulars workers from particular ethnicities or communities?

MR RICHTER: I'm not aware of that.

DR McEVOY: What sort of training would members of the Guild typically give personal care workers?

MR RICHTER: So like a lot of occasions in this industry it varies between member to member, and so the training programs are very – excuse me – different, but the Guild members do try and ensure all their personal care workers are training to have the certificate III or have the certificate III.

DR McEVOY: Just pausing there, is it your evidence to the Commission that all of the Guild members will ensure that personal care attendants have at least certificate III. Is that what you're saying?

MR RICHTER: Or are working towards their certificate III so are doing the training and will be under maybe a practical supervised arrangement as they do that training in the workplace.

DR McEVOY: And what's the Guild's position on the adequacy of a training regime of that kind? Do you regard it as adequate?

MR RICHTER: No, we don't.

DR McEVOY: And what do you say should be done in that space?

MR RICHTER: We support a identified mandatory minimum level of training for personal care workers.

DR McEVOY: Over and above level III and IV?

MR RICHTER: Yes.

DR McEVOY: And what might that involve?

MR RICHTER: The key area that I've identified in talking to members where members do additional training is in the area of dementia and in the area of – it's hard to describe it, but interpersonal skills and awareness. That's a very important area, you know, to work well in this industry. So that's a soft skill but an important skill.

DR McEVOY: Have you spoken to all of your members about that?

MR RICHTER: Yes, we've talked about this.

DR McEVOY: And are they all supportive of that.

MR RICHTER: Yes.

DR McEVOY: They're all supportive of that enhanced training regime.

MR RICHTER: Yes.

DR McEVOY: Have you got any plans in place to roll out training of that kind?

MR RICHTER: Not as the Guild but each member has its own training regimes that they operate.

DR McEVOY: Over and above category III and IV?

MR RICHTER: It differs, as I said, but I can check that for sure, but yes, they do.

DR McEVOY: Can I just ask you to switch your gaze for a moment to the home care space. Can you tell me whether you're aware of any policies which might exist on the part of your members imposing time constraints on nurses and personal care workers who deliver home care?

MR RICHTER: No, I'm not aware of any such policies.

DR McEVOY: Well, by that are you saying you're simply unaware of whether there are such policies, or are you saying that as far as you're concerned there are no such policies?

MR RICHTER: I'm unaware of any such policies, so there may be but I'm not aware of them.

DR McEVOY: One of the complaints – I suppose it's a complaint, a matter that you raise in your statement about paragraph 2.8 of your statement is that aged care is poorly integrated into other sectors and in particular you say the hospital system. Can you tell me what initiatives, if any, your members are taking or the Guild as the umbrella body is taking to deal with some of these problems of integration?

MR RICHTER: No, we've not really undertaken major effort in this area, so there's, you know, a need for – it's not the fault of hospitals or residential aged care; there's a need for us all to work together better.

DR McEVOY: But you're not undertaking any initiatives?

MR RICHTER: Not specifically as the Guild, no.

DR McEVOY: Do you have plans to undertake any initiatives?

MR RICHTER: We don't have any plans at the moment, no.

DR McEVOY: So your members are not coming to you agitating for some attention to be given to this particular aspect of the system?

MR RICHTER: They're certainly talking about this aspect of the system needing some attention. As the Guild, we don't have formal initiatives planned to overcome this issue, though.

DR McEVOY: Can I take you, Mr Richter, to page 9 of your statement. This is in answer to a question put to you by the Commission about whether parts of the aged care system meet certain needs, and it's apparently your evidence that in relation to dementia and palliative care, there are some deficiencies which you identify. Can I ask you whether the Guild, on behalf of its members, is doing anything about the problems in relation to dementia care, and in relation to palliative care that you outline in those two paragraphs which have been brought up onto the screen?

MR RICHTER: Again, we don't have formal initiatives in play but we're trying to raise awareness of these issues and have a discussion about how to do these things better.

DR McEVOY: Well, what does that mean, Mr Richter, if you don't mind me saying, what does that actually mean?

MR RICHTER: It means if we think about – as a country, the government thinks about these issues when it formulates policy and trying to address them better - - -

DR McEVOY: Yes. No but my question, Mr Richter, is what's the Guild doing? What's the Guild doing?

MR RICHTER: That's what we're doing, we're not doing anything more practically.

DR McEVOY: You're just thinking about it. Is that the position?

MR RICHTER: We're – we are thinking about it and we're talking about it but we don't have practical programs as the Guild, because that's not our role to have practical programs in the field.

DR McEVOY: Well, how does the thinking that you say you're doing manifest itself?

MR RICHTER: Into?

DR McEVOY: Well, you've said you're thinking about – you've identified in paragraph 4.1.3 and paragraph 4.1.4 the fact that more needs to be done in relation to dementia and you made remarks of a similar tenor in relation to palliative care. And I've asked you what you're doing about that and you've said you're thinking about that. And I've asked you what form does that thinking take. Does it take the form of the production of issues papers? Does it take the form of raising these issues with your members? Does it take the form of your members raising these issues with you? What form does it take, this thinking?

MR RICHTER: Sure. Thank you for clarifying my understanding of the question. It takes the form of raising the issues with our members and talking about these issues, but raising the issues with government and policy-makers as well to try and collectively come up with solutions and better ways of service.

DR McEVOY: When did you last raise the issue of palliative care that you advert to there in paragraph 4.1.4 with members of the Guild?

MR RICHTER: I can't specifically recall it, the specific instance but I can - - -

DR McEVOY: So does that mean the answer you gave me one question ago was simply incorrect or what does that mean?

MR RICHTER: No, it means that I would say last time we had a meeting, but I'm unsure exactly whether that's correct. I would like to look at my minutes to make sure that we talked about it. We talk about a broad range of issues all the time.

DR McEVOY: What about dementia care and the need to do more to manage that; when was the last time you raised that with members of the Guild?

MR RICHTER: I know we had a discussion about that in January of this year, one of the members in particular was doing quite a major piece of research on dementia design and facilities designed to support dementia care, which includes a capital costing component which hasn't really been done before to try and get an understanding of what the real cost of a different way of delivering dementia might be.

DR McEVOY: And which of your members is doing that, Mr Richter?

MR RICHTER: That is, sorry, I forgot their name all of a sudden. That is Japara. Apologies.

DR McEVOY: So they told you, did they, that they were doing this work, is that what happened?

MR RICHTER: Yes.

DR McEVOY: And are you doing anything in parallel with that work?

MR RICHTER: No.

DR McEVOY: You might recall that before lunch, Mr Richter, you indicated that members are concerned about their rate of return and you nominated an average rate of return which was in the three to four per cent range, I think. Do you recall – do you recall that?

MR RICHTER: Yes, I do, and I was – yes, making an estimate.

DR McEVOY: Yes.

MR RICHTER: At that time.

DR McEVOY: Can I take you to paragraph 8.9 of your second statement. Perhaps if we enlarge the size of that table so you can see that, Mr Richter. I will just read the introductory remarks to that table. You say:

> *An independent accounting firm was engaged to ensure that the collection and storage of data was independent and consistent to ensure integrity of this data was maintained and to ensure each operator's data remained invisible to the Guild or other members ensuring compliance with the Competition and Consumer Act.*

And then in the table you set out, starting from the period 1 October 2015 and going through up until 31 December 2018, and you've got a second column deals with existing facilities; the third column deals with new facilities; and the fourth column deals with operational beds. Do you see those?

MR RICHTER: Yes, I do.

DR McEVOY: Now, in the period 1 October 2015 to 31 December 2015, there are 30,883 beds. You see that?

MR RICHTER: Yes, I do.

DR McEVOY: And if you go down to the very bottom, that is to say the figure up until 31 December 2018 you will see the figures become 37,303 beds. So by my arithmetic, that's about a 20.77 per cent increase in numbers of beds over that period, or approximately, on a per annum basis, a 6.3 per cent increase over that period. Would you broadly accept that arithmetic?

MR RICHTER: Yes, I will broadly accept that mathematics.

DR McEVOY: It's not obvious, Mr Richter, is it, that there's significant concern about expansion on the part of members of the Guild, is it?

MR RICHTER: Not in this statement, it's not, no, but – if that's what you're saying.

DR McEVOY: Well, not on the basis of the increase in the number of beds.

MR RICHTER: Yes, that's right.

DR McEVOY: So just going back to the evidence that you gave before lunch in relation to the concern about expansion, would you regard that evidence as wholly accurate?

MR RICHTER: Yes, I would.

DR McEVOY: Well, how does it sit with a 20.77 percentage increase in the number of beds in the period from October 2015 to the present?

MR RICHTER: Because I'm talking about what the industry needs to do as a whole to meet future demands as expressed by the Aged Care Financing Authority. This is a component of the industry, The Aged Care Guild, but it's only a small component of the industry. We need to look at what the future needs are as a whole and ensure that we keep pace with that demand so we don't fall behind.

DR McEVOY: Commissioners, I don't have any further questions for present purposes of Mr Richter.

COMMISSIONER TRACEY: Thank you.

COMMISSIONER BRIGGS: Okay. You quoted earlier the Tune review, if I might pick up on Mr McEvoy's questions about bed numbers and so on. You were at pains to emphasise, Mr Richter that all of the Tune recommendations should be

implemented at once. Can I get a feel for the dynamics about the implementation around the home care side of the expansion, and what I'm wondering here is would there be some logic to see the home care sector grow, as we're seeing the government attempting to do at the moment now, while you maintain the supply side controls on the residential care side in order to grow or address the imbalance on the home care side?

MR RICHTER: Yes, there's absolute logic in seeing home care grow into the future. It should grow and it needs to grow. What we need to understand is the overall need is going to grow as well. So we're going to need more hospital capacity. We will need some kind of residential capacity. It may look very different in the future but we will need some kind of capacity which provides people with 24 hour support that they need and home care should significantly grow, so there is logic in that.

COMMISSIONER BRIGGS: Do you see logic as well, moving the fund holding arrangements to elderly people themselves for all the sectors of the system?

MR RICHTER: I do see logic in that and maybe there are other ways of doing it, but the intent of such a move is to essentially enable the consumer to vote with their feet. Now, as I said before, this is why the Tune review needs to come as a package because they need the information to be able to do that, they need information about performance and a whole range of things like I said before. So it doesn't happen alone. But the principle is it shouldn't be the only thing in the system, but that that competition could be another layer to help with quality and service standards. But you still have your regulatory regime in place.

COMMISSIONER BRIGGS: Do you envisage that in future there should be more of a case mix style of funding or maintenance of the current system or an advancement on that system?

MR RICHTER: I think it's likely that we will move to a case mix style of funding because it's a well-established style of funding in the hospital and health sector. What's very important, and I mentioned this earlier, is there's a couple of fundamental differences to keep in mind when we move to that type of funding arrangement. And I mentioned that the current arrangements operate on illness, I think I said earlier. So what I meant by that is how the Aged Care Funding Instrument works is you will look at a whole bunch of categories of what's wrong with you and you get scored and there's funding that gets attributed to that and that's – that's okay but this isn't a hospital. This is about living the rest of your life, so what else do you want to achieve in your life and how do we support that as well. So that component of, if you consider it care, we need to make sure that that's factored in as well. But I do think it will be a case mix style because that should be the most efficient thing to do because we have significant expertise and infrastructure in Australia already established because of the hospital systems.

COMMISSIONER BRIGGS: There has been a significant reduction in the proportion of the workforce in this sector who are registered nurses. Does the Guild have a view on that?

MR RICHTER: We do, and I think from the Guild's perspective there's not enough information at the moment to clearly address this issue, and that's why we supported, for example, Ms Rebekha Sharkie's transparency bill. There may be other ways of doing it, but her bill, in essence, was a mechanism to make clear across the entire industry the staffing situation and what the models of care are all at once. And that's a good starting point to be able to talk about staffing and what solutions we should be thinking about. The second point I make is I don't want us to think about staffing in isolation of other things. So we've got the workforce strategy which is great but we need to think about staffing in relation to the funding model and in relation to how we're going to do everything because they're so interlinked that they need to be considered together.

COMMISSIONER BRIGGS: Yes, we're certainly conscious of those interlinks.

MR RICHTER: It's very complicated.

COMMISSIONER BRIGGS: I think the Royal Commission really welcomed your statement at the beginning that you want to see the system move more towards being driven by the consumer. So we're particularly interesting to hear what Guild members are doing in terms of regular day-to-day consultation and feedback with the elderly people who use their services, and their families.

MR RICHTER: Yes, and I will answer that and I'm also happy to try and collect more information, as I've said earlier, if that will assist you. They're really, firstly, working hard to ensure that they've got multimodal feedback mechanisms in place, so one of the things you see with the My Aged Care website, for example, not everyone uses the internet and it's not a favourable way of providing feedback or information. In fact, what I hear from Guild members is that physical feedback forms are still the most popular way of providing feedback, but it's important to provide multiple other ways and other opportunities everywhere you can. So they're starting with that and making sure they've got those in place. They do each being at their own business, they do their own – you might call it market research, which is essentially talking to potential consumers and families about what their wants and needs are in their planning cycles. They don't bring that forward to me at the Guild in terms of their results because of potential anticompetitive issues which is – which is what it is, but they do do that and I expect that will be – that would be considerably enhanced if the consumer had even more ability to choose and more power to exercise choice.

COMMISSIONER BRIGGS: The issue of their power to exercise choice is a really important one. And the protection of these very vulnerable people from victimisation is another. Now, we've heard both today and, I think it was last week, that within the personal care worker sector and in the nursing sector, there has been

some victimisation of workers in the sector who have advised of quality and safety problems, and that victimisation extends from bullying through reductions in hours and so on. And they're things that are quite significant to people in this workforce who have more lowly paid jobs than many others. What work has the Guild done on whistleblowing activities and how to protect these workers or indeed elderly people who make complaints?

MR RICHTER: As I mentioned earlier, one of the strategic discussions I led with Guild members last year was about this exact issue. At the heart of quality and safety in these kind of systems – and if you look at reviews that have been undertaken from Mid Staffordshire in England through to Oakden here in South Australia, there's a constant, and that's culture. And poor culture will override everything every time. And having mechanisms where anyone can feel safe to report any kind of information is a critical component of any quality and safety system but it's just a first step. They then need to feel enabled and I don't think this industry is anywhere near a state of being enabled at the moment.

So in terms of what practical work we did, I provided examples of what we thought were really good whistleblowing services and confidential feedback lines that the Guild members could look at if they didn't have them in place. And I strongly – I didn't review the Guild members' current arrangements but I strongly recommended if they didn't have those things in place that they should because it's part of, in my view, best practice quality and safety. And if they did have them in place to ensure that they're activated and what I mean by that is, that people are aware of them, they know how to access them and they know how to use them.

COMMISSIONER BRIGGS: We've seen a flurry of policy reform initiatives from the government in the last six months and you might call that part of their ongoing system of reform. Indeed, I know the government does as part of their roadmap – their five year roadmap. Are we seeing a similar flurry of activity in the organisations that the Guild represents to reform their arrangement so that they do become much more customer-centred?

MR RICHTER: Yes, I think it's fair to say there is. This is an enormous year for all aged care operators and the Royal Commission is very, very important but my view has been – and this is not trying to put the Royal Commission in a negative light, but the single aged care quality framework that comes in this year is the most significant reform that aged care has seen in some time and I know there's a lot of work going on operationally to prepare for that.

COMMISSIONER BRIGGS: Okay. Thank you.

COMMISSIONER TRACEY: Thank you. Anything arising from that, Dr McEvoy?

DR McEVOY: There is just one matter, Commissioner.

Mr Richter, Commissioner Briggs asked you about reductions in the number of nurses, which is apparent, and whether the Guild had a position on that. And I think your answer to her was in essence that you didn't think there was enough information at the moment to address the reduction – the issue of the reduction in the number of nurses. In paragraph 6.3 of your second statement you have what looks to be a fairly clear indication that in the 2017/18 year you lost 1914 nurses which – I think I put these figures to you earlier.

MR RICHTER: Yes, you did.

DR McEVOY: Represented a turnover or a loss of about a third. I'm struggling to understand your answer to Commissioner Briggs and what information it is that you don't have that you need?

MR RICHTER: So please let me clarify then what I'm talking about is we've got this information from the Guild members. We don't have it - - -

DR McEVOY: Not including Bupa.

MR RICHTER: Not including Bupa, exactly. We don't have it for the rest of the industry but also we don't have this at a facility level or at an organisational level to see – or at a model of care level that's aggregated. I'm not disputing at all that there's – that trend that you've identified with nurses. I'm not disputing that at all. But I would like to see at a whole of system level what the structure looks like to see what – what the situation is. Because some organisations may have a different staffing situation than others, potentially.

DR McEVOY: Well, just going back to Commission Briggs' question then, what is the Guild doing about this trend, if anything?

MR RICHTER: The Guild itself is not doing anything about this trend.

DR McEVOY: Okay. And are you aware that individual members of the Guild are doing anything about this trend?

MR RICHTER: I'm aware that individual members of the Guild have programs focused on their workforce and different elements of their workforce.

DR McEVOY: No, now, Mr Richter, let's just go back to my question. Are you aware that individual members of the Guild are doing anything about this trend, which is to say, the reduction in the number of nurses? So work through, in your mind, each member and answer me that question.

MR RICHTER: I'm not, not in relation to this specific trend.

DR McEVOY: Right. And has the Guild asked individual members whether they're doing anything about that?

MR RICHTER: No, I haven't.

DR McEVOY: No. No further questions, Commissioners.

COMMISSIONER TRACEY: Thank you. Thank you for your evidence, Mr Richter. At various points you undertook to provide some supplementary information. The solicitors for the Commission will be in touch with you about providing that information when you're in a position to do that. But we've been greatly assisted by your evidence and thank you for coming.

MR RICHTER: Thank you.

<THE WITNESS WITHDREW [2.35 pm]

COMMISSIONER TRACEY: The Commission will adjourn briefly while arrangements are made for the next witness.

ADJOURNED [2.35 pm]

RESUMED [2.47 pm]

COMMISSIONER TRACEY: Yes, Dr McEvoy.

DR McEVOY: Commissioners, I call Dr Anthony Bartone.

<ANTHONY BARTONE, SWORN [2.48 pm]

<EXAMINATION-IN-CHIEF BY DR McEVOY

DR McEVOY: Operator, would you please bring up WIT.0015.0001.0001. And also on the same screen, WIT.0027.0001.0001. Now, Dr Bartone, you will see on the screen that there are two statements, both dated 18 February 2019. Do you see those statements?

DR BARTONE: I do.

DR McEVOY: Can I just distinguish between them and ask you whether I'm right in this respect. The statement on the left is your primary statement as it was

originally submitted to the Royal Commission on 31 January of this year, but with some slight amendments and redated 18 February; is that correct?

DR BARTONE: That is correct.

DR McEVOY: So I will refer to that statement this afternoon as your first statement or your primary statement just so we're clear about that. The statement on the right is, if you like, a supplementary statement dealing with Medicare-related issues. Would that be correct?

DR BARTONE: That is correct.

DR McEVOY: And you recognise both those statements as your statements?

DR BARTONE: They are.

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

DR BARTONE: No, I don't.

DR McEVOY: And the contents of both those statements are true and correct to the best of your knowledge and belief, I take it?

DR BARTONE: They are.

DR McEVOY: Commissioners, I would tender both those statements. They bear the same date, of course, so it may be convenient to refer to the first one, the one on the left as the primary statement of Dr Bartone and the one on the right by a separate exhibit number as the supplementary statement.

COMMISSIONER TRACEY: Yes. Although it might be even easier to follow the entitlements on the documents themselves, the first being amended, the second being additional.

DR McEVOY: Yes.

COMMISSIONER TRACEY: The amended statement of Dr Bartone dated 18 February 2019 which is an amended version of his primary statement will be exhibit 1-56.

EXHIBIT #1-56 AMENDED STATEMENT OF DR BARTONE DATED 18/02/2019 (WIT.0015.0001.0001)

COMMISSIONER TRACEY: And the additional statement of Dr Bartone bearing the same date, 18 February 2019, will be exhibit 1-57.

EXHIBIT #1-57 ADDITIONAL STATEMENT OF DR BARTONE DATED 18/02/2019 (WIT.0027.0001.0001)

DR McEVOY: Thank you, Commissioner.

Dr Bartone, could you give the Commission your full name, please.

DR BARTONE: Dr Anthony Bartone.

DR McEVOY: And you're in general practice.

DR BARTONE: Yes, I am.

DR McEVOY: And you are the national president of the AMA.

DR BARTONE: The federal president of the AMA, that's correct.

DR McEVOY: And you are also, I think, a fellow of the Australian College of General Practitioners.

DR BARTONE: I am.

DR McEVOY: Could you just give me some indication of the role played by the AMA.

DR BARTONE: Nationally, it would be the premier advocacy body representing doctors from all parts of the profession, ensuring that standards – that the health system works for the patient and for the betterment of outcomes for the whole community as well as funding options as well as also ensuring that there is a – some continuity of advocacy in that space across many different parts of the health system.

DR McEVOY: And the AMA has a representative function as well, does it not, in relation to medical practitioners and medical students?

DR BARTONE: It does.

DR McEVOY: It aims to promote and protect their interests; would you agree?

DR BARTONE: That's one of its core functions, yes.

DR McEVOY: Now, Dr Bartone, can I begin by dealing with one issue, which is highlighted in your amended statement which is to say your primary statement and which is also of keen interest to the Royal Commission, and that's the subject of access to nurses. And in your primary statement you deal with that at about paragraph 22. And one of the things that you observe there, Dr Bartone is that AMA members in response to a 2017 aged care survey said they believed that:

... having access to suitably trained and experienced nursing and other health professionals is critical to improving access and quality of medical care in residential aged care facilities.

Can you give the Commission a bit more information about why it is that visiting doctors need to have good access to nurses?

DR BARTONE: So if we step back for a moment, if we talk about the doctor/patient relationship and then the care around that patient, we often involve many members of the multidisciplinary care team. Now, obviously in this situation we're talking specifically about trained nurses and with trained nurses they are able to carry out our directions, our functions and we've got that communication, coordination and facilitation of that care to be then delivered. They then play a very vital role in – in carrying out that and ensuring it is carried out but then they also feed back, they complete the loop so to speak and then it becomes a continual process of feedback and improvement in terms of the outcome of the care that's exerted on the patient.

DR McEVOY: And what's the significance of handovers in connection with the relationship between doctors, nurses, apropos a patient?

DR BARTONE: Handover being, in any specific environment, whether it's an aged care facility, whether it's in a hospital, a ward round, whether it's in – even in a consultation room, when you're leaving for your shift to the next shift, handover provides a very important part of that exchange of information, critical and vital to the continuity of care of your patient.

DR McEVOY: And what does a good handover look like?

DR BARTONE: A good handover would consist of a number of elements. It would give some factual description about what has occurred, what are the current items in play, what are the current issues around the patient's conditions, what things might be changing, what tests might be expected to be received, and things to look out for in the – in the ongoing period of time that you're referring to.

DR McEVOY: And are your members reporting that a lack of nurses is compromising this process?

DR BARTONE: That is the feedback that we've got from this survey in particular, but in – in many anecdotal instances as well, that lack of opportunity to hand over, to receive the information and then to give back information after the visit is a critical part of the visit, a critical part of the care and that is of concern to our – to the members as being fed back there.

DR McEVOY: How often is that concern being fed back to the AMA?

DR BARTONE: We have many different committees, many different opportunities for our members to meet. That feedback can be through the process of normal flow of the committee work. It can be anecdotal in terms of other opportunities where members come together, but it's continual and consistent through many different venues in our association.

DR McEVOY: So if this problem is manifesting itself in the way that you say that it is, what implications is that having for the care of older Australians in residential facilities?

DR BARTONE: It has a number of implications. First, directly, it is subjecting the Australians in said facilities to a lesser standard of care. So it potentially could have unintended consequences in their own direct care. But it's also having a wider issue as well in terms of the – the drivers in terms of some of our members, members that have worked very hard, very long in this space, both in advocacy and directly with patients to then not continue to visit facilities because of that concern, that worry, that issue potentially around being involved in a lesser standard of care.

DR McEVOY: Can I just take you up on the lesser standard of care point. Can you just elaborate a bit on that?

DR BARTONE: If there is no one available to hand over, to have a good handover, that is – as we've already tried to address, it's potentially putting that patient at a – at a disadvantage. That does have a concern then that things might be missed, that tests might not be followed up on or not be carried out, that vital bits of information may not have been passed on in the first place. A good clinical handover, good clinical communication forms the foundation of, you know, the basis of good clinical care, and that – you can't have one without complete confidence of having the other.

COMMISSIONER TRACEY: In a practical sense, what happens when a doctor visits a patient in a residential nursing facility, decides that some form of medication is required. Does the – and there's no nurse. What happens to the script?

DR BARTONE: Depending on the facility – and it does get a bit complex so bear with me for a moment – sometimes the drug chart is part of a trial where in some facilities, where it becomes the source of truth and the pharmacist will pick that script up in the next – the next opportunity to get that. That's not typical of facilities. So on that occasion you would write the script and you would then either fax it off to the pharmacist so in an after-hours sense that potentially won't work if it's due to be started as soon as possible. Clearly, you need – in that situation you need that communication or handover to facilitate that script being acted upon in a – an appropriate length of time.

DR McEVOY: So are you suggesting, Dr Bartone, that it's not unusual for prescriptions to fall between the cracks, as it were?

DR BARTONE: There is the potential for that to happen and, of course, how often that happens, I can't give you a precise idea of, but the potential is there. Let's say that the potential for delay of that script being acted upon, and sent to the appropriate ultimate final place might be delayed rather than lost, or fall through the cracks.

DR McEVOY: So just stepping this through, if a doctor attends at a residential aged care facility and there is no nurse present, and the doctor sees the patient, would the doctor typically see the patient with a personal care attendant present?

DR BARTONE: Again, depending on the time and the – the occasion on the facility, there may not even be the personal care attendant present during that visit.

DR McEVOY: Well, what - - -

DR BARTONE: You would seek an attendant out to help you find the patient or find the resident, and unless they were in their room where you would expect them to be, yes, if you were familiar with that resident.

DR McEVOY: Well, what do you do if you see the patient, conduct a diagnosis, make a prescription, and there is not only not a nurse, but not a personal care attendant either available?

DR BARTONE: You would – there would be a personal care attendant available at some stage and you would just have to hunt them down, find them and say "This is - " you know, put this into your handover at the appropriate time and ensure that it gets communicated that I will be doing this, and then you would follow up. I'm fortunate that the facility that I attend has a chart that allows that communication to be – be communicated in its – in its primacy in terms of the script. In terms of the time of action, that obviously can't be acted upon if there is no registered nurse or no personal care attendant that's done – that has the ability to then distribute.

DR McEVOY: Well, a prescription is a relatively neat piece of medical advice. What about if the doctor wants to prescribe or put in place a care plan of some kind? How would the doctor in the circumstances we're discussing implement that?

DR BARTONE: So a care plan is a particular more detailed piece of clinical management. So you would make the appropriate entries into the record. You would have to discuss that with the – the charge nurse or the nurse involved in the care of the patient. To have a care plan without that kind of input would be to be – not having the best final outcome in terms of detail of that care plan available and would maybe subject to have to be amended at a subsequent later date.

DR McEVOY: Well, you were talking, I think, about two aspects of this problem. One is the lesser standard of care which you've just enlarged upon. Can I direct your attention to what I think you identified as the second part of the problem which is the attrition rate, if you like, of doctors by reason of the fact that they are effectively compelled to provide a lesser standard of care.

DR BARTONE: And specifically you would like me to expand upon that? So part of – if we look at the reasons why doctors visit patients – residents in aged care facilities, often it's because of a longstanding association with those residents, with those patients and that performs the basis of an ongoing desire to continue the clinical care. If you're having to then continually be – you're meeting barriers to exerting that care, to facilitating that care, that does really create anything from frustration to concern to worry. And ultimately for some of our members, that worry becomes an action item which leads to them to decide that no, I'm not going to continue – either I won't take on any new patients or I'm not going to continue to visit the facilities in a particular timeframe.

And that is a decision that's often – causes the doctor significant distress, significant concern and as a – not a decision they slightly, and often it's the final step or the final outcome of potentially – potentially a near miss or a near issue that may have created that concern for them, or they've just seen too many other instances around them where they just don't want to be – have that – that opportunity for that lesser standard of care to occur.

DR McEVOY: And would you regard this problem of doctors withdrawing from care as a widespread problem, would you?

DR BARTONE: It is – both – both our survey, both anecdotal feedback, both the reports of many of my colleagues, they will all be aware of people that are expressing that kind of desire, yes.

DR McEVOY: When you say your survey - - -

DR BARTONE: That's the AMA survey 2017 that's tendered as part of – that's referred to in the witness statement.

DR McEVOY: Yes. Can I move, Dr Bartone, to the related question of minimum acceptable staffing ratios, and whether they should be introduced. You may be aware that the Royal Commission has already heard evidence from a number of provider groups in relation to ratios. The AMAs position is that a minimum acceptable staffing ratio should be introduced in line with the care needs of residents and ensuring on-site 24 hour registered nurse availability. Can you just expand a bit on the AMAs position in relation to this question?

DR BARTONE: So when it comes to ratios, what we are – what we would like to see is a best practice, the best evidenced approach with all the stakeholders to come out with what are the – the minimum numbers of nurses and staff as well to – to a patient ratio that will facilitate and according to the best practice or the best evidence that's available. Now, what we know is that the level or the number will vary according to the complexity of the patients in the facility at the time, and that needs to be a flexible rather than a mandated hard number overall. But with the appropriate flexibility that recognises the complexity of the care, you can then have a reliable indication, based on evidence and research from many quarters, and with the

appropriate stakeholder input to have some confidence about the levels of staffing that's required.

DR McEVOY: One aspect of this issue is, of course, recruitment and retainment of staff, in particular of nurses but also of personal care attendants. What's the AMAs position on that?

DR BARTONE: So the workforce issues and the coordination of that workforce is an extremely difficult, but extremely poorly coordinated exercise, and that I think our table that was supplied as part of the witness statement, the primary one, indicates the – that the proportionality of trained nurses has reduced as a proportion of the staff in total involved in absolute numbers. But also, it does point to the fact that – and we're aware from other sources that both training and both conditions have put – are part of that impact on the availability of the trained workforce, and we also know from various inquiries that – that given the increasing demand of aged care and both residents and aged care – home aged care places, that demand is going to require an even more significant impost – importance on terms of training the right number, and it may be a very difficult number to achieve, especially in the short term.

DR McEVOY: Does the AMA have a position on the extent of training that would be appropriate for personal care attendants?

DR BARTONE: What we would say is that they need to be trained to the appropriate standards that are – one would expect. Now, those standards are not for us to say, but it's as required by their industry bodies.

DR McEVOY: One of the – you've touched already on some of the challenges that doctors face in attending on people who are in residential aged care facilities. One of the particular matters you raise in your statement is the fact that continuity of care is often not recognised in the context of GP visits to people in residential care facilities. What do you mean when you talk about continuity of care in that context?

DR BARTONE: So continuity of care relates to the doctor having a clinical history and connection with that patient. So if a patient has been part of my practice for many, many years, I know a lot of the – not only just the clinical ongoing history that's relevant, but a lot of – I know a lot of nuances about the patient. I know a lot of what concerns him or her and the values that go into the care that they would like to have. So that forms part of the understanding of the clinical relationship with – between doctor and patient. When you see a patient for the first time, yes, you might have a summary of their clinical past history but that does never ever come close to knowing the patient. So what we're talking about when we're looking at the continuity of care in aged care facilities is often the patients have been part of your practice in a particular suburb.

Now, not only have they been relocated, which for residents is a particularly stressful episode being to leave their home, they're also having to have a different relationship with a new provider that they've not had a relationship with, and when you combine

the anxiety, the stress, the worry, the fear of relocation from the home into a facility, that – to then further complicate that by then having a new doctor as part of that relationship is, again – doesn't reassure. And that process could be ameliorated by having the continuity of care by having the doctor who knows that patient coming in and continuing in that care which will then reassure the patient, the residents of that facility that they're still having the same medical care allowed and that goes a long way to allaying fears or concern.

DR McEVOY: And in terms of continuity of care and the pressure on continuity of care, are you able to say from your own experience what sort of distances and time are involved in attending on patients for whom you've had care responsibilities perhaps for some years, if they move out of the home and into a residential facility?

DR BARTONE: So I can talk from many years of experience and at different times. There have been many occasions when patients have left – had to be located into a facility and I haven't been able to continue the care with that facility because they're on – it's significantly located far away from the practice. Fortunately, at the practice I currently am at that facility and the practice have a longstanding relationship and there is that association and that allows that, but not all my patients from that practice, when they're having to access aged care, will go to one of the four or five facilities that we service.

DR McEVOY: Well, take the patient that doesn't go to one of those four or five facilities that you service, what does continuity of care look like for that patient? How are that – how is that older Australian's needs dealt with in whatever residential aged care facility that they end up in?

DR BARTONE: So when they enter that facility, they're usually given, this facility has a number of visiting GPS. They're given a list, and they may ask for a recommendation, do I know any of them, but they're given a summary, a fairly comprehensive summary which then is at the handover to the doctor. You will make yourself available to the doctor, take any questions and you can – you know, any points of the history that they want to have clarified but essentially that's the continuity of care is limited to records that you transfer, that you printout, that you give the patient to take with them, as well as any direct communication with the doctor, should that be required.

DR McEVOY: So in those circumstances, the person in the residential aged care facility ideally has access to some new doctor, but what happens if, for example, there are problems at a time when a doctor is not available?

DR BARTONE: So if a doctor is not available at a facility, there is an after-hours locum deputising service that's available to fill in, depending on the wishes and the instructions of that covering – of that caring or the treating GP. So there are processes in place for what – how the aged care facility will get in touch with the doctor. If they can't get in touch then they will have a – a drop-down next step of what to do.

DR McEVOY: And what would that next step what to do involve?

DR BARTONE: Usually it would be the deputising service in that respect. Sometimes there might be on the doctor that they can – that has agreed to take the calls if that doctor is not available. So sometimes there is a – an informal or an arrangement between two doctors, you know, if that doctor is away or not well that day, he will cover that doctor on that day, for example.

DR McEVOY: So you're saying that there's always going to be the ability of a residential aged care facility to obtain a doctor for somebody who lives there who needs one?

DR BARTONE: As a planned event, yes. As I say, an urgent event, it's dependent upon the load and the availability of the deputising service on that night, and sometimes that could stretch into an excessive time and that would then come to a clinical concern issue as to how urgent the care needed to be - - -

DR McEVOY: Well, who would make that decision, typically?

DR BARTONE: Well, this is – this goes to the issue about – the importance of having a trained nurse that has a clear instructions, handover from the doctor, and the concerns of the – conditions that they're treating. The more – the more there is no clear line of sight of that, the more likely that the things will be missed, delayed, deferred, or inappropriately acted upon and an ambulance is called, for example, sending the patient to the emergency facility.

DR McEVOY: Well, there's a deal of evidence the Royal Commission has already heard about the falling numbers of nurses. Are you suggesting in your answer to my last question that in the absence of appropriate nursing supervision, and the need for a personal care attendant to call an ambulance, that ultimately absent a doctor or a nurse, that is typically what you would see happen, that the person would be transferred to the emergency department of a – of an available hospital?

DR BARTONE: That is – that is a significant possible outcome of that situation that you're describing, yes.

DR McEVOY: And do you regard that clinically as an acceptable procedure?

DR BARTONE: Absolutely not. That's clear that – that there is a high level of – there is an inappropriately high level of transfer from community aged care facilities to emergency department of conditions that could be managed by – in the community by a good GP being available, and especially with good clinical handover and the reliance and the confidence of a trained nurse being available as well.

DR McEVOY: Well, can I shift attention, Dr Bartone, to what might be regarded as some of the systemic or the structural issues that are operating in this area and ask you to focus your attention on the way the Medicare system is impacting on the

preparedness of general practitioners to attend at residential aged care facilities. Now, of course, this is the subject, substantially, of your additional statement, the second statement of 18 February. Can we deal first of all with the subject of GP fees in the Medicare system. This, of course, is well known to you, but it's desirable to have the Commission walked through how that works. So can you explain what an item number means in the context of the Medicare Benefits Schedule.

DR BARTONE: An item number is – describes a specific episode of care. It has a number of components that are usually – that are well set out in the description – the item number descriptor and there's – and in some have a minimum time period as well allocated to that descriptor in some of the other item numbers as well. So there's a – there's clarity about both the content of the service being performed, the care, and the time.

DR McEVOY: So in the ordinary course, if someone – not necessarily an older Australian – but anyone comes to see a general practitioner in their surgery, the consultation will occur and the appropriate item number will typically be selected by the doctor and that will be charged to Medicare, if it's being bulk billed or if there's some shared payment facility there will be a payment made by the patient and Medicare will pay the balance; is that how that works?

DR BARTONE: Correct. So the item number determines the patient rebate and if the consultation is bulk billed the doctor accepts that patient rebate as full recompense for the service. If the patient has – is charged a private fee, the patient will receive the Medicare rebate as part of their reimbursement from the Commonwealth in regards to that service fee.

DR McEVOY: So whether or not an older Australian is coming to see a GP in his or her consulting rooms, or whether the GP is visiting the older Australian in a residential care facility, what are the most common MBS item numbers that you might have cause to utilise?

DR BARTONE: By far the most common item number would be what we call a level B or a – you know, that really reflects the most standard or most typical consultation. The other item numbers particularly that might have of relevance would be a level C which is a longer more complex consultation. And occasionally you might also, in – especially in clinic there might be the level A which is a brief consultation essentially for descriptor purposes, and very, very rarely, especially in the surgery but more so in a facility, it would be a level D, which is much longer.

DR McEVOY: Just perhaps focusing on level B and level C, how much does Medicare pay approximately for those?

DR BARTONE: So the Medicare rebate, patient rebate for a level B in the clinic is 37.60. In an aged care facility there is a complicated arrangement where it depends on the number of patients that are seen in the facility at the one time by that one practitioner as to determine what that rebate is.

DR McEVOY: Let's just unpack that a bit. If you're a GP and you travel to a residential aged care facility to see a patient, one patient, and you just see that one patient and it's a level B consultation, what does Medicare pay in those circumstances?

DR BARTONE: The rebate for one patient visit is for a level B, the most typical consultation is $85.

DR McEVOY: And - - -

DR BARTONE: And that may be subject, depending on the patient, to a bulk billing incentive but that's a separate item number, a separate level of – of eligibility as to whether that can be also accessed.

DR McEVOY: And so if a general practitioner attends at a residential aged care facility and sees a number of residents – of older Australians who are there, how does Medicare recognise that? What does that do to the amount that is able to be charged?

DR BARTONE: So essentially the next few patients from two to six essentially raise a standard – the level B Medicare rebate as an additional moiety on what that can be taken. However, it gets complicated because the additional amount gets to be divided between two patients or between three patients, but for practical purposes, after that first patient, the $85 Medicare rebate, the second patient, the additional rebate that can be accessed is 37.60 but those two rebates are put together and divided by two. The third patient, additional rebate is 37.60 but those three rebates are put together and divided by three and so on up to six. When you get to the seventh patient, all patients who are seen in the facility at that time have an item number – have a rebate of $40.95.

DR McEVOY: So would this system that you've described adequately compensate a general practitioner for attending patients at a residential aged care facility?

DR BARTONE: In – in my view, absolutely not. This is – the Medicare rebate, especially for one patient, is exceedingly – exceedingly insufficient. We know that – that's not just my view. We know from our survey that – that the survey respondents had a significant view of accordingly and that they – and the vast bulk of those respondents said that anywhere between a 50 to 100 per cent increase in that Medicare rebate was appropriate to compensate for the care – for the care that they were performing. That's not to say that doctors are going to en masse cease to deliver, but clearly we have – we have an ongoing desire – an ongoing want to continue the care of our patients, and – but in that – in that environment it's important to know that the recompense bears no resemblance to the cost of providing that care.

DR McEVOY: Well, I think you've said – I think the words you used were that it absolutely does not provide adequate compensation. What do you – what factors cause you to form the conclusion that the compensation is inadequate?

DR BARTONE: So if I – if I can direct you to the table as part of the second statement on page 4. Number 31. You can see some of the components that go into the time taken to visit the facility to carry out the appropriate care to make the appropriate entries to then – and appropriate notations regarding the script and to then have the appropriate clinical handover. And when you look - - -

DR McEVOY: Can I ask you to walk through those matters that you set out there in that table at paragraph 31 on page 4?

DR BARTONE: So, in essence, we have the travel time from the clinic to the facility. These numbers are averages for myself but these are not – not untypical averages for other doctors who are regularly performing care. So 20 minutes travel time, five minutes car park, depending the time of the day, then access the facility – to access the facility, access the – find the – a nurse to have the appropriate handover, to then find the patient who could be – if they're not in their room, they could be in any part of the facility. And then to have the patient come back to the room, have the patient go through the – the consultation. Then the handover of care, the entering of notes into the facility records, which often are not user friendly. They certainly don't have a resemblance to anything we use in general practice and it becomes a much more – a much more difficult or laborious task of entering notes and then amending the drug chart as required.

Then going back to your facility – to your clinic and then making the appropriate entries in terms of – especially in the facility that I'm describing for any SA or any drugs that require a State approved hard copy to be sent to the pharmacy. Or for just updating your medical list of drugs – of medications that the patient is on.

DR McEVOY: Are you able to say what it might work out as – as an hourly rate for a general practitioner attending on a – an older Australian in a residential aged care facility?

DR BARTONE: Well, clearly, that depends on the number of patients that you would see. In the example that's tendered there in the first table on 31, it's going to be $85 to 89 minutes and that gives you an idea of roughly the hourly rate which is $60 – just over a tick over $60 – and just a tick under $60 an hour.

DR McEVOY: And that doesn't allow for any of the other costs involved in travelling there in the car, parking, doing things of that kind.

DR BARTONE: So in terms of accessing the facility, performing your care, no, it doesn't take into account any of those costs. Of course, out of that hourly rate comes a lot of other practice expenses and ongoing expenses that the clinic requires to be taken out of that headline rate before that becomes a true hourly rate for the doctor.

DR McEVOY: Commissioners, at various times in Dr Bartone's evidence he has referred to "the survey". That survey, Dr Bartone, is the 2017AMA Aged Care Survey Report; is it not?

DR BARTONE: That's correct.

DR McEVOY: Commissioners, I would seek to tender that statement. It bears the number RCD.9999.0019.0003.

COMMISSIONER TRACEY: What is the full title of the document?

DR McEVOY: The AMA Aged Care Survey Report 2017.

COMMISSIONER TRACEY: Sorry, I missed the date.

DR McEVOY: 2017, Commissioner.

COMMISSIONER TRACEY: 2017. The AMA Aged Care Survey Report of 2017 will be exhibit 1-58.

EXHIBIT #1-58 AMA AGED CARE SURVEY REPORT 2017 (RCD.9999.0019.0003)

DR McEVOY: Thank you, Commissioner.

Can I move, Dr Bartone, to one of the other issues that might be confronted by general practitioners attending patients in residential aged care facilities, and that's the level of access to the patient's aged care records. Now, you've made one or two references to that. I wonder if you might just elaborate for the Commission what the particular difficulties are there.

DR BARTONE: Interoperability is an important part of the sharing of clinical records. The facility clinical records – the facility practice software is not compatible with our system, so we need to either – you can only access the information there in front of the computer there at the facility. Some doctors do have an ability, because of the load or the – the amount of patients they do see, they do have a remote access but that's far and few between so we will just park that to one side. So this patient management software that the aged care facility is using is counter-intuitive to everything that we do on our desktop in our surgeries, in our clinics.

So we do initially have to find our way around the various modules or the various frameworks and then enter – enter notes, log out of that part of the – you know, close that part of the – the software, go to another part of the software to enter the medication, and do have to sort of connect different pages at different points in the

electronic software that – that is part of the facility. That obviously doesn't – then we have the issue about logging on, having your own dedicated login, that's another layer of complexity and making sure that your notes are being attributed to you and not to any other member of staff.

DR McEVOY: In your additional statement, your supplementary statement, you deal at page 6 with the subject of technology-based patient consultations. What do you mean by a technology-based consultation?

DR BARTONE: So essentially the ideal consultation is where we can have a face-to-face opportunity to have the care and the history, the examination and the management of the patient. Sometimes that's not – not available and not as accessible and so a technology-based consultation gives us the opportunity for either a phone consult or even better still, a video consult which may or may not be available also, but they are the – when we refer to telehealth items or telehealth consultations that's essentially what we're referring to. In the right circumstances, where the doctor has a good – a good understanding or good – a good view of the patient's past history or a connection with that patient, that offers an additional opportunity for care which is patient-centred and patient-focused and appropriate to the needs of that patient.

However, when that episode of care occurs there is no Medicare rebate for that unless there is a three-way consultation and that is, you know, in terms of having a geriatrician present as well for that technology-based consultation.

DR McEVOY: And so when would you say that consultations – technology-based consultations are appropriate?

DR BARTONE: Often it's simple matters such as having to amend a medication chart because as a result of an investigation that has come since you've last seen the patient. As simple as that. Or there has been a change that needs to be communicated to staff, or there is a situation where the patient or patient relative – now, this is where we get – we need to be very clear about this – often consultations in this space are more than just a patient. It is a family that we're dealing with. We're dealing with the children or other important relative members of that patient. In particular, the substitute decision-maker often as well. And that becomes an even wider pool of people that are subject to that potential telehealth consultation.

DR McEVOY: Is it common for, in your experience, for general practitioners to receive calls from staff at residential aged care facilities wanting to have a consultation of this kind?

DR BARTONE: It is very common and it's one of the reasons why some – some of our members have found frustration in terms of continuing the ongoing arrangements in that space. It's – sometimes it's very frustrating because you've only left the facility a few hours earlier, or – and it was an oversight because of stress, because of pressures, because of patient load that the staff were having to look after that things

were overlooked and weren't carried out. So that's part – goes back to the issue of full and proper clinical handover. So sometimes that's the end result of that. Other times there has been a development or a new – a situation which requires a communication or discussion and that's – this is what clinical care is all about. It's not static. It's not, you know, press and forget. It's ongoing, it's dynamic and we're talking about people with complex conditions, complex situations which change regularly.

DR McEVOY: So if a general practitioner receives one of these calls from someone, a personal care attendant, a nurse, whoever, at a residential aged care facility, what's the Medicare situation in relation to a call of that kind?

DR BARTONE: The situation in that there, where there's a direct call to the doctor from the facility is not – is not subject to a Medicare rebate to the patient.

DR McEVOY: So the doctor is not able to make any charge at all?

DR BARTONE: Not through the Medicare system. If it – if the doctor was to, it would have to be a privately negotiated fee which we know is exceedingly rare.

DR McEVOY: What do you mean by "exceedingly rare"?

DR BARTONE: We know from statistics from the department that the vast, vast majority of all consultations in aged care facilities are being bulk billed.

DR McEVOY: Can I deal with another aspect of continuity of care which is the subject of treatment in your first statement, Dr Bartone. And this is the issue of access to allied health professionals. What are some of the issues confronting general practitioners here in their care of patients?

DR BARTONE: There are many reasons why we would – I will step back a moment. A multidisciplinary care team is fundamental in the care – the care of patients with chronic complex conditions. Whether they be of any type of allied health professional or mental health professional in that space, they all have a role to play in – in ensuring a comprehensive envelope of care for the patient. There are – in an aged care facility, they may be of variable access to appropriate allied health professionals. Sometimes a facility might have a visiting physiotherapist or a podiatrist that comes to the facility. But in general, the access has to be usually organised independently of the facility. When we're talking about psychologists, you know, this again is not covered under a Medicare arrangement, and doesn't through what is available in the community for a better access program, and so, again, older Australians in aged care facilities are at a disadvantage to the care that they can access compared to older Australian members in the community.

DR McEVOY: Another problem that you've identified as frequently confronting general practitioners in residential aged care facilities is the absence of private and appropriately equipped clinical treatment rooms. How often is that a problem?

DR BARTONE: It depends on the facility and depends on usually how new the facility is. Many of the new facilities are being built with those – with that construct being part of its design and that's – that's a great innovation, but that's not always the case. Not having a dedicated consultation room means that sometimes you're having to perform a consultation in the patient's own room. Sometimes that room is a shared room but more often than not it's a single room. And it's not – it doesn't usually have all your tools of trade, you might say, immediately handy. You will have a trolley often and if fortunate enough to have a nurse, you will have your nurse with your trolley in the room while you're examining the patient. But ideally you would love to have a patient in a consultation – a dedicated consultation room.

DR McEVOY: Can I move, Dr Bartone, to a new subject, namely, the use of physical and chemical restraints in residential aged care facilities, which as you will be aware is a subject of pressing concern to the Royal Commission. The AMA has a position statement on this, doesn't it, called Restraint in the Care of People in Residential Aged Care Facilities.

DR BARTONE: It does.

DR McEVOY: And can you tell the Commission what that position that the AMA has in relation to the use of restraints is?

DR BARTONE: Essentially, restraints should be the last form – the last episode of – of trying to deal with a patient's condition that need – that may be the subject of being restrained. It's important to realise that when we need – there are a couple of things going on at the same time. There's understanding why the clinical situation is occurring. There are many reasons why a patient may be experiencing episodes of everything from wandering to aggressive yelling to inappropriate activity, spitting or, you know, throwing food at another resident, all of these, and even worse still. But to understand why this is happening is crucial and fundamental to the question. So immediately you need to start to rule out is there an infection, is there an electrolyte imbalance, is there something going on which is causing my patient to become aggressive, confused, wandering, whatever.

Simultaneously you need to go through a process of assessing what are the patient's wishes. Obviously, not in that – not at that moment but from your previous dealings with the patient. Again, we come back to the continuity of care. If you know what are the important values, the important issues behind your patient and what they would like to see happen should situations occur, that informs you – the dignity and the patient-centredness of our approach. So you've got that to deal with. You've got then the safety of the patient and you don't want the patient to be harming themselves because of a fall, because of a trip, because of any other number of reasons. And you certainly don't – you need to assess the issue of ongoing risk to other residents, and, of course, the safety of staff.

So that is all happening at the one time and you're trying to go through a process of working out what's going on, using the minimum possible amount of any restraint, if

any, physical or any other type, that is appropriate to the situation, but you would always start with ensuring a conversation and before using any restraint, have a conversation with the substitute decision-maker who hopefully is attune to the values and the wishes of that patient.

DR McEVOY: Well, you said earlier in your answer to my question that the AMA regards the use of physical or chemical restraints as a last form. You mean by that a last resort.

DR BARTONE: Resort.

DR McEVOY: And you've outlined why that is so. But can you say something about the circumstances that unfold from time to time that have the consequence that perhaps the use of physical or chemical restraints is not a last resort?

DR BARTONE: I'm sorry, I'm not following exactly where you're trying to - - -

DR McEVOY: Well, you've identified that - - -

DR BARTONE: My apologies.

DR McEVOY: No, not at all. You've identified that the AMAs position is that this should be a last resort.

DR BARTONE: Correct.

DR McEVOY: Are you aware of circumstances in residential aged care facilities where physical or chemical restraints are being used in circumstances where it's not a last resort?

DR BARTONE: Obviously, I'm aware of media reports and a lot of other video evidence that has been available in the – in the public space. I have on previous occasions been approached by, usually an agency member that's not familiar with – with protocols with patients, with the facility's protocol in that space, and had to make a specific determination to, no, this is what we're going to do. But in terms of directly sighting or observing chemical restraint that was inappropriate, no, I'm – I can't give you an example of that.

DR McEVOY: Can I turn, Dr Bartone, to the issue of system governance and accountability in aged care, and one of the things you say in your primary statement is that there's a need for better integration here between, you know, residential aged care being federally funded on the one hand and how it fits in with hospital services to the extent that they're funded on a different basis. Can you just expand for the Royal Commission on how these issues of fragmentation that you're concerned about arise?

DR BARTONE: With two funders in the system, essentially State and federal, looking at different parts of the health system, there is opportunity for care – fragmentation of that care to occur. If we look at the transfer issue when it comes to emergency department, obviously if a patient is going to the ED facility, the ultimate person, or the ultimate funder is the State in terms of the – the impost on the service, on the system of which the government is a partial funder indirectly. When we're looking at the facility, obviously, that is subject to Commonwealth funding. So that's at one level an example of the disconnect between parts of the service, parts of the system because of funding.

If we look at other issues, it's about the coordination of training and workforce availability and standards in that respect. If we look at the funding behind aged care Medicare rebates, that again is another opportunity where, again, the system is not coordinated and aligned in a governing sense. Accreditation and quality issues again come in at a federal perspective. So there are – there is – all those parts of the puzzle, if they were better coordinated, better – and overall clearer governance and clearer and improved funding for all parts of that, we would have, I'm sure, better outcomes.

DR McEVOY: And what role does the available home care packages have in that system, would you say?

DR BARTONE: Home care packages are a very important part of the system. We know patients and older Australians prefer to remain at home. The age – those home care packages are a vital part of keeping patients at home. I know from a personal perspective, that my own mother was – was able to remain at home for nearly 10 years because of a high level home care package and has only recently gone into an aged care facility. They're an important and vital part of the cog but we have too many Australians waiting for those places and not only that, but there is a question about the ability to actually have the providers to fulfil all those places should they become online tomorrow. So we have a systems – potentially a systems mismatch and a systems funding issue as – which may lead to a systems failure if not corrected in – in the immediate future.

DR McEVOY: Commissioners, I referred earlier in the discussion with Dr Bartone about restraints to the AMA restraints policy. That is called Restraint in the Care of People in Residential Aged Care Facilities. I would seek to tender that document. It bears the number RCD.9999.0019.0001.

COMMISSIONER TRACEY: The AMA position statement entitled Restraint in the Care of People in Residential Aged Care Facilities dated 2001 as revised in 2015 will be exhibit 1-59.

EXHIBIT #1-59 AMA POSITION STATEMENT ENTITLED RESTRAINT IN THE CARE OF PEOPLE IN RESIDENTIAL AGED CARE FACILITIES DATED 2001 AS REVISED IN 2015 (RCD.9999.0019.0001)

DR McEVOY: Thank you, Commissioner.

Dr Bartone, just one last question, going back to the subject of restraints. Are you able to give the Commission an example of any last resort type situation where you have prescribed a restraint?

DR BARTONE: Not – not in – not one that comes immediately to mind in recent times, no. That's – as I say, it's a very complex decision but obviously after consultation – there was one occasion after consultation with a geriatrician regarding the patient, that we did prescribe an appropriate medication but that was a number of years ago. I can't even remember exactly how many, but it – it really does – if we start again where I – you know, where I tried to take you from, usually in that process you will find a number of answers, a number of situations where you don't need to go there. And clearly the patients – even just being aware of nonphysical ways of trying to ensure that you're looking at the behaviour.

Understanding that because of the patient's background, being treated in a certain way or offered a certain food may trigger certain cues which may trigger an inappropriate response, especially when they're stressed, fearful, worried, confused, and especially at certain parts of the day and especially when new staff members, who aren't clear – sorry, who aren't familiar with that patient – and this is where we come down to the level of continuing staff and the number of agency staff who often don't have an immediate awareness of that patient. But where there has been occasions where there's patients significantly becoming increasingly disruptive and – and aggressive and putting residents at risk, yes, you have to have to be able to have something to do for that patient to ensure they don't injure themselves or others.

But you would do that, as I say, following the protocol and following the opportunities to ensure there's no other reason and that you've tried everything – all the other potential ways of calming that patient down, of trying to ensure that the patient is treated with the dignity and respect that they would like and, again, when you've got that continuity of care, you know what matters to that patient, you know, you know, from previous episodes of discussions, you know – and I have to reflect on my mum's observations, and I'm sorry to bring it back to a personal level. But my mum in the last few weeks when observing certain residents, she says "I hope God takes me before I ever become like that." So that immediately tells me that certain situations she would like to be, you know, appropriately managed through appropriate medication rather than be physically restrained or rather than be treated with the lack of dignity or respect potentially.

DR McEVOY: Well, just perhaps two things arising out of that answer. The first is that you mentioned at the outset of your answer to my question that you would have consulted a geriatrician in relation to the decision to employ a restraint. Would you regard that as a typical thing to do in those circumstances?

DR BARTONE: When it – when it gets – when you've ruled off everything else, when you've tried all the other methods, you do need to engage either a – another

non-GP specialist, typically a geriatrician, or look to follow up in one of the other opportunities to try and assist you with that care, yes.

DR McEVOY: The second thing, and this was at the end of your answer in reference to your mother's comments to you, and you talked about the management of older Australians when they're coming to that sort of a situation. What views does the AMA have about palliative care in the residential aged care facility context?

DR BARTONE: The opportunity to access palliative care should be no less available in a aged care facility as it should be to any other older Australian. It's an important part of care. We know that Australians have – on many, many different surveys have expressed the desire that the vast majority would like to die at home, if that was the situation. They don't want to die in a hospital and so, you know, if the aged care facility is now their home, they would like the opportunity to have the appropriate palliative care available there.

DR McEVOY: You say they should have no less availability of that in a residential aged care facility to that which they might have anywhere else. Is it your experience that they do, in fact, have less access to palliative care in residential aged care facilities?

DR BARTONE: It's not my direct experience but obviously where there is lack of an appropriate trained nurse, especially in the overnight shifts, that obviously cannot happen in that situation.

DR McEVOY: Commissioners, I don't have any further questions of Dr Bartone.

COMMISSIONER TRACEY: Thank you. Doctor, we've heard some evidence that suggests that optimal care of an aged care patient in a residential facility will involve a team effort involving doctors and physicians sometimes, geriatricians amongst them, and various other professionals, podiatrists, physiotherapists and so on. I just want to focus for the moment on the role of a geriatrician. The impression we've got from other evidence is that it would be a rare day you would ever see a geriatrician in a nursing home. Is that a correct impression?

DR BARTONE: Yes, that's absolutely – we do have some examples of geriatricians who do regularly visit on a – obviously not as frequent a basis as their treating GP but there are some facilities that do have a relationship and the ability to have that. What I – and I think I can – if I can reflect on one of my answers, that was a conversation per phone with a geriatrician that I was referring to. Sorry.

COMMISSIONER TRACEY: So they're hospital-based and they would only have direct patient contact if a patient were removed from a nursing home and put into a hospital setting.

DR BARTONE: No, there are private geriatricians as well, so private visiting specialists that could have that opportunity to consult and review your patient if you so required.

COMMISSIONER TRACEY: We've also seen a good deal of statistical evidence suggesting that we're facing a considerable increase in the number of the aged in the community. Are you able to say whether, within the medical profession, there are additional training places being provided for geriatricians to deal with this larger group of aged citizens who are shortly going to join those already in that category?

DR BARTONE: I can't say with certainty but what I – and the department would be the best place to go for the actual numbers. Can I say that all special – all specialty parts of the profession are undergoing analysis and work modelling regarding future demands. Some of those modelling – modelling per craft group are becoming available now. Some are still in the process of being modelled. It's clear that age, complexity and longevity are all increasing. We see that in our patients who come to the clinic. We know that the average consultation time from as far – as recently as 2014 BEACH data, we know that the average consultation time is increasing and the number of conditions that need to be covered in a consultation is increasing also. The complexity is proportional to the incidents of chronic disease and the complications thereof.

In terms of your question specifically on geriatricians, I can't – I don't have that data with me. Physicians, there has been an increase in the graduating workforce, especially since 2004/05. There has been a significant initiative of the Commonwealth department to increase the number of graduating workforce medical practitioners. But what we do know – what we do know is that last year was the first time in a long while that the training program for general practice was undersubscribed in its first round.

COMMISSIONER TRACEY: Nothing arising?

DR McEVOY: No further questions, Commissioner.

COMMISSIONER TRACEY: Doctor, thank you so much for giving up your afternoon to come and assist us in better understanding the state of the aged care treatment facilities in this country. We're enormously grateful to you and, frankly, I don't know how you could reasonably continue to describe yourself as a practicing general practitioner.

DR BARTONE: As treating general practitioners go I'm probably the least typical because of my role at the moment, but I will be going back to that role at the end of my term, a role that I look forward to continuing for many more years to come in that space.

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

<THE WITNESS WITHDREW [4.07 pm]

MATTER ADJOURNED at 4.07 pm UNTIL
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