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TRANSCRIPT OF PROCEEDINGS

O/N H-1149372

THE HONOURABLE T. PAGONE QC, Commissioner
MS L.J. BRIGGS AO, Commissioner

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

ADELAIDE

9.00 AM, FRIDAY, 21 FEBRUARY 2020

Continued from 11.2.20

DAY 76

MR P. ROZEN QC, Counsel Assisting, appears with MR P. BOLSTER, MS Z. MAUD, MS E. HILL and MS E. BERGIN

COMMISSIONER PAGONE: Mr Rozen.

MR ROZEN: Good morning Commissioners. I appear today with Ms Maud, Ms Hill and Ms Bergin to assist the Royal Commission. Commissioners, you will recall that in October of 2019 the Royal Commission held a public hearing in Melbourne, Melbourne 3 hearing. That hearing was concerned with issues that arise in relation to the aged care workforce. A great deal of evidence was adduced during the course of that hearing and some very brief closing submissions were made at the conclusion. The purpose of today's hearing is for Counsel Assisting to make more detailed submissions about the recommendations that we propose the Royal Commission ought make in relation to the aged care workforce. I will shortly make those detailed submissions.

Before I do that, though, Commissioners, there are two witnesses that we would seek to call this morning. They're both from overseas. Their evidence in each case relates to aged care workforce issues. One of the witnesses, Professor Charlene Harrington will give evidence from the United States and the second witness we will call, Professor Ravenswood, will give evidence from New Zealand. Commissioners, it will be necessary, with your leave, to have a brief break between the two witnesses so that proper arrangements can be made for the video facilities and it will be necessary to have a further brief break at the conclusion of the second witness, Professor Ravenswood, prior to me commencing the submissions that I would seek to make. Commissioners, I call Professor Harrington.

COMMISSIONER PAGONE: Yes.

<CHARLENE HARRINGTON, AFFIRMED [9.02 am]

<EXAMINATION BY MR ROZEN

COMMISSIONER PAGONE: Yes, Mr Rozen.

MR ROZEN: Thank you, Commissioner.

MR ROZEN: Professor Harrington, for the purposes of the transcript could I please ask you to state your full name

PROF HARRINGTON: Charlene Harrington.

MR ROZEN: Charlene is spelt C-h-a-r-l-e-n-e.

PROF HARRINGTON: Yes.

MR ROZEN: And you are a Professor of Sociology and Nursing at the University of California in San Francisco.

PROF HARRINGTON: Yes.

MR ROZEN: And judging by the decor you are joining us from your home today.

PROF HARRINGTON: Yes.

MR ROZEN: We are very grateful that you have made the time available to join us. Professor, what I propose to do is address a few formalities that are necessary for us and then I will ask you some questions about your history of research in relation to what are called nursing homes in the United States and particularly about staffing levels in those homes. You've been kind enough to provide us with your curriculum vitae; is that right?

PROF HARRINGTON: Yes.

MR ROZEN: And, for the record, it's RCD.0011.0042.0012. It comes in at a very impressive 74 pages, Professor.

PROF HARRINGTON: Yes.

MR ROZEN: And single spaced as well, it should be noted. And in the document you set out your very extensive list of publications, chapters of books and the like; is that right?

PROF HARRINGTON: Yes.

MR ROZEN: You have also provided us with a witness statement which, for the record is RCD.0011.0042.0001, and in that statement – I wonder do you have a copy of that in front of you, Professor?

PROF HARRINGTON: Yes, I do.

MR ROZEN: I just ask you to have a look at that, briefly, if you could, please, and if I could draw your attention to paragraph 3 on the first page.

PROF HARRINGTON: Yes.

MR ROZEN: You say there in the second sentence that you are currently employed as a professor at the University of California San Francisco, and you've been in that role since 1980, is that right?

PROF HARRINGTON: Yes, it is.

MR ROZEN: And you are a registered nurse, that's your initial qualification?

PROF HARRINGTON: Yes.

MR ROZEN: And did you ever work as a registered nurse or have you spent your life in a university?

PROF HARRINGTON: Yes, I worked in clinical nursing in a hospital and school settings and public health.

MR ROZEN: And did you ever spend any time working in your capacity as a nurse in a nursing home?

PROF HARRINGTON: No.

MR ROZEN: Now, you set out in the remainder of paragraph 3 various research initiatives that you've been involved in. I won't go through those in detail, but I note from that paragraph that you are a member of the Centres for Medicare and Medicaid Technical Advisory Committee for the Medicare Nursing Home Compare website. Can you - - -

PROF HARRINGTON: Yes.

MR ROZEN: - - - just tell us briefly what the Medicare Nursing Home Compare website is and what you do as a member of that technical advisory committee.

PROF HARRINGTON: It's a website that was set up by the Centres for Medicare and Medicaid Services in 2008, and it provides public information about nursing homes and the quality of nursing home care. So it has a five star rating system.

MR ROZEN: Yes.

PROF HARRINGTON: And so it's the major information for the country on nursing home quality.

MR ROZEN: Can you briefly explain - - -

PROF HARRINGTON: And - - -

MR ROZEN: I'm sorry, I didn't mean to interrupt you.

PROF HARRINGTON: The advisory committee consists of about 15 people and we consult with the CMS staff about two or three times a year regarding any kinds of changes or issues related to the website.

MR ROZEN: Thank you. I will ask you a little bit more about the website in a moment. Before I do that, though, can you explain briefly to us what Medicare and Medicaid are in the American health system.

PROF HARRINGTON: Medicare is the national program that pays for all elderly and disabled people, and it covers hospitals and nursing homes and medical care services, and for nursing homes it covers short-term, acute and rehabilitation services. And Medicaid is the program for low income people across the country and it's primarily – it offers comprehensive services. And that includes long-term care services including nursing homes, home health and hospice services. So anyone who meets the financial criteria is eligible to get those services. And if individuals don't qualify for either one of those programs, then they pay for nursing home services out of pocket.

MR ROZEN: Thank you. Now, in addition to the statement that you have provided us, you have included an annexure which is headed Annexure A, and it commences at RCD.0011.0042.0003. Is your intention, Professor, that we should read your statement and the annexure together as the sum total of your answers to the various questions that you were asked by the staff of the Royal Commission?

PROF HARRINGTON: Yes.

MR ROZEN: And have you had a chance to read through the statement and the annexure before giving evidence today?

PROF HARRINGTON: Yes.

MR ROZEN: And is there anything that you would like to change in either of those documents?

PROF HARRINGTON: No.

MR ROZEN: And are their contents true and correct?

PROF HARRINGTON: Yes.

MR ROZEN: I tender the statement and the annexure.

COMMISSIONER PAGONE: All right, the statement and annexure will be exhibit 15-1.

EXHIBIT #15-1 STATEMENT AND ANNEXURE OF PROFESSOR HARRINGTON (RCD.0011.0042.0001, RCD.0011.0042.0003)

MR ROZEN: Now, if I could get down to asking you about some detail, Professor. Firstly, it might be helpful for us to clarify a little bit of terminology because I think the terminology we use in Australia to describe aged care staff, if I could take a generic expression, is slightly different to what you use in the United States. Particularly, I understand from reading a number of articles that you have authored

and co-authored that when there's a reference to nursing staff in nursing homes, that's lower case nursing staff, that that's a reference to registered nurses, care workers and anyone else who is involved in the provision of care.

PROF HARRINGTON: Yes, in the nursing care.

MR ROZEN: Yes. Within that broader group there are workers who are registered nurses; is that right?

PROF HARRINGTON: Yes.

MR ROZEN: And those registered nurses, do they complete a university degree to be able to be registered as nurses in the United States?

PROF HARRINGTON: No. They complete at least a two-year university degree.

MR ROZEN: Yes.

PROF HARRINGTON: And some of them do have a bachelor's degree or a master's degree.

MR ROZEN: Yes. And you also have - - -

PROF HARRINGTON: And then they must pass a licence test in order to practise.

MR ROZEN: Yes, thank you. So I don't know how much you know about the structure of the nursing profession in Australia but it certainly sounds very similar to what we would call a registered nurse in Australia.

PROF HARRINGTON: Yes.

MR ROZEN: The second - - -

PROF HARRINGTON: That is so.

MR ROZEN: Yes. The second category of workers that you referred to are licensed vocational or practical nurses, that is LVNs, also known as LPNs; is that right?

PROF HARRINGTON: Yes.

MR ROZEN: And what sort of training do they have, Professor?

PROF HARRINGTON: They have at least one year of vocational training, and sometimes it's 18 months of training, and they have to have a licence to practise.

MR ROZEN: Yes. And do they work under the supervision of registered nurses or are they able to work without that supervision?

PROF HARRINGTON: They're under the supervision of registered nurses.

MR ROZEN: Yes. And then the third category, certified nursing assistants or CNAs. Is that right?

PROF HARRINGTON: Yes.

MR ROZEN: And I don't know if you are familiar with the Australian expression, a personal care worker: is that an expression you are familiar with?

PROF HARRINGTON: Yes.

MR ROZEN: And are you able to tell us whether the CNA in the United States is broadly equivalent to our personal care worker?

PROF HARRINGTON: Well, I assume it is. The CNA has to have 150 hours of training, which can be on-the-job training.

MR ROZEN: Yes.

PROF HARRINGTON: And then they must pass a test that they are able to provide basic care with activities of daily living.

MR ROZEN: And is that something that applies uniformly throughout the United States or are there differences from one state to the other in that regard?

PROF HARRINGTON: Yes, some states may require more training than other states, but there's still very minimal training.

MR ROZEN: Thank you. One of the many activities that you've been engaged in in relation to nursing staff caught my eye from your CV. There's a reference to you having testified in 1999 – so going back some time now – on staffing and nursing home quality before the Californian legislature.

PROF HARRINGTON: Yes.

MR ROZEN: And in your CV it states that those efforts led to budget legislation on high minimum staffing standards and salary increases for all Californian nursing home staff in 1999. Do I understand - - -

PROF HARRINGTON: Yes.

MR ROZEN: - - - from that reference to nursing home staff that that applied across the board to all three categories of workers that we have just been talking about?

PROF HARRINGTON: Yes.

MR ROZEN: And can you provide the Royal Commission with a little bit of background to how that all came about?

PROF HARRINGTON: Well, there had been many discussions about the fact that we needed higher minimum staffing standards for nursing homes in California, and so California did pass the legislation; although the level that was set for the minimum was below what was recommended by experts.

MR ROZEN: At that time, that was prior to the 2001 CMS study that you refer us to; is that right?

PROF HARRINGTON: Yes.

MR ROZEN: It must have been.

PROF HARRINGTON: Yes.

MR ROZEN: And are you able to tell us what, at that time, experts were recommending as you've just said?

PROF HARRINGTON: Well, at that time experts were recommending a 4.55 minimum staffing hours, and that was based on a paper that I wrote with Hoover national experts. It was published in the year 2000.

MR ROZEN: Yes. And - - -

PROF HARRINGTON: And we had specific recommendations for RNs as well as total staff.

MR ROZEN: That's a matter that you refer us to in your statement, the importance of there being both minimum staffing requirements for RNs as well as total staff; is that right?

PROF HARRINGTON: Yes.

MR ROZEN: Why, from your perspective and based on your research, is it important to address both, both cohorts, that the registered nurses and the other workers within nursing homes in relation to staffing times?

PROF HARRINGTON: Well, there have been over 150 research studies looking at nursing home staffing. And many of those studies show that it's the RN hours that makes the big difference. And far more important than the LVN or the nursing assistant hours. So it's very important that nursing homes have adequate RN staffing levels. And, of course, these are the most expensive staff. So nursing homes like to save money so they don't always have enough RNs.

MR ROZEN: If I'm understanding your statement correctly, by reference to some studies that you were asked to comment on by Chen and Grabowski and also a study by Bowblis and Ghattas – these are dealt with on page 5 of your statement, if it assists you, Professor. As I understand the evidence you are giving there, you draw on those studies which, in turn, examined laws that were introduced in some states in America which merely prescribed minimum staffing requirements without in addition prescribing minimum registered nurse requirements. Is that right?

PROF HARRINGTON: Yes. In those cases, many of the nursing homes did not have enough RNs because they – the nursing homes could hire the less expensive staff. And so it's very important to specify the RN level.

MR ROZEN: The studies, in fact, concluded that one of the unintended consequences of the introduction of those laws was that very thing: that the nursing homes, in order to meet the minimum requirements, employed the cheapest staff to achieve those requirements and, therefore, reduced the proportion of their staff that were nurses.

PROF HARRINGTON: Yes. But that was not true of all States, because some States do specify the RN staffing. But the big problem in the United States is that all of the States staffing laws are inadequate in comparison to what the research shows is necessary.

MR ROZEN: So even the minima that are specified from your point of view are not high enough; is that what you're saying?

PROF HARRINGTON: Yes, that's correct.

MR ROZEN: Can I ask you about the CMS study, which you refer to in your statement as the gold standard study on minimum staffing levels since 2001. Why do you refer to it as the "gold standard"?

PROF HARRINGTON: Well, because it was the most important study, our first major study that showed if you didn't have a certain level of staffing there was harm or jeopardy to the residents. And since that time, there have been many other research studies that have looked at the importance of staffing. But they haven't always set a level for the staffing.

MR ROZEN: And, as I read your statement, the stipulated minimum standard set out in the 2001 CMS study is 4.1 hours per resident per day; is that right?

PROF HARRINGTON: Yes.

MR ROZEN: And that's obviously nearly 20 years old now, that study. We've heard a lot of evidence in this Royal Commission about the increasing acuity of residents in residential care homes and we have also heard evidence that that, to some extent, parallels the experience in the United States. So my question is does

the 4.1 hours still stand from your perspective as an appropriate minimum number of hours on average per day per resident to provide quality care?

PROF HARRINGTON: Well, yes, it's still applicable. I think it could actually be higher, but this is the main study that we have to show that if it's lower than that, there's serious consequences. But I want to point out that study also specified the RN levels.

MR ROZEN: Yes.

PROF HARRINGTON: And the RN level is .75 hours per resident per day at a minimum.

MR ROZEN: So that's 45 minutes as a minimum.

PROF HARRINGTON: Yes.

MR ROZEN: Your statement, quite emphatically, if I may say so, makes the point that nurse staffing levels are the most important factor that determines the quality of care provided by nursing homes. I'm reading from the bottom of page 1 of your statement, and you go on and say insufficient staffing levels negatively impact all residents in a nursing home on a systemic basis. Could I just pause there. The references there to nursing staffing levels, I take it that's the broader meaning of nursing that you ascribe when I started asking you questions. You mean all staff?

PROF HARRINGTON: Yes.

MR ROZEN: But as - - -

PROF HARRINGTON: I want to point out that – point back to your previous question about the minimum. That minimum is for residents that have the lowest possible acuity. Any residents that have higher than that minimum level need to have higher staffing.

MR ROZEN: So is that why that 4.1 hour figure holds even though it's 20 years later because it was pitched at the lowest acuity?

PROF HARRINGTON: Yes.

MR ROZEN: I understand.

PROF HARRINGTON: And a recent study verified that the CAN staffing for the very lightest care should be 2.8 hours per resident per day. So we know that any acuity over that lowest level needs to have higher staffing. So that hasn't been specified but we have guidelines for what it should be.

MR ROZEN: Now, I want to ask you about the notion of quality because we've had quite a bit of evidence in the Royal Commission about the meaning of quality and what one should measure to ascertain the quality of care that is provided in a nursing home. As I read the various research reports that you've been involved in, the quality indicators which have been measured have tended to be clinical indicators. Is that a fair observation?

PROF HARRINGTON: Well, the most – no, I don't think so. There's different indicators but the indicator we use and consider to be the most important indicator in the United States is the deficiencies that are issued as the time of the surveys of nursing homes. And the reason that is considered to be the most important measure of quality is that it involves observation and record reviews and a comprehensive assessment by surveyors. So it's given the most weight in terms of quality measures. And the clinical measures, there are many clinical measures and some are self-reported and so they're not as accurate, and others are based on claims data and those are more accurate.

MR ROZEN: Those assessments that you referred to a moment ago as being that good source of data about quality, who's conducting those assessments?

PROF HARRINGTON: The surveyors are trained at the State level and they operate on behalf of the Federal Government to conduct the assessments. The assessments are done about every year but they can be more frequent whenever there are complaints about quality.

MR ROZEN: And you said a moment ago that part of the assessment process is to conduct interviews; is that right?

PROF HARRINGTON: Yes, interviews with residents and family members as well as observation and reviews of medical records.

MR ROZEN: So that's a form of qualitative data, is it, about the performance of the particular home?

PROF HARRINGTON: Yes.

MR ROZEN: And is your evidence that considering that qualitative data, that is equally impacted by staffing levels as, say, the clinical measurements that we referred to a moment ago?

PROF HARRINGTON: Well, we know from the research that that has the very strongest relationship to staffing, facilities that have low staffing have higher deficiencies. So it's the best indicator; that's why the centres for Medicare and Medicaid services on its nursing home rating system gives that – the strongest weight in terms of measuring and rating the quality.

MR ROZEN: Thank you, Professor. I want to ask you about some evidence that is included on page 6 of your statement. It's at .0008. So it's page 6 in the bottom right-hand corner of your version, professor.

PROF HARRINGTON: Yes.

MR ROZEN: You were asked the question at the top of the page what role does the market play in improving staffing standards in residential aged care facilities or nursing homes? And your response commences with the statement:

Homes with the highest profit margins have been found to have the worst quality in the US.

And you go on and note the relationship between high profitability, low quality and low staffing levels. Is that right?

PROF HARRINGTON: Yes.

MR ROZEN: It's the third paragraph of your answer that I want to ask you about. You say:

If the government would expand financial support to nursing homes owned and operated by government and non-profit organisations, that could expand the number of high quality nursing homes and make the market more competitive.

Can I ask you to - - -

PROF HARRINGTON: Yes.

MR ROZEN: - - - expand on that.

PROF HARRINGTON: Well, the research that I've done and many other people have done shows that the only facilities – well, primarily the only facilities in the United States that meet the staffing standards that are recommended are non-profit and government facilities. And so if we have more of those facilities, then it would give people more access to higher quality care and it would encourage the for-profit facilities to improve their staffing and their quality.

MR ROZEN: Is the point there that the power of the market, if I can put it that way, could be harnessed in that way so that competitive pressures drove quality up rather than driving it down?

PROF HARRINGTON: Yes. Yes.

MR ROZEN: And in your experience, are there examples of that in the research that you've done of that process, that sort of market forces working?

PROF HARRINGTON: Not particularly, because most countries are quite privatised in their nursing home market, and the only country that has primarily all government facilities is Norway and their facilities are quite high quality and they don't depend on the market. But the other countries that I've studied are very privatised and these for-profit companies are not well regulated. And if you don't have minimum staffing standards for those for-profit companies, then they have an incentive to cut staffing and to increase profits. And that causes the quality problems. And many people don't know that there are rating systems; that the government has a rating system. So they're not aware that there are these big differences in quality. So they tend to go to the – a nursing home that is closest to their home rather than to select on the basis of the quality measures.

MR ROZEN: Yes. Thank you. That seems to be a point that you make on page 5 of your statement. You refer to a recent study by Cornell, Grabowski, Norton and Rahman from 2019 which looked at the effect of being discharged presumably from a hospital to a higher star nursing home. Are you familiar with the study that I'm referring to?

PROF HARRINGTON: Yes.

MR ROZEN: Am I reading that correctly? The study was examining circumstances in which a person was discharged from a hospital to a nursing home, presumably after maybe having a fall at home or something like that; is that right?

PROF HARRINGTON: Yes.

MR ROZEN: And your summary of that study is that the discharge to the better quality nursing homes led to significantly lower mortality, fewer days in the nursing home, fewer hospital readmissions and more days at home or with home health during the first six-month post nursing home admission. Is that right?

PROF HARRINGTON: Yes.

MR ROZEN: And is the point there, professor, that discharge in those circumstances to a higher quality nursing home improves the chances of the person actually being able to return to their own home after perhaps a short period of time in the nursing home?

PROF HARRINGTON: Yes. Yes. This is – it's a very powerful study that shows that the rating system does work but, unfortunately, many people are not aware of the rating system or there are other reasons why they're unable to go to those higher quality homes.

MR ROZEN: Yes.

PROF HARRINGTON: Because some of those higher quality homes are private non-profit homes, and they don't take Medicaid or the lower income patients.

MR ROZEN: I see. Is there evidence that the rating system has worked to improve quality, particularly since I think it's 2017 when the reporting – the new reporting system came into operation. So that the data, as you explain it on the rating system is now more reliable?

PROF HARRINGTON: Well, I can't say that it's – we have the data to look at it from 2017 on. But we do know that staffing has increased quite a bit and so that's good, over time. So I think the website has been responsible for that. But, of course, the data weren't always accurate so that's ..... and then we know that quality measures such as pressure sores and falls and things, have been reported to be lower. But, unfortunately, many of those clinical indicators are not very accurate. So the nursing homes have an incentive to make their reports look better. But these – the measures that are reported in this article are hospitalisations, mortality and days at home. And those are very accurate output measures.

MR ROZEN: Professor, we've heard evidence during the course of this Royal Commission about the importance of allied health workers being present in nursing homes, particularly to assist in the rehabilitation of residents promoting the quality of life that they at the can have. But as I understand the CMS study and the star rating system, there's no provision made for minutes of allied health care in the total number of care minutes. Is that right?

PROF HARRINGTON: Well, no, because the way the payment system has been set up is the nursing payment is separate from the therapy payment. And so CMS is paying extra money for nursing care if there's higher acuity and they have been paying extra money for – separately for therapy. But on the website, there is an indicator of the therapy minutes, the physical therapy minutes but it's not used as part of the rating. And that's because the minutes are very, very low. So it's hard – of course, it's very, very important but the minutes are so low that they're not that measurable.

MR ROZEN: From your perspective, if you were designing such a system from scratch, would you include a component for allied health minutes?

PROF HARRINGTON: Well, we have that component, it's available.

MR ROZEN: Yes.

PROF HARRINGTON: - - - on the website but it's not a part of the rating because it's so low. So I would not include it at this time because it's not – they don't give enough time to differentiate well between facilities.

MR ROZEN: Now, it's important for us to understand, isn't it, that the star rating system is just that: it's not a compulsory requirement that homes provide a certain number of minutes of care. Rather, it's just a description of the minutes of care that are actually provided. Is that right?

PROF HARRINGTON: Yes, that's right.

MR ROZEN: We asked you, this is question 11, what measures should be introduced to regulate staffing levels in residential aged care facilities and your answer was that mandated minimum staffing standards are needed along with a requirement to increase staffing levels as resident acuity levels increase. I would just like to explore that with you, if I could. When you say mandated minimum staffing standards, what do you actually mean? Do you say there should be a sanction attached to not meeting the minimum staffing standards?

PROF HARRINGTON: Yes. We think they should have that minimum that was identified in the 2001 CMS study and then the requirements, we don't have that minimum. The requirements I stated are to – that nursing homes must have sufficient staffing to meet the needs of the residents and then they must increase the staffing to meet the acuity of the residents. But it's not specified and so it's very difficult for the inspectors, the surveyors, to determine when the staffing is inadequate. And so there's very little sanctions for low staffing because the surveyors primarily focus on whether or not there has been harm to the resident, like a pressure ulcer or a fall. And they don't look at the staffing.

MR ROZEN: They look at the outputs, not the inputs, to use the jargon; is that right?

PROF HARRINGTON: Yes, that's right.

MR ROZEN: And do you say they should be looking at the inputs as well as the outputs?

PROF HARRINGTON: Well, we say they need to specify more clearly where that standard is so that they can more easily determine whether or not a facility is meeting that minimum standard. And I think they should also specify more clearly standards for higher acuity. So that they can determine if those standards are being met. It's too vague at this point.

MR ROZEN: So the current standard is the one that's set out on page 3 of your statement, the facility must have sufficient nursing staff with the appropriate competencies and skills and so on. Is that what you are referring to?

PROF HARRINGTON: Yes.

MR ROZEN: And - - -

PROF HARRINGTON: So we are saying that's not a sufficient standard. It needs to be specified more clearly.

MR ROZEN: And if it was specified more clearly, what do you say should be the consequences of a home's failure to meet those more specific standards, and would

the consequences vary according to whether the infraction was frequent or systemic from your perspective?

PROF HARRINGTON: Yes, I think the consequences should be quite severe. We have a penalty system where you can issue fines. But we also have a system, its federal system allows the inspectors to put a hold on admissions of residents and that is the most effective standard. So we would like to see holds put on any new resident admissions until a facility has met minimum standards for staffing or has adequate staffing levels to meet the needs of the residents.

MR ROZEN: The last thing I want to ask you about picks up on that observation and it's this: if the reason why the facility is unable to meet the minimum staffing standards is because it's not financially viable, is there a risk that by imposing a sanction whether it be a fine or a prohibition on admitting new residents that you are just compounding the financial difficulties and making it less likely that they will be able to meet the staffing standards?

PROF HARRINGTON: Well, we don't think facilities should be operating if they don't have adequate financial resources. But most nursing homes in the United States are making quite a lot of money, the for-profit homes.

MR ROZEN: Yes.

PROF HARRINGTON: And so that's generally not a problem and they do receive fines now. They can receive up to $100,000 in fines if someone has been injured severely or there's a death. And this is kind of the cost of doing business for nursing homes. So I don't see that as a problem. I think – but I would rather than having a fine, I think they should have a halt so that – put on the admissions so that – and they need to reduce their residents until they have sufficient staff to care for the residents, or they should be closed if they can't comply.

MR ROZEN: Thank you. The final matter relates to that and this relates to question 12 that you were asked by us, which is on page 6 of your statement. You were asked:

How can aged care workforce supply shortages, particularly in rural and remote areas, be addressed?

And the context of that from within the Royal Commission is that we've heard a deal of evidence here about particularly smaller residential facilities in regional areas, struggling financially and also at times struggling to attract the staff that they need to operate. And the concern is that if mandatory staffing requirement was to be introduced it might impact disproportionately on such operators in rural and remote areas. As I understand the answer, you refer to the potential operation of the market; that is, that if one introduced mandatory staffing requirements then in areas where there was high competition for staff that might have the effect of driving up wages for staff. Am I understanding that correctly?

PROF HARRINGTON: Yes. There's a strong relationship between not having adequate staffing and high turnover and it's also related to low wages and benefits. So in the US we think that in general there's adequate availability of people to work in rural areas. The problem is the wages and benefits are too low and the nursing homes are not hiring enough people. So you have a circular situation where people don't want to work because the workload is too heavy and the wages and benefits are not sufficient. And the way our payment system is set up, the rural facilities get – they get payments that are designed for them. So I think if there were – if there was going to be a problem with financial viability in a rural area then the issue is more of what the government should be paying for the residents to make sure there is adequate resources. But in the United States, we have very poor financial accountability and very few audits of nursing homes. And so this is a big problem where a nursing home can complain that they don't have resources when they don't have to show that that, in fact, is the case.

MR ROZEN: Professor, last question and it's an open-ended one. The Royal Commission here is tasked with looking at the entire aged care system in Australia and is on the public record as stating that it would like to redesign the system so that it provides high quality care to the care recipients. Drawing on your many decades of research and experience, particularly in the United States but also in Canada and in Western Europe, what do you say to the Commissioners are the lessons that are to be learnt from your research? What should be the primary focus of the Royal Commission in meeting those requirements?

PROF HARRINGTON: Is the question for nursing homes or for home health and other illnesses?

MR ROZEN: Well it could be for both but if we could start with nursing homes.

PROF HARRINGTON: Yes. Well, I feel strongly that staffing is the number one issue and the failure to set minimum staffing standards is fundamental to all of the quality problems we're having. And in addition, nurses are paid 15 per cent below what hospital workers receive. So the nursing home workers are often compensated inadequately. And then – so there's also a big problem with the quality oversight by the government, and the poor fiducial accountability requirements. So the government needs to set up much stricter financial oversight to make sure that when they do give money for staffing that the money is used for the staffing. So it's a complicated system but we definitely know it's not going well in the United States anyway.

MR ROZEN: Thank you, professor. Commissioners, they're the questions that I have for Professor Harrington.

COMMISSIONER BRIGGS: I think it might be good evening, Professor Harrington, is it? It's Lynelle Briggs here, one of the Commissioners. I wanted to go back to the discussion you had with senior counsel about allied health and it was in the context of star ratings, I think. And I think, if I heard you correctly, you were

saying that in a star rating system, the inclusion of allied health because the numbers required are so small, it wouldn't provide indicative data. What I would like to know more generally is if you think ratings – sorry, allied health staff ratios might be as valuable or valuable more generally for allied health as they are, in your view, for nursing.

PROF HARRINGTON: No, I don't think as valuable as they are for nursing because the nurses are there 24 hours a day and the allied health are supplemental workers that come in during the day to provide different therapies. In our situation, it is complicated because our reimbursement system for the therapy staff is quite complicated. And, in fact, the government has just changed the payment system for allied health workers and decreased the payment system substantially. And we're quite concerned that that is going to have a very negative effect on the rehabilitation of residents. But the allied health payment system was set up so that the more therapy, higher the payment. So the concern was that some patients were receiving too much therapy, even in their last weeks of life they were being given therapy. So the government has tried to correct that situation and it may have gone the other way. So - - -

COMMISSIONER BRIGGS: Thank you. That explains a lot. Thank you.

COMMISSIONER PAGONE: Professor, I've got just two matters that I want to ask you about. One of them is to get a slightly more detailed sense of the sanctions that apply in the United States. You referred, you remember, a moment ago where you said the sanctions were a cost of doing business and that you thought it was appropriate for sanctions to be imposed and I understand that. I was wondering whether, in the United States there are examples where sanctions are imposed not on the facility but secondarily upon individual people who might have positions of responsibility within the facility so that it's either a primary or a secondary liability where there's a default in the facility but the sanction is imposed upon, for example, a managing director or the directors of a company. Do you know whether that's how it operates in the States at all?

PROF HARRINGTON: The sanction system that we have in the United States through the stay survey process is only on the facility. Although we do know that the poor quality in some of these facilities is the result of decisions by the executives and the corporate management. But they are not sanctioned, although – and we also know that in some cases, if a nursing home does receive a lot of deficiencies and fines, the administrator or the owners of the nursing homes will sometimes dismiss the administer or the director of nursing after the fines have been issued.

COMMISSIONER PAGONE: And - - -

PROF HARRINGTON: But it's only - - -

COMMISSIONER PAGONE: Sorry, go on.

PROF HARRINGTON: It's only set up for the facility.

COMMISSIONER PAGONE: Yes. It would seem to me to make more sense the fines or sanctions to be imposed on somebody who is likely to feel the effect without the effect then being off-loaded on to the elderly or the residents. So that if you impose a fine upon the facility, for example, or you close the doors on the facility, or you restrict the number of new entrants, in each of those instances the sanction will be felt by the people who are designed to be helped rather than the people who are culpable. From your perspective, do you see value in the sanction being imposed not upon the facility but upon the owners or the controllers or people of that ilk?

PROF HARRINGTON: Well, in the United States we've done a number of studies looking at corporate owners of nursing homes and we find that the quality is highly tied to that corporate ownership often. And so we have urged the government not just to focus on individual facilities but to focus on all of the authorities under corporate ownership. But they have not elected to do that. The government does – the Department of Justice is able to go after some of the corporate owners for fraud and what we call work plus services and in that case they do sanction the entire corporation. But they don't sanction individuals within a corporation in terms of the leadership. And they sometimes look at the entire corporation under a five-year oversight by the government, give them special attention and take large amounts of money back from these companies. But it's still rather a weak system.

COMMISSIONER PAGONE: The second thing I wanted to ask about, Professor Harrington, was you remember that Mr Rozen asked you questions about what you said under section 10 of your response on page 6 where you said that if the government could expand the services that it provides, that might have a secondary effect on providing increasing the quality in the private sector. And I think in answer to one of Mr Rozen's questions, you said you weren't aware of that ever happening. I can think of lots of examples where the opposite would happen, not necessarily in the aged care sector but where government subsidises or funds an activity and then the result is to drive down the private sector delivery rather than increase it. Now, I'm conscious of the answer that you gave earlier on, but are you aware of any studies that have looked at whether what you've said there is anything – has any likelihood that it would go your way rather than my pessimistic prediction?

PROF HARRINGTON: No, I'm not aware of any studies. I mean, there have been many studies showing that the poor quality is primarily in the private for-profit sector and, unfortunately, that sector is getting bigger while the non-profits that are primarily owned and operated many times by churches or religious organisations, they have a certain standard and they generally have higher staffing and better quality. And they have more difficulty making the facilities financially viable because of that. So you see that we're losing non-profits and we're losing the highest quality facilities because of the economics, because they are not subsidised in any way by the government.

COMMISSIONER PAGONE: Yes. Thank you. Mr Rozen, anything from that?

MR ROZEN: Nothing arises, thank you.

COMMISSIONER PAGONE: Professor, thank you very much for making time available. I'm not sure what time it is over there but I'm sure it's a lot later than it is here and thank you very much indeed for your testimony, it has been very helpful indeed.

PROF HARRINGTON: Okay. Good luck with your work. Thank you.

COMMISSIONER PAGONE: We will adjourn for about 10 minutes.

PROF HARRINGTON: Okay so I'm going to sign off now?

MR ROZEN: Yes, I think that's fine. And thank you very much for your time. Goodbye.

<THE WITNESS WITHDREW [10.03 am]

ADJOURNED [10.03 am]

RESUMED [10.22 am]

MS HILL: If the Commission pleases I call Dr Katherine Ravenswood, who appears by video link.

COMMISSIONER PAGONE: Yes. Thank you.

<KATHERINE RAVENSWOOD, AFFIRMED [10.22 am]

<EXAMINATION BY MS HILL

MS HILL: Dr Ravenswood, could I please ask you to state your full name.

DR RAVENSWOOD: My name is Katherine Jean Ravenswood.

MS HILL: And what is your role?

DR RAVENSWOOD: I'm an Associate Professor in employment relations at Auckland University of Technology.

MS HILL: And is Auckland University of Technology where we find you giving evidence from at the end of the video link this morning?

DR RAVENSWOOD: Yes, it is.

MS HILL: Dr Ravenswood, you've provided a copy of your curriculum vitae to the Royal Commission, haven't you?

DR RAVENSWOOD: Yes.

MS HILL: And you've got a copy of that there in front of you?

DR RAVENSWOOD: Yes, I do.

MS HILL: For the benefit of the Commissioners, I will ask for the operator to display document ID RCD.0011.0043.0013. That's the document that we've got on the screen that you've got in front of you, Dr Ravenswood, your curriculum vitae. And for the benefit of the transcript, I can see that you're nodding, but I will ask you to indicate that that's your CV.

DR RAVENSWOOD: Yes, it is.

MS HILL: And, Dr Ravenswood, could you briefly describe your professional background and experience to the Commissioners.

DR RAVENSWOOD: I have been an Associate Professor since 2019 and prior to that a senior lecturer in employment relations at Auckland University of Technology. I have over 12 years research experience and am an expert in care work, specifically employment relations and work conditions in aged care. I have also held a number of appointments on sector-based committees and I have a PhD in employment relations.

MS HILL: Dr Ravenswood, you've also prepared a statement for the Royal Commission, haven't you?

DR RAVENSWOOD: Yes, I have.

MS HILL: And I will ask the operator to display, for the benefit of the hearing room, document ID RCD.0011.0043.0001. You've got a copy of that statement in front of you?

DR RAVENSWOOD: Yes, I have.

MS HILL: And that statement is dated 20 February 2020.

DR RAVENSWOOD: Yes, it is.

MS HILL: And you've indicated to the staff of the Royal Commission that there's an additional reference that you'd seek to add at page 11 of your statement. Is that correct?

DR RAVENSWOOD: Yes, that's correct.

MS HILL: Could I ask you to read the additional reference that you would seek to include on page 11 of your statement.

DR RAVENSWOOD: Yes. The additional reference is Douglas J and Ravenswood K, 2019, the Value of Care: Understanding the Impact of the 2017 Pay Equity Settlement On the Residential Aged Care Home and Community Care And Disability Support Sectors, published by Auckland – in Auckland by the New Zealand Work Research Institute.

MS HILL: And, with that addition of that reference, are the contents of your statement true and correct?

DR RAVENSWOOD: Yes, they are.

MS HILL: Commissioners, I'd seek to tender the statement, along with the curriculum vitae of Dr Katherine Ravenswood.

COMMISSIONER PAGONE: Yes. The statement and the curriculum vitae will be exhibit 15-2.

EXHIBIT #15-2 STATEMENT AND CV OF DR RAVENSWOOD (RCD.0011.0043.0001)

MS HILL: Thank you. Dr Ravenswood, sitting there in New Zealand back to us over the pond in Australia, are there similarities between the delivery of aged care that you identify in your research in your experience, which makes a comparison between the two countries, Australia and New Zealand, a useful academic exercise?

DR RAVENSWOOD: Yes, there are. The similarities are in some of the traditions around the regulation of employment relations and labour standards, but also in the way that aged care is delivered and funded by the government in both countries.

MS HILL: In your statement, you describe a reluctance to prioritise labour standards in aged care. Are you referring to Australia or New Zealand when you make that statement?

DR RAVENSWOOD: I am referring to New Zealand when I make that statement. I suspect, but do not have sufficient experience, to verify that it would be very similar in Australia.

MS HILL: And are you referring to residential aged care or home care when you describe a reluctance to prioritise labour standards in aged care or both?

DR RAVENSWOOD: I'm referring to both.

MS HILL: And who is reluctant?

DR RAVENSWOOD: I think the reluctance is complex. Ultimately, the funding comes from the government and the government is reluctant to increase funding. However, I think this is also influenced by social values of aged care and social and business values around prioritising labour standards against ..... profit or efficiencies.

MS HILL: Could I ask you to expand on why you observe a reluctance there.

DR RAVENSWOOD: Could you – do you mean why in terms of how the sector operates or perhaps the ideas around why labour standards aren't, I guess?

MS HILL: Why aren't labour standards prioritised, in your view?

DR RAVENSWOOD: I think it really comes down to a shift in government and social views around the role of the public sector and government, and that in recent decades we've had a shift towards a neoliberal view in many western countries whereby we are aiming to keep investment and funding at a minimum cost. So we're making efficiencies. We also, simultaneously, have a focus on allowing employers to have more freedom to manage and employ workers as they like, which is a shift from industrial relations last century. And so ..... those concurrent ..... it means that increased regulation and also in relation to funding is not very welcome.

MS HILL: And is that an answer that you'd give, in respect of that last point, with respect to how the sector operates, or are there further reasons that for you demonstrate a reluctance within the sector to prioritise wages and conditions of aged care workers?

DR RAVENSWOOD: There's a reluctance in how the sector operates for both residential aged care and home and community support. But it's also how the government operates. What we must note is that in this care work we've relied on low labour standards and low wages for a long time. And that's based on gender discrimination that perceives the work to be low skilled, low valued and low worth.

I think this also does interact with the clients, we often say, older people. And older people are perhaps not prioritised either in society or in health care. So when we connect prevailing – maybe unspoken attitudes towards the workers, who are in a feminised occupation, as well as their clients, who are older people, I think that means that, essentially, discriminatory attitudes stop us moving forward and prioritising the labour standards, in addition to the previous kind of ideology around neoliberalism, as well.

MS HILL: Do you consider that there's a need to reframe how aged care work is recognised and perceived within the community?

DR RAVENSWOOD: Absolutely. And New Zealand, despite our landmark case taken by Kristine Bartlett, our care workers do have increased wages, but, overall, the status of the job as it's perceived in the community and by managers, is still low. So the attitudes towards the work and the workers have not changed significantly.

MS HILL: What was the Kristine Bartlett case, if I could ask you to briefly describe that?

DR RAVENSWOOD: Yes. This was a case taken by Kristine Bartlett and supported by her union against her employer and residential aged care. It was taken under the Equal Pay Act 1972. And the claim was that her wages were low, because of historic gender discrimination. The case ultimately was decided in favour of Kristine and was appealed several times, at which point the New Zealand Government intervened and set up working parties to try and come to a solution.

MS HILL: And was that in 2017 that those discussions – in 2016/17 that those discussions commenced?

DR RAVENSWOOD: Yes, around that period, perhaps the end of 2015. They were concluded in 2017.

MS HILL: And who was involved in those discussions?

DR RAVENSWOOD: There were government representatives through the Ministry of Health, unions. And then aged care provider representatives were part of the discussions, but were not party to the resulting settlement.

MS HILL: And were workers or employees in aged care part of those discussions?

DR RAVENSWOOD: They were represented by their unions in the discussions.

MS HILL: And are you able to describe the outcome that takes place in 2017?

DR RAVENSWOOD: Yes. A settlement was agreed to between the parties that prescribed hourly wages according to four levels. The lowest level was for someone with no qualification. And the higher three were scaled according to the achievement of national qualifications in aged care. Workers at the time of the settlement who did not have qualifications could have increased hourly wages based on their experience.

However, they cannot carry that experience to another employer. So if they change employers and have no qualifications, they would go to the lowest hourly wage. It was very significant, because in New Zealand we only have the minimum wage. We do not have sector or industry award-type agreements that occur in Australia. So

these were wages across the – wage levels prescribed above the minimum wage across the entire sector, which is very uncommon in New Zealand.

MS HILL: Drawing on the experience of the settlement in New Zealand, what role, Dr Ravenswood, does increasing remuneration, as you've just described in that settlement, have in improving labour conditions for aged care workers?

DR RAVENSWOOD: These – the increase in hourly wages were significant. Many of the workers had been on the minimum wage. So these increases made a huge difference to their lives. We're talking about workers who couldn't always afford things like buying eye glasses, taking holidays and many chose to work very long hours to make ends meet which meant they couldn't have time with their family. The increased wages gave them more choice in how they worked. They could reduce hours if they could – if they wanted to spend time with family and they could afford things that many of us would expect to be able to, such as glasses, in our normal lives.

MS HILL: I want to pick up on a matter you've raised a moment ago in respect of a consequence of the settlement being that aged care workers are tied to their employer insofar as their experience is counted, and also what you've said earlier in your evidence that attitudes have not changed since in respect of aged care workers. And drawing on those two things, in your view was the settlement that took place in 2017 a success?

DR RAVENSWOOD: I think that, yes, it was a success. We are talking about tens of thousands of workers overall have increased wages. However, it has not been implemented in the way that was expected and so all of that – the potential has not been felt by all of the workers in the sector.

MS HILL: And in your research, what does your research tell you as to matters that have arisen that you've described as unintended consequences coming out of the settlement?

DR RAVENSWOOD: What has happened is changes in how these workers are managed. So, for example, the way that training is delivered has been changed. It's more likely to be – or qualification study is more likely to be delivered via online courses with less on-the-job training. And that is to minimise the cost involved in training. There has been a change in how workers are recruited and many employers are aiming to recruit people with no qualifications in aged care because they are cheaper to employ. In some instances some of the workers have had their hours reduced and not by their choice. And that is often because they are on the higher wage levels in the scale.

And particularly in home and community support, some workers have had their overall income decreased after the settlement has been implemented because their hours have systematically been reduced by their employer.

MS HILL: Are you able to identify an underlying cause of these unintended consequences from the settlement?

DR RAVENSWOOD: It must be noted that the legislation that enacted the settlement does not cover the entire costs associated with the settlement. It covers some direct costs, such as the increased wages. For employers there are greater reporting and administrative requirements in the legislation, and they've had to change how they roster and manage their employees. This has meant that some have had to purchase new payroll software, for example, and maybe employ new people in order to administer the new legislation. Those things in themselves are not necessarily bad but that is an increased cost that has not been covered by the funding for it. So that is one reason, and I think that the settlement was not fully funded and it comes on top of an already under-funded sector.

However, I think that the perceptions of the workers has not changed. So there are many views that the workers are now paid more, so they should take on more responsibilities or a higher workload. And that was not the intention of the legal action taken by Kristine Bartlett or the settlement. The intention was to address the gender discrimination represented by low wages.

MS HILL: How could those consequences have been avoided and, really, I ask that question with a view to understanding from you what lessons we can learn to ameliorate those types of risks, those types of consequences, as we consider the aged care system in Australia.

DR RAVENSWOOD: I think that adding one industrial relations mechanism across a funding model that is not changed does not work effectively.

MS HILL: And you refer there to the increased remuneration?

DR RAVENSWOOD: Yes. So the increased remuneration is funded kind of on top of the funding per client and care. I think that in order to avoid some of those unintended consequences that the funding needs to move from being based on individual clients and their needs to address the overall costs of delivering care. But it also relates to how labour standards and workers are referred to in the service agreements, accreditation criteria and the funding model. There are very low minimum staffing levels required. For example, you could give one care worker to 30 residents in a rest home and that would meet the minimum requirements, and that is the basis of the funding model. So I think it's important that labour standards are prioritised and that they're met through multiple – through all aspects of regulating aged care.

MS HILL: What role - - -

DR RAVENSWOOD: I think it's also – no, sorry.

MS HILL: No, I apologise for interrupting. Please proceed.

DR RAVENSWOOD: That's okay. We also need more social discussion and I think social campaigns led by government. The settlement and ensuing legislation was rushed through by government in the space of two to three months. It placed undue pressure on employers and on people in the sector, and didn't allow time for the – really for the social campaign around valuing the work and the workers and, of course, the clients that they care for. And I think those pressures and the under-funding and rushing it through has probably contributed to some of the lack of change in social attitudes towards these workers.

MS HILL: Focusing on labour standards, being wages and conditions for aged care workers, what role do you say government should take in respect of labour standards in aged care?

DR RAVENSWOOD: Government needs to step back into this relationship and recognise that it is not solely a funder. Both in Australia and New Zealand they really do have the power in terms of being the main provider through the supply chain of aged care. So they should be in a position to include labour standards in the service agreements and the procurement policies. In New Zealand perhaps they should also be paying attention to that because under our Health and Safety at Work Act indirect employers in the supply chain are actually liable for all workers throughout in terms of health and safety. So we do have some examples of how that could work already in New Zealand.

MS HILL: How do you observe the mechanisms that exist in New Zealand and Australia being such that government has the power to prioritise labour standards in aged care?

DR RAVENSWOOD: Could you explain what you mean by how I observe the mechanisms, please?

MS HILL: How do governments have the power to prioritise labour standards?

DR RAVENSWOOD: This is work that government is ultimately – or a service that government is providing. So our government through the Ministry of Health in New Zealand funds – puts the money through the Ministry of Health to our district health boards who then outsource the work to private providers. So ultimately the government is making the decision around how much funding they put through for aged care and what terms and conditions they place around the procurement of those services.

MS HILL: What could governments do as head of the supply chain to prioritise labour, labour standards?

DR RAVENSWOOD: They can make better labour standards a requirement of their procurement policy. And the New Zealand government appears to be moving towards that. But they can also make it a requirement of the service agreements that are between district health boards and providers in New Zealand, and have more

specific and higher standards of labour standards in those agreements. The accreditation criteria do mention needing sufficient care workers but do not provide very high minimum requirements. So if the service for – the agreement for services included labour standards and the accreditation included clear labour standards then this would put a very strong message that labour standards were an integral and important part of delivering high quality care.

If they were included in accreditation, then that would also allow monitoring and enforcement of those standards as well. And it would provide incentive to aged care providers to meet those because if they didn't then they may lose their accreditation and, of course, their business.

MS HILL: How do you get governments on board to take this on?

DR RAVENSWOOD: Well, clearly we don't have the answer to that entirely in New Zealand. I think, as I mentioned, it's around prevailing social attitudes that are around neoliberal ideas of the role of government, the role of business, also gender discrimination and potentially age discrimination. Voters, of course, direct governments and that then depends on social change. So I think that in order to kind of incentivise government to change then the people who keep them there need to be clear and strong on what it is that we all want. So I think it is probably social campaigns, ideally led from the government that value aged care, value the people receiving aged care, and value the workers that provide it.

MS HILL: What does a social campaign that you've described is ideally led from government that values aged care, values the people receiving care and the workers providing it, what does that look like to you?

DR RAVENSWOOD: Well, we've had some around smoking in New Zealand, for example. I remember people used to smoke everywhere and now we can't. So that's advertising that puts the message of what we are aiming for, what we do view as being ideal and good. So it could be that kind of messaging through social media, TV and other avenues that governments use for, say, health promotion, social campaigns.

MS HILL: Dr Ravenswood, you describe in your statement that there's a need for governments to be bold, to be bold and to recognise its role as an employer in the domestic supply chain. Do you consider that the New Zealand government's response to the Kristine Bartlett case is an example of a government being bold?

DR RAVENSWOOD: No. That could be seen as the government stepping back into the employment relationship and in a way it did, but that intervention was to contain costs and to control what was happening in the sector. So the terms of reference that they – that government put in to the negotiations towards the settlement prioritised containing costs over addressing gender discrimination. So that was – its purpose meant it was not a bold move. It was a move that we have

seen in the past around the government taking on a role, I guess, as arbitrator of the employment relationship.

MS HILL: How can governments be bold, in your view?

DR RAVENSWOOD: They can take the step to say that this is important, add the labour standards in and address publicly the low funding and why they continue low funding or how they're choosing to increase that.

MS HILL: Dr Ravenswood, you've referred to the need for there to be standards for it to come from government as the head of the supply chain. Is there a role for a voluntary – to have the conditions of aged care workers, wages and remuneration drawn, not from government at the head of the supply chain but from a more voluntary level, in your view?

DR RAVENSWOOD: That could happen, except that we've had, you know, 20 years of a similar funding regime and no one has chosen to provide those labour standards overall. International research shows that voluntary codes are not as effective and they are often monitored by the business or the employer themselves. So they're very difficult to enforce. Sometimes consumer-based codes have worked where consumers take action and say that actually we're not happy with what is happening in that supply chain. And perhaps that could be a possibility that might create some of the social change necessary as well, if consumers and their families started demanding a code or a certain level of labour standards.

MS HILL: Drawing on your research and your experience, what's the message that you want to share with the Royal Commission sitting here in Adelaide, Australia, today?

DR RAVENSWOOD: This is no easy task. You asked how we change the government, and I don't know, aside from getting more social consensus, I guess. However, in order to guarantee improved labour standards, we really need to make sure that that is made important through how we fund aged care, through the accreditation requirements and also through including and valuing the employees in negotiations for funding agreements and service agreements on a national basis, in addition to any current collective bargaining guarantees.

MS HILL: Commissioners, that concludes the questions I have for Dr Ravenswood.

COMMISSIONER PAGONE: Yes, thank you, Ms Hill. Dr Ravenswood, thank you very much for giving your evidence. It has been very, very helpful and very interesting. We thank you also for doing it at what isn't quite a difficult time for you; I think it's only – is it late morning or early afternoon in New Zealand?

DR RAVENSWOOD: Just around lunchtime.

COMMISSIONER PAGONE: Well, thank you very much, it has been very helpful and thank you for sharing your experiences and thoughts with us. It is indeed very helpful.

DR RAVENSWOOD: Thank you.

COMMISSIONER PAGONE: We will adjourn, I think, momentarily now.

MS HILL: There will be a short break, I believe, for the morning break through to five past 11.

COMMISSIONER PAGONE: Yes, thank you.

<THE WITNESS WITHDREW [10.54 am]

ADJOURNED [10.55 am]

RESUMED [11.12 am]

COMMISSIONER PAGONE: Mr Rozen.

MR ROZEN: Thank you, Commissioners. I understand that a document has been provided to each of you setting out the submissions that I will be making on behalf of the Counsel Assisting team. Commissioners, these submissions concern the aged care workforce. We note that the Royal Commission is relevantly required to inquire into what the Australian Government can do to strengthen the system of aged care services to ensure that the services provided are of high quality and safe, and how to ensure that aged care services are person-centred. We further note, Commissioners, that under the Terms of Reference in meeting those terms, the Royal Commission is directed to have regard to the critical role of the aged care workforce in delivering high quality, safe, person-centred care, and the need for close partnerships with families, carers and others providing care and support.

Commissioners, these submissions are directed to assist you to fulfil the requirements of those terms of the reference. Commissioners, earlier this week, along with members of the Royal Commission staff, I had the privilege of visiting an aged care home in regional Victoria. All of us were struck by two things in visiting that home. First, the obvious frailty of the residents in the home, the majority of whom were afflicted by dementia. Secondly, the compassion and love with which the staff were caring for those residents and the obvious joy that they derived from their difficult and vital work.

The staff in our aged care homes, Commissioners, are not well paid. All too often, there are not enough of them to provide the care that they would like to, for example, to sit and have a chat over a cup of tea. Many work in stressful and sometimes unsafe work places, some are untrained and others have inadequate training. As a community we owe these workers a lot. These submissions are aimed at improving their working lives so that our elderly citizens can receive safe care of the quality of care that they should receive in a country as rich as ours. The submissions we make today are informed by the following principles.

Firstly, an approved provider should have to meet mandatory minimum staffing requirements. Registered nurses including nurse practitioners should make up a greater proportion of the care workforce than is presently the case. All aged care workers should receive better training. Unregulated care workers should be subject to a registration process with a minimum mandatory qualification as an entry requirement. The care workforce should be better remunerated and should work in safe work places. The organisations for which they work should be better managed and better governed. And finally, the Australian Government should provide practical leadership in relation to all these things.

Commissioners, the implementation of the recommendations we propose today as a holistic package will over time make aged care a more attractive sector in which to work. This will help to retain the current workforce and attract new workers to the sector. In conjunction with recommendations about system design, funding and finance, regulation, provider governance, the role of the Commonwealth and other areas which Counsel Assisting will be proposing in the coming months, the implementation of the recommendations we propose today should result in improved quality and safety in aged care for elderly Australians.

At the Royal Commission's hearing in Perth last year which focused on person and relationship-centred care, an internationally recognised aged care expert, Dr Lisa Trigg, gave evidence. Dr Trigg studied aged care systems around the world including in Australia and she explained that to deliver really excellent relationship-centred care, care workers have to be more than just respected, they have to be valued and supported. Also at the Perth hearing the Royal Commission was informed about the importance of attracting the right people to work in aged care.

Mr Jason Burton, Head of Dementia Practice and Innovation at Alzheimer's WA explained that in recruiting care staff, he looks for warmth in a person. Staff without the right empathetic attributes are unlikely to succeed, he told us. Ms Kate Rice, a manager of 18 years' experience at aged care provider Wintringham, emphasised during our Perth hearings that care workers must have the right attitude and commitment. They can be trained to provide good care. Ms Rice told the Royal Commission:

I'm excited about working in aged care. I love it. So I think if I love it, I want to find other people who are equally as excited as me.

The Royal Commission has heard from a number of other workers who spoke of their passion for working in aged care. For example, at our Darwin hearings, Ms Sharai Johnson, a Larrakia woman who is the aged care coordinator at Larrakia Nation, spoke of the rewarding nature of aged care work. She said:

what makes it so rewarding is that you know that you are impacting – you are having a positive impact on each individual's daily life, their daily living. And if you can be that one person to make that change on a daily basis then that's a wonderful knock not only for my personal satisfaction, my professional development and giving that back to the community, giving that back to the workforce and also mentoring younger staff members. Just the younger generation in general, showing them that aged care is a great place to be. It's a wonderful place to be. It's so rewarding and you know what, you just keep going every day.

Commissioner Briggs can probably remember her smile as she said all that to us. Commissioners, the challenge for the aged care sector is to attract more Kate Rices and more Sharai Johnson and to retain them. One way of doing that would be for the Federal Government, together with the sector, to engage in a campaign of social change along the lines that Dr Ravenswood has just been talking about in relation to New Zealand.

There are examples of such campaigns. One is the internet based Every Day is Different initiative which is being promoted by the Department of Health and Social Care in the United Kingdom. Not a particularly sophisticated website but nonetheless very interesting. It includes inspiring stories about people working in caring roles as well as links to job opportunities and other resources. A short clip from that video will now be shown on the screen.

VIDEO SHOWN

MR THOMAS: My experience of having done the job as the carer has helped me hugely in the role as a manager. Too often we underestimate the value of a kind word, a gentle touch, a listening ear. And these simple kind acts have got a huge potential to change somebody's life around. When you actually see that smile on the resident's face, the joy they have, that is actually what motivates me to come back every day back into work, with huge passion. I am Blesson Thomas, the registered manager for The Heights Nursing Home, in High Wycombe.

I'm a registered nurse qualified in India. I came to the United Kingdom in 2007 to do my Masters in Nursing, and following that I started looking for jobs in care homes. In 2010 I joined here as a care worker. I thought that must be the first step into health and social care. Over the years I started applying for the various posts. I became a clinical lead, a deputy manager, a home manager in 2014 and that's how I ended up being a registered manager. In this particular trust I was given training support so that I could progress. I was given the one to one support supervisions so that they could identify what my skills were and what kind of support was needed and they helped me reach the goal that I wanted.

MR ROZEN: Commissioners, the particular website contains many other similarly inspiring stories and it could potentially or something along those lines could be adapted for Australian conditions and reproduced in the form of an application for smart phone use. This would not be particularly costly and it would be a tangible and practical demonstration of Commonwealth Government leadership in the sector, a topic to which I will return.

Commissioners, the 2011 aged care report by the Productivity Commission predicted that the aged care workforce will need to have at least doubled by 2050 to meet the projected target of 980,000 workers and that three and a half million Australians will be accessing aged care services every year, largely through community-based services. A coordinated approach to workforce planning is required, said the Productivity Commission, to create a much larger workforce with the skills to care for people with forms of dementia and significant levels of frailty or impairment in home or residential settings.

Commissioners, the Royal Commission's interim report observed that Australia's demography is changing in ways that are very significant for the aged care workforce. The report referred to what is known as the aged care dependency ratio which measures the number of people of traditional working age, that is 15 to 64 for every person aged 85 or older. In 1978 that ratio was 101.4 people of traditional working age to every person aged 85 or older.

By 2018, within 40 years, the ratio was 32.5 to 1. It is estimated that decline over the next four decades will be even starker. By 2058 there will only be 14.6 people aged between 15 and 64 for every person aged over 85. These trends have clear implications for the aged care sector's ability to attract the many new workers that it needs in the future. As a country we may need to look outside Australia to fill some of these roles.

Without such an approach, the aged care system which we described in our third Melbourne hearing as under serious strain is indeed at risk of collapsing. Addressing the significant challenges will require new thinking. It will require policy makers and the sector to take some risks, not every initiative will succeed. This must be something we as a community accept. What future generations will not forgive is an unwillingness to learn from the mistakes of the past.

A further complicating consideration is that in its search for a significantly increased workforce the aged care sector is competing with both the acute health sector and the disability workforce. Both of these sectors are growing for many of the same reasons that explain the growth in demand for aged care. Australia's ageing population is challenging for a number of sectors.

In the Royal Commission's Melbourne hearing about workforce in October last year, it heard from the Assistant Branch Secretary of the Australian Nursing and Midwifery Federation, the ANMF, Mr Paul Gilbert. Mr Gilbert told the Commission that he began working as an enrolled nurse in what was then called a nursing home in

the mid-1980s. At that time the workforce was made up nearly exclusively of enrolled and registered nurses. Since that time he has worked as a union representative since 1982. All up he has had 38 years of experience. His evidence was that many of the problems we confront in 2020 have been around for years. During his time with the ANMF Mr Gilbert has worked with the aged care sector representing his union's members in both the private and public sector in Victoria. When asked by Counsel Assisting to identify the issues that resonate from the ground up, what were the concerns of his members on a consistent basis he was asked, his succinct answer was this "Not enough staff. Not enough staff". Simple as that. Mr Gilbert's witness statement provides the Royal Commission with a detailed account of attempts to improve the terms and conditions of employment of aged care workers over his 35 years in the sector. He said that when it comes to staffing numbers in aged care it's time, "To stop kicking the can down the road". Commissioners, Counsel Assisting agree with that observation.

We submit that if the goal of this Royal Commission is to make recommendations to achieve high quality, safe and person-centred aged care services, as it must be under the terms of reference, then the time for real action on staffing numbers and mix, skill levels, remuneration, conditions of work and registration of the unregulated portion of the aged care workforce is now.

As we will explain these issues have been the subject of numerous inquiries and recommendations over the last two decades and these inquiries have repeatedly recognised the same problems and often made the same recommendations to address those problems. Despite this, the problems have persisted and in many ways have become more entrenched. This is, of course, a pattern that bedevils the entire aged care sector. These submissions are aimed at assisting you, Commissioners, to address the problems in a way that will benefit residents in aged care now and in the future, their families, those working in aged care, providers of aged care and ultimately the nation as a whole.

I need to say something about the scope of the submissions we're making today. The first important point to make is that they're limited to workforce questions. Counsel Assisting along with all of those work for the Royal Commission appreciate that the serious problems of our aged care system documented in the Royal Commission's interim report will not be fixed by reform that is solely concerned with the aged care workforce. Such a reform is in our submission a necessary but not sufficient answer to those problems.

Reform is needed in many aspects of the system including regulation, governance and funding to name a few. The workshop you held, Commissioners, in this building a fortnight ago examined some proposed big picture changes to the design of the system. That work will be ongoing in the months ahead. The submissions we make today are but one piece of a complex puzzle. To take one obvious example, significant increases in funding will be needed to pay for the additional staff that will in turn be needed to meet the minimum ratios that we propose. The various pieces are linked.

The second preliminary matter to raise is that these submissions are primarily focused on the residential aged care sector. While we address the workforce challenges of the provision of aged care in private homes in a number of parts of the submissions, we consider the home care workforce raises a number of unique challenges which are better addressed in a separate set of submissions which we will deliver later this year.

We consider there are and will continue to be significant differences between workforce policy in a residential aged care context, which will increasingly be dementia related and end of life clinical care focused and aged care in a home care context will necessarily impose different challenges. The two settings are very different and they call for different and tailored policy responses. Commissioners, Counsel Assisting recognise that numbers alone will not guarantee high quality care. As well as the right number of staff there needs to be the right skill mix to provide the care needed by particular residents.

The quality of the staff must also be high. Staff with the right aptitude but also the right attitude to provide the relationship based care that is person-centred. They are the hallmarks of quality aged care according to the evidence that this Commission has heard. Finally, the staff must themselves be cared for and valued. The evidence in this Royal Commission is that if all of those features are in place care, that is of a high standard and is safe should follow.

Before I address you on five specific areas and outline the recommendations that we, your Counsel Assisting team, consider you should make, two contextual matters are worthy of special mention. The first concerns the changing nature of the residential aged care sector and the second concerns the role of nurses in our aged care system. As will be seen, the two are related.

Are care needs increasing? Commissioners, the overwhelming weight of evidence given to the Royal Commission by general practitioners, geriatricians, nurses, academics, policy makers, advocacy bodies, residents and their families, carers, aged care workers and aged care providers suggests that the care needs of people in residential aged care have increased significantly in recent years. As a witness in the Darwin hearing described it with reference to her mother's experience in care:

The aged care sector has undergone a monumental shift over the past decade, but reform has not kept place. When mum entered the system, the majority of resident were low care. The facility was essentially a supporting living arrangement where meals, laundry, cleaning and medical services were provided but normal life continued to a substantive degree. By the time mum was deemed high care, the centre had also morphed much like a frog in boiling water into a secure dementia facility where the doors no longer opened without code access and hoists, electrical hospital beds and medical paraphernalia were the norm. The situation had effectively reversed with the majority of residents high care patients and around half suffering some form of dementia. Their needs are greater than ever before and the work of the carer so much more important.

Commissioners, the Resource Utilisation and Classification Study, or RUCS as it's known, undertaken for the Department of Health by the Australian Health Services Research Institute at the University of Wollongong undertook profiling of approximately 5000 people receiving aged care for classification development purposes.

Professor Eagar who led that study gave evidence in the Melbourne 3 hearing as you will recall. Professor Eagar pointed to compelling evidence from the study that shows the majority of residents currently in residential aged care are very frail and have significant care needs. Professor Eagar referred to the aged care residents who were assessed as part of the RUCS studies and noted that the cohort was a representative sample of residents living in residential aged care across Australia in 2018. The overall finding from the studies is that residents are typically very frail with significant care needs, she told us. Specifically, only 15 per cent of the residents are independently mobile. 35 per cent cannot mobilise at all and are therefore at highest risk of pressure injuries.

Nearly 90 per cent need assistance with bathing and showering. Nearly two-thirds need assistance with eating. 80 per cent need assistance with toileting and two-thirds need support because of communication problems. In her evidence, Professor Eagar proposed a focus on clinical care in residential aged care in response to those needs. She said when people describe residential aged care as a person's home, it is somehow implying that it's a lifestyle choice rather than people are going into residential aged care now because they're so frail or have other significant care needs that they can no longer be at home.

She told us that the population currently in care needs more clinical skills, not less. Professor Eagar's view is supported by other evidence that is before the Royal Commission. For example, in 2004/5, 62.9 per cent of people in residential aged care were classified as having high care needs. By 2016 this proportion had increased to 92 per cent. Four years later in 2020 it's no doubt higher and rising. Modern medicine has developed to a stage where Australians live longer despite multiple medical illnesses. The people most in need of residential aged care therefore are likely to be frailer and sicker and the complexity of their care needs greater.

To use one example, in 2015 over half of people living in residential aged care had five to eight long-term health conditions while one in five had nine or more such conditions. Also significant to the delivery of aged care services is the expected increase in the number of people with dementia as a leading cause of disability in older Australians. An estimated 365,000 Australians had dementia in 2017, 99 per cent of whom were aged 60 and over. Australia does not have national data that can provide reliable prevalence estimates of dementia but estimates about the current and future prevalence of dementia are primarily based on continued ageing of the population and the assumption that the age specific prevalence of dementia will remain consistent.

The Australian Institute of Health and Welfare estimates that in 2018 some 376,000 Australians had dementia. The total number is estimated to increase to over half a million by 2030. The rise in scope and complexity of health care needs for people in residential aged care can also be attributed to people entering that environment later in their life than previously. Over the last 10 years entry to permanent residential aged care has tended to take place much later in life. These general health trends need to be understood in the context of an aged care system that has changed significantly over the last 20 to 25 years. Over this period we have seen a shift away from people entering care with lower needs and for social reasons.

People now enter aged care at a later stage due in part to the effectiveness of home care in supporting individuals to live at home for longer. People with lower acuity prefer to remain supported at home for as long as possible, and so the proportion of lower needs care recipients in residential care is declining. These trends have been borne out in evidence during the Royal Commission's public hearings. For example, Ms Butler from the ANMF noted that there's drift towards residential aged care now being more subacute facilities. And the point was echoed by Peter Jenkin, a palliative care specialist who gave evidence in the Commission's Canberra hearings. He noted:

I think we have moved very much from a social model, a housing model in aged care to what really is subacute care these days. People are coming in older, sicker, frailer, multimorbidities and are needing much more care, and they're coming in because – they're coming in significant numbers of them needing palliative care in the first instance.

And Nikki Johnston, a nurse practitioner who worked in palliative care gave similar evidence which we have quoted at paragraph 41. The second threshold issue is the importance of registered nurses in aged care. Commissioners, aged care workforce census data shows that registered nurses comprised 21 per cent of the residential direct care workforce in 2003 but this proportion had dropped to 14.9 per cent by 2016. This represents a decrease of more than 25 per cent. The proportion of enrolled nurses had dropped from 14.4 to 9.3 per cent over the same period, and the proportion of direct care employees working in allied health had dropped from 7.6 to 4 per cent.

In contrast the proportion of the residential direct care workforce who are unregistered and in many cases unqualified personal care workers increased from 56.5 per cent to 71.5 per cent. These trends are revealed in the graph which will now be displayed on the screen from the AMA submission to the Royal Commission. It's at page .0017 – there it is. Perhaps if that could just be increased in size, please, and the yellow line at the top, Commissioners, is the period between 2003 and 2016. The yellow line shows the increase of personal care workers as a proportion of the overall workforce, and you can see the orange line, the decline in registered nurses. The allied health line is the blue where measurements have only been made in the last four years.

What these statistics show is, in summary, that care work that was being performed by qualified nurses, physiotherapists, speech pathologists, etcetera, is now being performed by unqualified, unregistered and, in many cases, untrained personal care workers. It is hardly surprising in these circumstances that this Royal Commission has received thousands of submissions by members of the public complaining about the substandard care being provided in residential aged care. These trends are also revealed in other data. That data reveals that in 2010, 19 per cent of direct care in those aged care facilities caring for those residents with the highest care needs was delivered by registered nurses. By 2019, this had dropped to 12 per cent.

Commissioners, why does this apparent exodus of nurses from our aged care system matter? Dr Deborah Parker, Professor of Aged Care (Dementia) at the University of Technology Sydney and chair of the Ageing Policy Chapter of the Australian College of Nursing gave evidence in the first Adelaide hearing. Dr Parker explained that the College of Nursing holds the view that care delivered in residential aged care facilities must be led by registered nurses. Due to the growing prevalence of comorbidities associated with physical and cognitive decline, polypharmacy, and greater professional accountability, increasingly the residential aged care population requires more complex care that can only be provided under the direct supervision of RNs.

Referring to the scope of practice of an RN, Dr Parker explained that RNs provide frontline leadership in the delivery of nursing care and in the coordination, delegation and supervision of care provided by enrolled nurses and unregulated health care workers and she concluded that the continuous presence of an RN is essential to ensure that timely access to effective nursing assessment and comprehensive nursing care and the evaluation of that care. Dr Parker proposed that this Royal Commission should recommend that the Australian Government should mandate that an RN be on site and available at all times in residential aged care facilities as a minimum. Counsel Assisting endorse this proposal. And I will return to that in a little more detail presently.

While we recognise that the evidence shows that residential aged care is best provided by multidisciplinary teams involving a range of medical professionals including doctors, nurse practitioners, allied health practitioners and others we submit that for too long the role of nurses, especially registered nurses, has been downplayed in our aged care system. We submit this is one of the mistakes of the past that must be confronted if the aged care system is to provide high quality and safe care in the future, having regard to the characteristics of the cohort in residential aged care that I have just outlined. This evidence about the crucial role of RNs in residential aged care is supported by considerable evidence before the Royal Commission. I won't read out that but I note that there's evidence referred to at paragraphs 52 and 53 in relation to that.

Turning then to paragraph 54 of the document, the vital importance of registered nurses being rostered to work in residential aged care facilities at all times was brought home by a recent coronial case in Victoria. John Reimers died on the 17th of

December 2016 at the Mayflower Residential Aged Care facility in Reservoir in suburban Melbourne. Mr Reimers had fallen from his wheelchair and his head had become trapped in the bottom drawer of his bedside drawers. In her findings dated 23 August 2019 the coroner found that the enrolled nurse and a personal care attendant on duty had not adequately cared for Mr Reimers between the time of his fall and the time an ambulance attended by which time Mr Reimers had died. The quality of the first aid he received was inadequate.

The coroner found there was no registered nurse rostered on duty that night although there was one on call. The coroner questioned both the training of the care worker and the leadership abilities of the enrolled nurse. In handing down her findings, Coroner Jamieson concluded that the circumstances of Mr Reimers' death:

...have highlighted a concerning norm in aged care. Staffing to patient ratios administered at minimalistic levels which places the delivery of appropriate care at risk. Additionally, the delivery of appropriate care is being further compromised by an industry approach to employing enrolled nurses to act in charge of their shift. In many cases the enrolled nurses are supported only by a minimally trained group of care providers who by their mere dominance of presence in the sector give the impression that they have the status of a profession.

The coroner recommended:

...that the Federal and State government health departments legislate minimum ratios of nursing staff to patient residents of aged care facilities as prescribed by national standards –

that she referred to. Commissioners, in the submissions we ask what's in a name. It may be no coincidence that the reduction in the proportion of nurses in the aged care workforce noted by the coroner in those findings has coincided with a change in the name of our aged care homes from the comforting and familiar nursing homes to the impersonal residential aged care facilities. Commissioners, perhaps it's time to accept that the term nursing home was the right one all along.

Commissioners, I would like to say briefly a little about the structure of the submissions that I will be outlining today. We commence in part 2 with a detailed examination of staffing numbers and mix and we propose a new legally enforceable requirement for mandatory minimum staffing levels in Australian residential aged care for the first time since the passage of the Aged Care Act in 1997. In part 3 of the submissions we address the need to improve the education, skills and training of aged care workers. A discussion of the ways in which the unregistered portion of the workforce can be professionalised by compulsory registration appears in part 4 of our submissions. This is followed in part 5 by a discussion of the terms and conditions of employment of aged care workers. And finally, and certainly not leastly, part 6 examines the important question of leadership and workforce planning and proposes some recommendations for improvements.

Commissioners, as you are well aware, this Royal Commission has been operated on a highly consultative basis. It has been very well supported by the public and we are, of course, very grateful for that support. As at 14 February 2020 the Royal Commission had received a total of 8058 submissions. Of these, 54 per cent have raised concerns about substandard or unsafe aged care facilities and 53 per cent just over half, have raised concerns about staffing issues, including ratios. In addition, many of the members of the public who have attended the community forums organised by the Royal Commission have raised these same concerns.

Witnesses at our public hearings have been selected from those who have made submissions and those who have attended our public events, and as I told the Melbourne 3 hearing in October last year, 85 per cent of the 296 witnesses who had given evidence in the public hearings to date had raised concerns about the aged care workforce. Since then we have, of course, held further public hearings. That trend has continued. In preparing these submissions, we have been guided by the evidence that has been presented to the Royal Commission and the latest Australian and international research. We have produced what I'm sorry is a very long document because we have tried to do justice to the wealth of evidence at our disposal. We have also taken account of previous reports and inquiries where appropriate.

Commissioners, the length of the submissions means that reading them out in full is not practical. I will merely note what we have written in some parts and I will be reading out others. We, of course, rely on the entire document which we commend to you. And the full submissions will appear on the Royal Commission's website today. I turn to the topic of staffing numbers and mix which appears on page 15 of the document. Commissioners, in the interim report, the Royal Commissioners wrote as follows:

Our final report will give close consideration to options to ensure staffing levels and the mix of staffing are sufficient to ensure quality and safe care.

In this part of these submission we examine those options and we ultimately conclude that the most efficacious way of ensuring high quality and safe aged care in a residential setting is by imposing requirements on providers of that care to have a minimum number of care staff in a mix that takes into account the care needs of their residents. We submit that the evidence demonstrates that requiring minimum staffing numbers is a necessary but not sufficient step towards improving the quality and safety of aged care. The other steps that are specific to the workforce include improved training, better management and more attractive terms and conditions of employment.

More broadly, these workforce reforms cannot expect to be effective unless they're introduced as part of a package of reforms that addresses other defects that have been identified in the Royal Commission's interim report. There are too few workers in aged care. In earlier hearings, the Royal Commission has heard from a range of witnesses that staff who are working in aged care do not necessarily have the required skills and training to assist vulnerable people in their care and there just

aren't enough of them. The Commission has heard the sworn testimony of many family members of elderly people in care. These deeply moving accounts demonstrate the reality behind the statistics. I will refer to a small selection of these accounts.

The first is from Mrs Lisa Backhouse who gave evidence at the Commission's Darwin hearings in July 2019. Ms Backhouse described her mother's experience of two residential care facilities in New South Wales between 2016 and 2019. She just explained in her evidence how her mother had a fall in 2018 and then she told the Commission:

In the months leading up to this incident I had been increasingly concerned about the number of times Mum was found on the floor by nursing home staff. Staffing levels had reached such a low level that carers were unable to perform basic duties. Early in 2018 I had a series of conversations with staff at the facility about checking on Mum more frequently during the afternoons. I recall on one particular day I asked a carer during a conversation in the facility's hallway to please check on Mum in her room to try and prevent her being found on the floor. I was told, "I'm sorry, I just don't have time".

Reading towards the bottom of the page, Ms Backhouse told us:

Adequate staffing levels should be provided to allow for a contingency including the management of priority situations without the safety and wellbeing of other residents being compromised.

She told us:

This issue goes directly to the need to mandate staff to resident ratios to ensure adequate numbers of staff are available at all times. Without this being enforced facilities are able to not replace staff who are unwell or fail to attend shifts resulting in cost savings to the providers to the detriment of residents' safety and wellbeing.

Commissioners you will recall the evidence you heard in Hobart about the provider Bupa doing just that under the guise of a program called Save A Shift. Returning to Ms Backhouse's evidence, she told the Commission:

Politicians are great at kicking the can down the road delaying public policy imperatives such as mandating minimum staff to resident ratios. Ask any family member of an aged care resident and they will tell you that you can shoot a cannon down the empty corridors on weekend and afternoon shifts in particular. I've observed that residents are often left sitting in chairs all day long, more often than not in soaking incontinence aids, lying on the floor unable to mobilise after falls, unable to reach fluids or with spills covering them. Sometimes they have pressure sores and infections that go unnoticed in the busy task-focused environment.

Even the best facilities are operating a staff to resident ratio of around one to eight. That means the most basic care needs such as bathing, dressing, feeding and toileting are just being met. Sometimes not. There's no time for true care where humanitarian and comfort needs are also met in a proactive way.

Commissioners, the second brief extract from the evidence is from a witness who was referred to as DJ at the Sydney hearing. DJs mother was in a residential aged care facility and DJ told us that:

There was no one around to help my mum. I went around the facility doing laps of the corridors trying to find a nurse or just someone to assist. I felt quite panicked at this stage and my sister and I pretty much were taking turns running around looking for help and then one of us would stay with Mum. This went on tore at least 30 minutes before we could find someone to help us. Even when we were able to find people we felt they did not know how to handle the situation.

Finally, Commissioners, in one of the most heartbreaking pieces of the evidence we have heard in this Royal Commission, I refer to the evidence of Ms Diane Daniels at the Hobart hearings. Ms Daniels' mother was in a residential aged care facility in south Hobart in 2017. Ms Daniels had described to the Commission a meeting she had with facility management to discuss her mother's care and her concerns about staffing levels:

> *On Tuesday, 14 March 2017, 11 days after this meeting, I sent an email to facility manager David Neil and regional support manager Elizabeth Wesols explaining that on Sunday at 11.50 am mum had somehow hit a redial button on her phone and called me. Mum did not realise that she had done this. I could hear that mum was calling out for a nurse and getting more agitated. Because it was lunchtime I thought someone would come into mum's room but I could hear that no one did. But I waited and mum began sobbing and saying, "I wish I was out of it" and this broke my heart.*

There's a small selection of similar accounts. If there's one constant theme running through all of the hearings it is the concern raised with the Commission about the lack of appropriate trained staff in residential aged care facilities and the impact of the staff shortages on the quality of care. We have also, of course, heard from many people who worked in aged care. I refer at paragraph 76 to a submission that was made to the Commission by an experienced registered nurse working in residential aged care, I won't read that out but she makes the point about the ageing group of workers of which she is part and she wonders whether younger people will replace them.

Commissioners, at paragraph 77 through to 79 we also make reference to some of the evidence that has been provided in the form of responses to surveys that have been conducted by trade unions where their members were asked to identify concerns they had, that is members working in aged care and the statistics show both in relation to the ANMF members and also the Health Workers Union members – that is, the

nurses and the personal care workers respectively – that a large proportion of those that responded to the surveys – and they were quite significant numbers of respondents – raised concerns about staffing levels and workloads in the facilities in which they worked.

Is there a link, Commissioners, between substandard care and staffing levels and mix? We heard Professor Harrington this morning in no doubt from her research there is such a link but what does the evidence before this Royal Commission say. In my submission, Commissioners, the evidence is clear. It reveals a disturbing extent of substandard care, that there's not enough staff and never enough time to do the work, that aged care workers work in poor and sometimes unsafe conditions and lack the training that is required of them to perform all facets of their work.

We summarise that evidence in the submissions starting from paragraph 81 through several pages which I will not read out, but if I can summarise the evidence under several headings. We note that the Commission has heard evidence from experts in a range of clinical fields. It has heard evidence from experts in continence care, in fall prevention, in wound management, in nutrition, in dental health and in palliative care. Commissioners, between paragraphs 81 and 108 of the submissions, we summarise that evidence, particularly from the Darwin and Cairns Hearing where so much of that evidence was given, and we submit that there are two themes that run through that evidence.

In relation to each of the specialty areas, take continence care as an example, the experts' evidence to this Royal Commission is that continence care is poorly managed as a general proposition in residential aged care and the related proposition when asked about why that is the case, is that the evidence clearly establishes that it's a combination of not enough staff to address the particular need that the expert was talking about, often combined with a lack of training of those staff in addressing the particular area of need, be it continence care, oral health, palliative care and so on. That evidence with the references is set out through to paragraph 107.

If I could turn, then, to page 26 of the submissions, Commissioners. You will see a heading at the bottom of the page "A Question of Philosophy". Commissioners, in 2019, the Royal Commission engaged Professor Kathy Eagar of the University of Wollongong to produce a report entitled, "How Australian residential aged care staffing levels compare with the international and national benchmarks". Professor Eagar, who is one of the six co-authors of that report and is director of the Australian Health Services Research Institute, was, was you will recall, the first witness called by Counsel Assisting in Melbourne Hearing 3.

We submit that the report produced by Professor Eagar and her colleagues is a very important part of the evidence before this Commission. It grapples with the key issues between the relationship of quality and safety of care on the one hand and staffing levels on the other. It's practical in its approach and it acknowledges that the adequacy of staffing levels is just one necessary component of the overall reform needed in our aged care system. We rely heavily on the report of Professor Eagar

and her colleagues. The report commences with an examination of what is referred to as the changing policy context of the Australian aged care sector in the last 30 years. There's two important features of that that are worthy of special note.

The first is the introduction of the Aged Care Act in 1997 sought to reframe the role of residential aged care services as being people's homes and to move away from the institutionalised model of care that previously dominated the sector. The Act also included provisions to underpin the expansion of community aged care services to allow older people to stay living in their homes longer which in turn has resulted in people having much higher levels and/or complexity of need by the time they enter residential aged care. The report explains, and I quote:

> *This reconceptualization of residential aged care as a home has inadvertently encouraged the development of a workforce that is less clinically skilled and oriented with greater reliance on lower skilled personal care workers. Similarly, there has been limited incentive for either government or the sector to invest in systems that routinely capture and monitor resident needs or outcomes over time.*

Professor Eagar was asked by Counsel Assisting to expand on the first sentence in this passage – that is, the reconceptualization of residential aged care as a home. She replied that when people described residential aged care as a partner's home it's somehow implying it's a lifestyle course rather than people going into residential aged care now because they are so frail or have other significant care needs and can no longer be at home.

Professor Eagar responded to the workforce survey and noted that overall there has been a reduction in the proportion of direct care employees and the total residential aged care workforce during the period since 2003. Professor Eagar drew the Commission's attention to the trends revealed in the four yearly aged care workforce surveys that I alluded to earlier, particularly the decrease in the proportion of registered nurses amongst the workforce.

Before one can consider how to respond to the developments described by Professor Eagar and experienced by so many of the witnesses that have given evidence at the Royal Commission, it's our submission that it's necessary to understand how these developments have come about. Professor Eagar who drew specific attention to these changes was asked about the trends by Counsel Assisting. She explained the staffing changes had resulted in more staff with minimal training working as direct care providers. As noted above, this occurred as part of a policy of making residential aged care more homely.

Professor Eagar was asked by Commissioner Pagone if the driver for these changes had been to provide homeliness or as an economic driver about returns on investments. Professor Eagar's response was as follows:

I think the driver was actually economic, but it was also a driver from consumers that they wanted a more socially engaged less institutional, a less patronising model of care. So I think it's a combination but I think it has been an unholy set of interests to come together to have a deskilled workforce and I'm not sure consumers would actually believe that the workforce has actually given them what they wanted, a less institutional feel.

And she concluded:

I think the reduction in health professionals has been largely economic.

Commissioners, in our submission this evidence is concerning. Professor Eagar, who has had years of experience as an observer of aged care and health sectors has told the Royal Commission that the aged care providers have deliberately reduced their ability to cater for the clinical and health needs of the residents in their care by replacing qualified nurses with minimally qualified personal care workers. And as noted above, this has occurred at the very time that the clinical and health needs of those residents has been increasing.

What's more, the process has been overseen by policy makers who must have been aware of the trends from the four yearly government run surveys. And it has been permitted by successive aged care regulators. In our submission, it represents the deregulated aged care market in operation. As a former Commonwealth public servant, who was part of implementing those changes in 1998, said in a submission to the Royal Commission, it stemmed from what she referred to as the "religion" that the Aged Care Act was outputs based and did not stipulate inputs. Commissioners, you will recall the evidence from Professor Harrington about the distinction between regulating outputs and inputs.

The incentive to deskill the staffing mix in residential aged care was identified as long ago as 2011 by the proficient Commission in its report Caring for Older Australians. The Productivity Commission reported as follows:

Under current arrangements, providers in seeking to minimise costs have an incentive, particularly in an environment of high occupancy rates, to employ a high proportion of lower qualified (and therefore less expensive) care workers. A high proportion of lower qualified workers means that nurses working in aged care facilities can experience excessive workloads where they spend a large proportion of their time on administrative tasks (as they are effectively managers) rather than on caring. This in turn can drive nurses away from aged care to acute care settings.

Finally, Commissioners, and perhaps most concerningly of all, these trends are precisely what the government of the day was warned would happen when it introduced the Aged Care Act in 1997. In 1997 the Senate Community Affairs References Committee Report on Funding of Aged Care Institutions examined the impact on quality and equity arising from the proposed changes to aged care

arrangements that were set out in what was then the Aged Care Bill 1997. In our submission this report is particularly important to the work of this Royal Commission because it provides an understanding of how the Aged Care Act took the form that it ultimately did.

The Committee examined the implications of the fundamental change in funding arrangements that were proposed by the Aged Care Bill. The previous arrangements required nursing homes to acquit a portion of their funding, a so-called care aggregated module, or CAM as it was known, against expenditure on direct care and duties with the compensation of ensuring quality of care and providing nursing homes with more flexibility in staffing levels. The proposed change would see nursing home operators, and I quote the report, 'receive a single non-acquitted payment for each resident instead of the existing fund structure based on CAM and also the standard aggregated model, SAM, which covered expenditure food and electricity, etcetera.'

The new payment was called the resident classification scale. It was in turn replaced by the aged care funding instrument or ACFI about which we have heard so much in March of 2008. In a submission to that report, concerning the abolition of CAM funding, the New South Wales Nurses' Association expressed the concern, and I quote, that:

> *Under the proposed system there is a real danger that proprietors will attempt to maximise profits by deskilling their workforce and thereby compromising care given to residents.*

The Committee accepted this evidence and recommended:

> *That nursing homes continued to be required to acquit that proportion of their funding expended on nursing and personal care.*

On the question of ensuring that nursing homes employ appropriately qualified nursing staff the Senate report noted:

> *As a result of comments provided on an exposure draft to the Aged Care Bill, division 54 was amended to include a requirement that nursing homes maintain an adequate number of appropriately skilled staff to ensure that the needs of care recipients are met.*

And this, of course, is now section 54(1)(b) of the Aged Care Act 1997. The report noted the concerns expressed by the New South Wales College of Nursing about the absence of any definition of the terms "appropriate" and "adequate". And Commissioners, you will recall Professor Harrington giving similar evidence about the law in the United States some uses similar, very general terms. And the New South Wales College of Nursing said this:

Without those terms being defined we simply can't guarantee the safety and high quality care that is dictated by their needs.

That is the residents' needs:

Because not only do they require qualified registered nurse care to a great extent but it cannot be given without those nurses employed and more so without nurses who have specialised qualifications in the area.

The New South Wales College of Nursing had drawn to the committee's attention that:

There are increasing numbers of people being admitted to nursing homes with severe multi system disorders and illnesses that require the equivalent of services that are provided by acute medical units in teaching hospitals.

And as, of course, you are well aware, these trends have continued unabated in the subsequent 23 years. The report noted from the New South Wales Nurses Association that under the proposed reforms:

Nursing staff numbers, skills and the level of experience and expertise will be systematically reduced. Non-nursing staff will be forced to carry the role of nurses and in the end care for residents will suffer.

Commissioners, given the relevance to the work of this Royal Commission in 2020 the Senate committee's conclusions and recommendations published in 1997 are worth setting out in full. And we do set those out in paragraphs 127 and 128. I won't read out the findings but I will refer to the recommendations at paragraph 128. The committee recommended firstly that nursing homes continue to be required to acquit that proportion of their funding expended on nursing and personal care. It remained that the accreditation standards and quality assurance system provide for the employment of appropriately skilled and trained nursing staff to ensure that quality of care is maintained in aged care facilities and that the aged care standards agency monitor the ratio of trained nursing staff to the resident in nursing homes through a transparent reporting procedure which would signal significant change in the ratio.

Commissioners, the recommendation of the inquiry were not accepted by the government of the day. The government's response to the committee's report is recorded in Hansard on 2 December 1997, Senator Campbell representing the, presented the government's response to the committee's report and said as follows:

The Senate passed the Aged Care Bill on 27 June 1997 which then received royal assent on 7 July 1997. The government does not intend to respond further to this report.

Commissioners Briggs may recall the evidence given by Mr Paul Versteege, representing the Pensioners and Superannuants Association told the Commission that leaving it up to individual facilities to determine what constitutes appropriate staffing levels and what constitutes an appropriate staff qualification mix has had the predictable consequence that qualified nursing staffing levels have declined. His evidence was, in our submission, to the effect that the trends that have been observed since 1997 were foreseeable trends for the reasons explained by the Senate Committee.

Returning to Professor Eagar's evidence, she told the Commission that this philosophical approach which conceptualised residential aged care facilities as homes has become what she referred to as a justification for failing to prioritise clinical governance and care. And in turn this has hampered the development of evidence based policy development and resourcing. Taken together, these factors have worked against the development of a credible evidence base regarding the needs of residents in care. And we note, Commissioners, that deponents of minimum staffing ratios rely to this day on the characterisation of a residential aged care facility as a home and not a hospital. In our submission, they ignore history.

Finally, Commissioners, as Professor Eagar noted the more successful we are in providing genuine options for people to stay in their own home, the more the cohort that go to residential aged care will be extremely high need. Turning then to the first recommendation that we propose, which you will see on page 33. That recommendation is that an approved provider of a residential aged care facility should be required by law to have a minimum ratio of care staff to residents working at all times. The ratio should be set at the level that is necessary to provide high quality and safe care to the residents in its facility and should be based on the following.

Firstly, it must be sufficient to achieve a four star rating under the current CMS staffing rating as adjusted for Australian conditions. I will return presently to that. Secondly, average case mix total care minutes are between 186 and 265 minutes per resident per day delivered by a trained workforce comprising nurses and personal care workers. A minimum of 30 minutes of registered nurse care time per resident per day. In addition, at least 22 minutes of allied health care per resident per day on average. And there be present a registered nurse on each shift and available to direct or provide care subject to limited exceptions. Commissioners, the Royal Commission is proposing mandated staffing ratios to address the staffing and skills mix requirements of aged care facilities. The Commission has heard evidence from advocates for and opponents of mandatory staff ratios. We set out at paragraph 134 the two arguments that are generally advanced in favour of staffing ratios, and they are consistent with the evidence that was given by Professor Harrington this morning. Arguments against ratios or rather sometimes issues that make implementation of mandatory ratios challenging include, firstly, that staffing ratios cannot be set until there is clarity around the expectations and aims of residential aged care facilities.

This point was made by a number of providers and provider peaks in submissions to the Royal Commission. Secondly, as noted by peak body, LASA, it's hard to identify the staffing required to deliver good care when we cannot clearly agree on what good care looks like. Thirdly, staffing ratios will vary depending on the model of care. For example, while ratios may be able to implemented in institutional settings, there may be challenges translating them to cottage-style aged care which is a desirable development, of course. Related to this, having a set staffing ratio could stifle innovation around models of care and, finally, we don't currently have sufficient understanding of the range of care models in Australia to set an appropriate staff ratio.

The Royal Commission has received a range of views in its evidence and we refer to the evidence of the aged care taskforce which I will take you to in more detail presently. The taskforce concluded:

> *There's no single optimum number of staff or combination of staff qualifications that will result in quality aged care in all circumstances. Rather, the number of staff required will change according to the varying needs of those individuals, the service or facility size and design, the way work is organised, including the extent to which services are outsourced and ultimately the business model.*

However, significantly, in our submission, in the context of the first Adelaide hearing, Professor Pollaers who chaired that taskforce advocated for mandated minimum staff ratios, and I quote from a letter that Professor Pollaers provided to the Royal Commission. He said:

> *The only way we can be sure that every elderly Australian has access to the safe and best practice care they deserve is to legislate minimum staffing ratios in aged care that deliver the holistic care plans required. This is not about nurse ratios but the full suite of skills required to deliver holistic care.*

We note in the remainder of this section, submissions that we have received from both proponents for and opponents of minimum mandatory staffing ratios and I won't read out the summary of that evidence. It's consistent with those two approaches that I have indicated. Turning to page 36, Commissioners, and we ask what is the right level of staffing and skills mix. And we examine in this part of our submissions, the US Centres for Medicare and Medicaid Services research, that is the CMS research about which Professor Harrington spoke this morning, and Professor Eagar and her colleagues deal with at length in the University of Wollongong report. We note that Professor Harrington in her statement, Exhibit 15-1, refers to the CMS research as the "gold standard on minimum staffing levels since 2001".

Commissioners, at paragraph 145, we submit that research undertaken on behalf of the CMS in the United States from 2001 substantiated a case for prescribing staffing levels. The CMS phase 1 study found a strong relationship between staffing and quality. The phase 2 study identified the following staffing mix and direct care hour

thresholds required to meet the recommended government standard of 4.1 hours per resident per day of total direct care. The threshold ranges depend on the acuity of the resident. We note subsequent research, both overseas and in Australia in the remainder of this part of our submissions.

In particular, towards the bottom of page 37, Commissioners, we note the work commissioned by the ANMF from Flinders University and the report that is in evidence from 2016 entitled National Aged Care Staffing and Skills Mix Project report and we seek in this part of our submissions to summarise the contents of that report. We note at paragraph 153, that there are estimates for daily care hours which form the basis of the calculations in that report and they are based on the amount of time ideally required, given a resident's characteristics, rather than the actual time taken in environments where there may be staffing constraints. And the ANMF witnesses, particularly Mr Bonner in Melbourne hearing 3, were very keen to emphasise that that was the basis upon which those calculations were made.

At 154, Commissioners, we summarise that the researchers in that report concluded that:

> *Aged care residents should be receiving an average of four hours and 18 minutes of care per day for safe residential and restorative care.*

And the report authors proposed that:

> *Mandated staffing arrangements with minimum direct care hours, nurse ratios and staff mix needs should be implemented over a transition period from 2019 to 2025. The proposed skill mix requirement is 30 per cent registered nurse, 20 per cent enrolled nurse and 50 per cent personal carer.*

And if I could just pause in the reading, Counsel Assisting accept that a phasing in or a transitional approach to the implementation of ratios will be necessary in Australia. The second report to which we refer to in considerable detail in our submissions is, of course, the report by Professor Eagar and her team from the University of Wollongong. We note at paragraphs 155 to 156 that it was based on the RUCS study which I have already referred to, and at 157 we note the conclusions of the report which are threefold. Firstly:

> *That the current average care time per resident per day in Australian residential aged care facilities is 180 minutes including 36 minutes of registered nurse care time.*

The authors concluded that to achieve the three star rating under the CMS Australian facilities would need to deliver a minimum of 215 minutes of direct care per resident per day including at least 30 minutes of RN care, and to achieve the four star rating under the CMS Australian facilities would need to deliver a minimum of 242 – the document says hours of care, it's actually minutes of care that should be provided. Commissioners, we don't read the next paragraphs which set out some more detail

explaining the basis for the conclusion by the authors of that report that it was legitimate to make a comparison between the Australian residential aged care sector and the American aged care sector on the basis of the countries being similar enough economically, socially and in other respects to make that comparison, and you may recall that I asked Professor Eagar about that and she gave evidence about that.

Turning then to paragraph 163 on page 40, Commissioners, we note the American system takes into account both nursing hours and total care hours. It does so in a manner that gives additional weight to nursing hours. As Professor Eagar explained:

> *30 minutes of registered nursing time is not equal to 30 minutes of a personal care worker. It is absolutely worth more. It costs more but it's worth more.*

And you will recall the evidence of Professor Harrington about that matter this morning. Commissioners, the system that we propose is flexible in that it permits several different combinations of nursing and care staff to reach the same star rating level. As the University of Wollongong report explains:

> *The system allows homes some flexibility around their specific skill mix while still ensuring a minimum level of care.*

For example, as can be seen from the table on page 42 there are nine staffing combinations that can be employed to obtain a three star rating and there are six combinations which will achieve a four star rating. Commissioners, if you can turn to the table, you will see the darker green boxes are ones where a combination of total care minutes and registered nursing minutes lead to a combination that achieves a four star rating. To break this down a little further, Commissioners, as we say at paragraph 165, a home could achieve a four star staffing rating by employing registered nurses in sufficient numbers to provide each of its residents on average with 31 minutes of nursing care per day provided the total number of care minutes provided is an average of at least 264 minutes.

Similarly, three hours and 53 minutes of care would have to be provided by staff who are not registered nurses. Alternatively, four stars could be achieved by decreasing the total daily care time to three hours and six minutes provided that at least 63 minutes of that care is provided by registered nurses. Only two hours and three minutes of care time would need to be provided by staff who are not registered nurses to achieve the four star rating.

Professor Eagar's evidence is this sort of system allows for homes to have a quite different mix of staff depending on the unique needs of the residents. We set out then some detail which I won't read out about the calculations involved in determining the particular star ratings, and we note that there is further detail there explaining how one calculates three and four stars.

Commissioners, turning to the topic of allied health about which some questions were asked of a witness this morning. This is on page 44. We note that Professor

Eagar considers a significant limitation of the US system is it doesn't include allied health staffing needs. Professor Eagar points us to the situation in British Columbia and ultimately concluded that a component of allied health as part of the minimum staffing requirements is an appropriate approach to take for the reasons we set out in the submissions.

And finally, Commissioners, before leaving the report, we just draw your attention to paragraph 256 on page 45 where we set out the key conclusions that Professor Eagar reached. Commissioners, you will see at the bottom of that page there's a heading counsel's proposed mandatory minimum staff ratio. Our submission in relation to staff ratio is a model should be adopted that would attain a four star rating under the current system.

Professor Eagar in her report told us that in her judgment a three star rating is what she described as acceptable. Four stars is good. In her statement she indicated that three stars is the level at which facilities below that level are likely to experience quality problems. We submit, Commissioners, the Royal Commission should determine that the mandatory minimum staffing levels should be structured to require facilities to staff at a level that would enable them to attain a four star rating. Noted that there are six combinations set out in the analysis which is explained in the University of Wollongong report. In addition to nursing and personal care staff, facilities should be required to provide minimum levels of allied health care as we have noted.

Commissioners, we deal in some detail with the particular challenges that we anticipate may be faced by at least some operators in rural and remote regions in complying with such a requirement. We deal with that, as I say, at paragraph 263 and the principal submission that we make is summarised at paragraph 267 about this. And that is, that our starting point in relation to this is, Australia can't have two aged care systems.

If one accepts that adequate staffing is vital to ensure that care recipients receive high quality and safe aged care, that must hold true whether the care recipients are in suburban Sydney or remote Western Australia. What we mean by Australia can't have two aged care systems, we can't have different levels of quality applying in some aged care facilities compared to others. Other laws, we note, at ensuring safety, such as those concerned with workplace health and safety, apply in an identical fashion in all Australian work places regardless of the financial health of a particular employer. So do minimum wage laws. And we submit aged care laws should be no different.

It may be that as is the case under the Victorian laws which prescribe minimum staffing ratios for nurses in public sector aged care facilities that there should be some scope for exceptions in appropriate cases which would need to be justified. We draw your attention to the evidence that was given by Ms Peak, the Secretary of the Victorian Department of Health, who told the Commission that that exception of the

Victorian laws allows a health service to vary staffing requirements with the primary consideration being the impact on the quality of patient care.

It may be necessary to have a similar mechanism in the Commonwealth legislation giving effect to this recommendation. We make some other submissions there about some examples of approved aged care providers in rural and regional areas who have engaged in some innovative thinking in relation to staffing and we commend that evidence, that part of the submissions to you.

On page 49 Commissioners, we deal with what we propose to be the recommendation for there to be a registered nurse on every shift and we note that there are such requirements in a number of jurisdictions. We summarise that evidence at paragraph 283 and in our submission, that is justified on the basis of both the evidence that you have heard including the evidence that we heard earlier today about what the research tells us about the presence of registered nurses in relation to its impact on quality. On that basis, Commissioners, we support a recommendation that would require there to be a registered nurse on every shift in residential aged care.

Commissioners, at paragraph 51 we propose a related recommendation which is concerned with increasing transparency. It is Recommendation 2, which is in the following terms. All approved providers must provide the Department with quarterly staffing levels for registered and enrolled nurses, allied health and other care staff by shift in residential aged care. The proposal is the department would publish this information at a service level and there needs to be clear explanatory material to enable them to understand the published information and to make appropriate comparisons of services. We note the research about transparency and we summarise some of the submissions that have been made to the Royal Commission in support of the proposal for there to be transparency in relation to staffing numbers and skill mix.

In summary at paragraph 300, Commissioners, at the top of page 54, we submit the Royal Commission should recommend along the lines set out in that Recommendation number 2. Commissioners, before I leave the topic of staffing ratios, which is obviously a very important one and has taken up a considerable amount of time today, I merely draw your attention to what appears from paragraph 301 onwards where some other related measures where we don't propose recommendations but do raise – we do discuss the importance of there being benchmarking and star ratings. They are dealt with at paragraphs 302 to 307 and the importance of there being some mechanism for evaluating staff levels over time. That is some flexibility in the system along the lines of Professor Eagar's recommendation that any staffing requirements be progressively refined and adapted in Australia to inform staffing levels.

Finally, Commissioners, we note at paragraph 312 that it goes without saying that the proposal for mandatory minimum staffing levels cannot be achieved within the current funding envelope. We accept that the recommendations we are proposing

would have very significant funding implications for the aged care system as a whole. We note some of the research that has been done which would suggest that there would be benefits that could flow from the imposition of mandatory staffing ratios in terms of lower staffing turnover, and potentially more stability of the workforce which could potentially impact on training requirements.

These things are able to be costed. We note that some costing was done in the aged care workforce taskforce. We summarise that at page 319. We note also that there is evidence before the Commission about costing that was done as part of the ANMF staffing ratios work. And that the report that was provided and is in evidence before the Commission was that the proposal there would actually be cost benefit neutral at worst, taking into account potential savings.

Now, Commissioners, a number of the assumptions in that work on admission of the authors are somewhat speculative. We accept that there is significant work that needs to be done in relation to the costing of this proposed reform together with other proposed reforms that are under consideration by the Royal Commission staff. That work, I can indicate, is underway. There will be a public hearing about funding and financing in due course and submissions will be made in relation to those matters in some detail.

The final matters, Commissioners, that I would just draw your attention to briefly is that the aged care sector is, of course, not the only sector where questions of mandatory staffing ratios arise. The early childhood sector has some similarities to the aged care sector. It's a care-based sector where those receiving care are vulnerable, in that case because they are young, of course, rather than old. It's also a system that's heavily reliant on government funding and we note that for some years now there have been minimum mandatory staffing requirements imposed in the early childhood sector. And one's starting position may well be that if it's good enough for the young, why isn't it good enough for our old. And we set out in the submissions from paragraph 328 to 337 a discussion of what we submit are some of the lessons to be learnt from the experience of the earlier childhood sector.

In conclusion on this topic, Commissioners, at paragraph 338 on page 60, we note that in addition to directly improving the quality and safety of residential aged care, the implementation of minimum staffing requirements is likely to contribute to improvements in indirect ways. Mr Paul Versteege told the Adelaide hearing that a subsidiary but critical outcome of introducing staffing ratios would be an increase in staff satisfaction and overall improvement in the stability of the workforce as staff would be supported to provide care of a high quality and this is a key aspect of job satisfaction.

And to close that loop, Commissioners, you will recall the evidence of Dr Trigg about the importance of staff satisfaction as part of ensuring that they are working in a caring working environment and are providing quality care themselves. We submit that the overwhelming weight of the evidence that this Royal Commission has heard is supportive of the submissions that we make about Recommendations 1 and 2.

Finally, Commissioners, we note at paragraph 341 that any redesign of the aged care system that does not remove the incentive that presently exists for providers to reduce the number of nurses they employ to cut their costs will necessarily fail. Picking up on the observations about incentives in the Productivity Commission report from 2011, we submit to achieve high quality aged care the employment and rostering decisions made by providers must be focused solely on providing care to the appropriate level. The regulatory environment must be aimed at achieving the same outcomes.

If I can turn, Commissioners, to the other topics that we address in the submissions. I'm conscious of the time and I understand we have to conclude by 1 o'clock. I'm getting the nod. I will do my best to provide you with an overview of the submissions we make in relation to the other topics as best I can. Part 3 of our submissions deals with the need for - - -

COMMISSIONER BRIGGS: Excuse me, Counsel. Can I just ask: is that half an hour sufficient to do justice to the matters that need to be covered?

MR ROZEN: Probably not, Commissioner, in the circumstances.

COMMISSIONER PAGONE: Mr Rozen, if we give you to 1.15, is that likely to sufficiently assist?

MR ROZEN: It will. It will.

COMMISSIONER PAGONE: All right.

MR ROZEN: Thank you very much, Commissioners. Part 3, as we say, is concerned with transforming the aged care education and training. Commissioners, in addition to having the right numbers of aged care workers which we have obviously addressed it's vitally important to ensure the workers have the correct skills and qualifications. We have noted a great deal of evidence already and we summarise more of it in Part 3 of the submissions which indicate that that is not the case presently, and in this part of our submissions we are not concerned solely with the direct care workforce of care workers, enrolled nurses and registered nurses. We make submissions about the need for improved training for allied health workers, for nurses, for general practitioners and we make a number of submissions about nurse practitioners and geriatricians as well. There are a number of proposed recommendations in Part 3.

And perhaps the best approach that I can take to it is to point out to you that there are – the recommendations are dealt with in two sections. The first deals with the VET system, the vocational education and training system, and we set out in some detail, which I do not need to read out, the background to the VET sector and its overall structure. It is important because there are two parallel reform processes. One that generally arises in the VET sector, that is, coming out of the Joyce Review and one that is specific to aged care which is being developed by the aged care services

Industry Reference Committee. There is evidence before you of some concerning overlap between the two that is not necessarily productive and we raise concerns about that. Although, we don't seek any specific recommendation to address that but it is a matter that the Royal Commission is aware of and is monitoring carefully.

Our first proposed recommendation in this part of our submissions concerns personal care workers and it's at paragraph 381 on page 69. And we propose that there be a mandatory minimum qualification requirement for personal care workers, working in aged care. At 382 we propose that a Certificate III in individual support ageing should be the minimum mandatory qualification required for personal care workers performing paid work in aged care. We submit that there's a need to lift the skills and training of personal care workers and to build the capacity of the workforce to provide high quality and safe care and the recommendation is aimed at achieving that outcome. The recommendation is part of a suite of measures that aim to professionalise the workforce and ensure that the worker performance is appropriately recognised and valued. We submit this is critical if the aged care sector is able to attract and maintain a capable and caring workforce in sufficient numbers to meet Australia's growing needs.

We make a general observation here that there is a big supply site challenge for the aged care workforce but, importantly, there are a number of steps that can be taken to address that by making the aged care sector more desirable place to work in the first place and attract the staff to work in it and we are very much informed by that proposition in the submissions that we make in this part of the recommendations. We note, and I just draw your attention to this, Commissioners, the possibility of a portable training scheme which may be of particular relevance to home care workers. That's set out at paragraph 398 under which a worker would get credits for time spent working and those credits could be used to be cashed in, in effect, for the provision of training.

We note in the evidence that there is considerable support for there to be a mandatory minimum qualification for personal care workers but we think it's worth noting some concerns raised by Associate Professor McFarlane who gave evidence the Sydney hearings, Commissioner Briggs may recall. He is the head of dementia at HammondCare, this is page 406 of our submissions. He warned that minimum qualifications in aged care are not a panacea and should not be seen as one. He said that the demand to improve staff skills and experience must also be balanced with the need to hire on the basis of attitude and character. No amount of training produces kind and compassionate people, he told us and they are important submissions – sorry, important evidence to take into account.

Commissioners, before turning to the health professional side of the aged care workforce, we note, starting at paragraph 412, there are submissions made about job profiling and job design, followed by submissions about career paths, continuing professional development as well are dealt with. I won't read out those submissions but they each address important areas.

If I could ask you, Commissioners, then to turn to paragraph 446 please, on page 82. You will see that we deal there with the higher education system and as was the case with VET, we set out some background information, which I won't read, about what's described as the higher education system architecture, that is, the various institutions and organisations that come together. And then I would ask you to go to Recommendation 3 which you will find on page 86. And the recommendation, as you will see there is that the Medical Deans of Australia, and I'm now concerned with doctors, of course, in conjunction with the Australian Medical Council, the Royal Australian College of General Practitioners and the Australian Medical Association should establish a working group to review the skills needed by GPs to enable them to meet the anticipated aged care needs of the Australian population over the next 30 years.

The group should determine the anticipated need for GPs to deliver geriatric medical services particularly in the aged care context over that period and should review the state of geriatric undergraduate medical education with a view to mandating a core subject that enables the medical graduate to adequately meet clinical needs and anticipate demand. And, in so doing, they should have express regard to the ANZSGM position statement number 4, education and training in geriatric medicine for medical students. This proposed recommendation and the following one which are concerned with making geriatric medicine a core element of the undergraduate medical curriculum arise out of the evidence that we heard on day 4 of the Melbourne 3 hearing, and in our submissions we set out the background and the explanation for why we submit those recommendations ought be made by you in relation to general practitioners. I won't read out those submissions.

Turning then to Recommendation 5, Commissioners, which is on page 88, this deals with assessing projected demand for geriatric health services. The recommendation is the Commonwealth Department of Health should fund and collaborate with the Royal Australian College of Medical Practitioners, the Royal Australian College of Physicians and the Australian Medical Association to conduct an ongoing research program designed to estimate the short, medium and long-term demand for geriatric services for older Australians, and we set out some of the background to that proposed recommendation on page 88 of the submissions.

Turning, Commissioners, to the nursing profession, we include a recommendation at page 89, the proposed recommendation that the Nursing and Midwifery Board of Australia and the Australian Nursing and Midwifery Accreditation Council should incorporate an introductory module or subject on geriatric medicine and gerontology care into the enrolled nurse accreditation standards, and the registered nurse accreditation standards. We note there the evidence in this Commission, concerns expressed by both nurses, nurse practitioners and general practitioners about levels of skills and training on the part of both enrolled and registered nurses and, in our submission, those matters ought be addressed in accordance with the recommendation that we are proposing.

The final recommendation in this part of our submissions, Commissioners, concerns nurse practitioners. You'll recall hearing quite a deal of evidence in the Canberra hearings about that and we summarise that evidence, starting at paragraph 485. The proposed recommendation is concerned with the supply of nurse practitioners rather than imposing any particular requirement for providers, for example, to engage nurse practitioners. We think at this time it's more appropriate to address the question of supply. We do, in our submissions, make the point that we consider that there's a great deal to be said for greater involvement of nurse practitioners in residential aged care generally as a means of addressing serious clinical need and in a context where, for a variety of reasons, which were canvassed in the evidence in Canberra, general practitioners are not necessarily attending residential aged care facilities in the numbers and with the frequency that is perhaps desirable.

We accept this is a complicated question that a nurse practitioner is not some substitute general practitioner. We understand there's a different scope of practice but nonetheless we think that's an area that, in the years ahead should receive greater attention. So the recommendation is that to increase the supply of nurse practitioners, the Australian Government should introduce scholarship programs with aged care return of service obligations for nurse practitioner training and advanced skill nursing. In our submission, Commissioners, our nursing schools need to do much more to enthuse nursing graduates to pursue careers in residential aged care. It must be accepted that whilst there are structural reasons why nursing numbers have dropped, it is a sad reality that there doesn't seem to be the attractive career path that other fields such as paediatrics, which is often mentioned, are more attractive for nurses.

Commissioners, I don't think I need to say any more about education and training, which are dealt with in the remaining parts of part 3. So I will turn to part 4 of our submissions, which starts on page 98, and part 4 deals specifically with the regulation of personal care workers and there is one recommendation in part 4 and it is a recommendation that there be a registration scheme for personal care workers which should be established. We identify some key features of such a scheme, and there should be a requirement for mandatory minimum qualifications. There should be scope to require that qualifications be obtained from certain approved training providers and that part of the recommendation picks up on some of the evidence we have heard about the quality of personal care worker certificate III courses.

We propose that there be a requirement for ongoing training and continuing professional development. There should be minimum levels of English language proficiency. That would, of course, need to be implemented in a sensitive way, bearing in mind the need for at least bilingual workers in many aged care settings but nonetheless the evidence that has been presented in the Royal Commission would suggest that English language deficiencies are contributing to some aspects of substandard care. We submit that there ought to be criminal history screening requirements as part of a registration scheme and there should be a code of conduct and power for the registering body to investigate complaints into breaches of that code of conduct.

Commissioners, we note in this part of our submissions that the recommendations the Royal Commission is asked to make are to be aimed at aged care that is high quality and safe. The evidence before you is that there are clear examples of instances where conditions in aged care facilities have been unsafe, in part due to the conduct of people charged with the care of residents. In some cases where such conduct has been drawn to the attention of the providers at the aged care services where it has occurred the response has been unsatisfactory and has even bordered on callous. Perhaps the most compelling and confronting example of this was that evidence of Clarence Hausler who you heard evidence about, Commissioner Briggs, in the Perth hearing. The late Mr Hausler lived in the Japara Aged Care facility in Adelaide.

The Commission viewed video recordings that were secretly recorded by Mr Hausler's daughter, Noleen, which showed the late Mr Hausler being violently assaulted in his room by one of his carers on more than one occasion. Mr Hausler's assailant was identified as a personal care worker, Corey Lucas. Mr Hausler's daughter complained to the police. Mr Lucas was ultimately charged with and convicted of assault. He was sentenced to a brief period of imprisonment. As is explained in part 4 of our submissions, that means that Mr Lucas is not allowed to become a staff member in an approved aged care provider as a result of that conviction. However, had the police had not pursued the case, as often happens in some circumstances for a variety of reasons, there would be no such prohibition.

Essentially, whether or not someone who engages in that conduct is prohibited from being able to work in aged care is really contingent on whether or not there's a complaint made to the police, whether or not the police pursue the matter, whether or not there's a conviction if they do pursue the matter, and so on. There are a number of hoops that one needs to jump through. Sadly, Commissioners, the case Mr Hausler is not isolated based on the evidence before the Royal Commission. In the Darwin hearing, Ms Backhouse gave evidence about her mother being assaulted twice by her carers in a residential aged care facility, and Sarah Holland-Batt who gave evidence in Brisbane described being informed by a whistleblower registered nurse that a care worker had "deliberately and repeatedly abused" Ms Holland-Batt's helpless father.

Commissioners, there was also the case of UA in the Melbourne hearing 3. In that case study the management of the Bayview Aged Care facility substantiated through an internal investigation several occasions on which a carer, who was given pseudonym UA, had engaged in violent and abusive conduct towards several residents of the facility over a period of more than 12 months. UA's employment was ultimately terminated after he was given several warnings by his employer. However, in contrast to the case involving the carer, Mr Lucas, in Adelaide no charges were laid by the police against UA. There's therefore no prohibition under the existing law that would stop UA continuing to work in the aged care sector when, in all likelihood, he is probably, if what was substantiated by the provider, as unsuitable to work in aged care, as was Mr Lucas.

The Royal Commission has heard evidence from care recipients and their representatives including those involved in these cases that more rigorous screening and monitoring of aged care workers is needed to ensure the safety, health and wellbeing of care recipients. Returning to Ms Backhouse's case, she said this to the Royal Commission:

> *I've proceeded with pressing an assault charge against the carer not because I'm vindictive but because I don't want her to work again in the aged care sector, and this is my only choice. There's no regulation for care workers in Australia, no national register to guard against this type of behaviour, not even a blue card or equivalent. Without any way to check employment history and dismissals, this carer can walk into another centre tomorrow with no record of this event to follow her. Nurses and other health professionals are regulated under the Australian Health Practitioners Regulation Agency, AHPRA, but this does not currently extend to carers.*

Ms Holland-Batt explained that she was ultimately informed by the provider that the carer who had abused her father was dismissed from her employment, however, she added this in her evidence:

> *It was unclear from his phrasing whether she had been fired or just moved to another facility. I do not know whether this carer continues to work in a different facility. The thought haunts me. I think there should be some sort of register that keeps track of any substantiated complaints so that abusive carers do not have access to vulnerable persons in the future.*

In our submission, Commissioners, the evidence received by the Royal Commission during the course of the Melbourne hearing number 3 has clearly identified there are significant gaps in the existing regulatory regime. In part, that is a result of limits in the Commonwealth law which I've just examined, and also the states and territories having different regulatory regimes or different approaches to the application of those regimes. These problems are exacerbated by ineffective communication between the Aged Care Quality and Safety Commission, and State and Territory regulatory bodies. On any view, we submit the present position is quite inadequate and is in need of urgent and fundamental reform.

As with many of the issues the Royal Commission has examined these deficiencies are not new. They have been identified previously by other inquiries; recommendations have been made to address them. We note before leaving this topic, Commissioners, that the evidence before the Commission is that the Commonwealth Government is broadly supportive of the idea of a registration scheme and is examining it as part of its implementation of the Carnell-Paterson Report recommendation proposing a Serious Incident Response Scheme. All we will say about that at this juncture is that progress is slow. It has been raised with Commonwealth witnesses in Brisbane and again in Melbourne. Submissions have been provided to us outlining the steps that are being taken but it's now three years

since Carnell-Paterson and these matters, as the evidence before you indicates, require a more urgent response.

Commissioners, the remainder of chapter 4 sets out in some detail or seeks to summarise the evidence that was heard in the Melbourne 3 hearing both about the Commonwealth law about the different State and Territory approaches to the application of their health complaints law to the aged care sector and, importantly, to the different ways in which some states like Queensland has a particularly active approach to addressing aged care complaints. Victoria is almost the opposite where complaints are referred back to the Aged Care Quality and Safety Commission. One hesitates to use literary adjectives but Kafkaesque comes to mind from that evidence where it was Ms Holland-Batt, from memory, who was referred by the aged care regulator to the state regulator, who in turn sent them back. No one seemed prepared to address that. The word "malarkey" appeared in her evidence as a description of what she was told by the various regulators.

I won't spend any more time on that topic except to point out that there is still work to be done on a number of features of a scheme, in particular, the interrelationship between any such scheme and, for example, the Disability Workers Registration Scheme. It's important that there be, at the very least, consistency of approach and perhaps more than that, perhaps some combining of such schemes given that the purpose of them is quite similar. And there is also an outstanding question which we don't have a proposed answer to at this time as to what body should oversee such scheme, whether AHPRA, which is an existing body, ought do that. There's some attraction to using an existing body but, of course, AHPRA's remit is concerned with the health professional workforce, and there's a question about whether personal care workers are appropriately dealt with.

I can indicate to you, Commissioners, that work continues on those matters within the Royal Commission and we will be in a position to make public submissions about those matters in due course. Turning then to part 5 of our submissions, which I can deal with quite quickly. In part 5 starting at page 123 we deal with terms and conditions of employment. When I say I can deal with it quickly, it's not because it's an unimportant topic but because it presents real challenges, particularly for this Royal Commission. A consistent theme, as we note in paragraph 608, Commissioners, in the evidence is that aged care workers are insufficiently remunerated for the work they perform and they endure poor working conditions.

We submit these deficiencies need to be addressed so that this important work is appropriately rewarded and, correspondingly, the sector becomes a more attractive one in which to work to improve both attraction of new employees and retention of existing ones. Commissioners, under the heading Remuneration we set out in some detail the evidence you've heard in which workers, aged care providers and union officials have related to you concerns about the low pay received by aged care workers. Many of whom get paid on the base grade or just above it of the applicable awards of which there are two, and the evidence is that the low level of pay, whilst not the only consideration about questions of attraction and retention, clearly plays a

role. It's not helpful, put it that way, having low levels of pay, particularly when it's combined with low staffing levels and the other matters that we have already addressed.

Commissioners, what we seek to do in part 5 in relation to remuneration is to summarise for you the existing industrial relations framework in Australia of awards and enterprise bargaining, and conclude particularly in relation to enterprise bargaining that that is unlikely to deliver any significant increases in wages to aged care workers essentially because it hasn't done to date in the past 20 years, on the evidence that is before you, and that's principally because of the low level of unionisation in the sector, the lack of preparedness to take industrial action in support of claims, and the other matters that we deal with.

We do note that in the Fair Work Act there are two mechanisms which at least on paper look like they could be of assistance in addressing the remuneration deficiencies in aged care. There is the ability under the Fair Work Act to obtain what is called a low-paid authorisation as part of a low-paid bargaining stream. I won't go into the detail of that in my oral submissions; we do set those out in the written submissions. The history of that stream of low-paid bargaining is that it hasn't been particularly successful in practice for a number of reasons, centring on the way in which the legislation has been drafted and the way it has been interpreted by the Fair Work Commission.

The first case that was brought was actually an aged care case which was brought on behalf of 60,000 aged care workers. The Fair Work Commission – or it was called Fair Work Australia at that time – excluded from its consideration a number of approved providers that had historically had enterprise agreements, and the academic commentary on those cases which we cite in part 5 of the submissions suggests that the approach that has been taken by the Fair Work Commission renders that mechanism largely useless in terms of increasing wages. We note also Commissioners that there is scope for equal remuneration orders under the Fair Work Act in cases where it is demonstrated that there has been historical discrimination on the grounds of gender, and that is precisely the mechanism that led to the pay increases in New Zealand that you heard about from Dr Ravenswood this morning.

So once again, superficially it looks attractive to address the concerns but as with the low wage bargaining, a combination of the drafting of the provisions and the way they've been interpreted, particularly recently by the Fair Work Commission, means that despite a promising start where significant pay increases were delivered to care workers operating under the Social and Community Services Award, the advice we have received as part of the research we've done at the Royal Commission is that that mechanism is unlikely to achieve in the foreseeable future any significant increases in remuneration as well.

When I say the advice we received, Commissioners, I should indicate that earlier this week a roundtable of industrial relations and labour law experts was convened by the staff of the Royal Commission which I also attended, and if I can summarise the

advice that was provided to us by that group of experts, as we say on page 135 of the submissions, we draw attention to the identity of the five experts that attended that; we note at paragraph 665 that the group were asked to assume that it was desirable for levels of remuneration, classification structures, levels of training and career paths of aged care workers to be improved and they were asked about the best available mechanism under the current law to achieve those outcomes.

We note, Commissioners, the advice from the group was that for the reasons discussed in our submissions, which I have summarised, neither the low wage bargaining stream nor the equal remuneration orders were likely to be fruitful. The group considered that it may be possible to amend the three awards that apply, the nurses' award is the third award that applies in aged care, to aged care workers to effect such improvements. However, and this is the important submission that we would seek to make based on what they told us, without strong Federal Government commitment and a cooperative approach that involves employers, unions and care recipients, along with the government, success will be elusive. And that's the lesson from not only the New Zealand experience which you heard about from Dr Ravenswood this morning, but also in that case where pay increases were obtained but under the Social and Community Services Award the Federal Government committed to funding that to the tune of $3 billion.

That was a commitment that was made publicly in 2012 by the Prime Minister and was acted upon by the Fair Work Commission accordingly. So both history and the advice of this group that we have consulted have pointed to the crucial importance of Federal Government leadership in relation to this topic. We make a number of submissions about employment conditions generally, which I draw to your attention, noting the concerns that have been raised by a number of witnesses about health and safety issues, about payment for travelling time, for example, for home care workers, and so on.

We conclude on page 141, Commissioners, as follows, that it appears to be broadly recognised that poor terms and conditions of employment, exacerbated by low staffing levels and poor training opportunities and career paths, are a disincentive for people to want to work in aged care. They also are part of the reason why the sector has difficulty retaining its existing staff. Most workers are working on minimum award rates. Commissioners, as I said at the outset of this part of our submissions, the issues are complex and statutory mechanisms such as the low-paid bargaining scheme appear to hold promise but fail in practice to deliver.

The staff of the Royal Commission will continue to examine these issues. Based on the work to date, two things are clear: firstly, there needs to be a cooperative approach; secondly, as I indicated, there's the need for leadership. Commissioners, in the final part of our submissions, which I will now turn to, we address questions of leadership and those submissions appear at page 142. Commissioners, you will recall the submissions that I've made earlier where I've touched on the importance of leadership in relation to the workforce, and we note the evidence that was given by Professor Harrington about that this morning as well.

We deal with two topics which are related in this part of our submissions. The first is leadership at the provider level which we start making our submissions about at paragraph 694. I won't, given the time, spend any time making oral submissions about provider leadership except to say that you heard considerable evidence about the importance of governance in proved providers in the Hobart hearing and also in the Mudgee hearing and there will be a public workshop in relation to approved provider governance and leadership questions which will take place later in the year, in fact in the coming month or so, and those matters will be canvassed in some detail there.

What I would like to do in the time that's available, Commissioners, is ask you to go to paragraph 721, which is on page 148 of the document where we deal with the role of the Commonwealth and its interrelationship with industry leadership. Commissioners, as was indicated by Dr Ravenswood this morning and other witnesses that you have heard from, the Commonwealth Government sets the regulatory framework, implements that framework and establishes the policy settings for the aged care sector. It also provides the overwhelming majority of the funding.

We submit, in those circumstances, that it's appropriate for the Royal Commission to make the recommendation concerning workforce planning that we have set out on page 149. In that proposed recommendation we submit that the Commonwealth should leave workforce planning for the aged care sector, and should identify an agency or body that has overall responsibility for aged care workforce planning with the key actions that we have set out at subparagraphs (a) to (e). We then note some of the evidence that you have heard about the role of the Commonwealth, and particularly the evidence that you heard from senior members of the Aged Care Workforce Industry Council, the body that has the responsibility of implementing the Pollaers Taskforce strategic actions, and you'll recall that they consistently said two things: they need Commonwealth support and leadership to operate effectively, and they also said that they weren't getting enough of that support.

You will recall the evidence of Mr McCoy in Melbourne. Ms Hills gave consistent evidence and, of course, there was the evidence of Mr Pollaers as well about his concerns about the response that he had received from the Minister concerning the Commonwealth's own implementation of the five strategic actions that are identified for its responsibility. If I could turn, Commissioners, to page 151, paragraph 730, where we note the evidence in the Melbourne 3 hearings that there is evidence of turnover and churn at the senior executive level in the Department of Health, and that that turnover, particularly at higher levels, is a feature of the Commonwealth's own aged care workforce.

In our submission, Commissioners, there appears to be a lack of leadership and expertise about aged care within the Department of Health. Professor Pollaers' evidence was that the Department of Health:

> *...is not a department that is resourced well enough, that has sufficient experience and/or weight within the current government department that it sits.*

Quite often the Secretary, the Deputy Secretaries have other portfolios and not the focus.

Professor Pollaers said that based on his nearly two years of dealing with the government in many ways the industry is undergoing a level of oppression, he said. And he explained what he meant by this was that:

The government has positioned itself over the last few years to the extent that this can be an industry issue and they can leave industry to deal with the union and then use the fragmentation as a reason to say, well, without one voice we don't know what you're asking.

He said:

It has been, you know, a reasonably successful approach, if not a strategic approach then a real shame because the answers to many of these questions have been on the table for quite some time.

Commissioners, Professor Pollaers has devoted a considerable amount of energy, enthusiasm and expertise to the task he was given by the government, that is, to chair the Aged Care Workforce Taskforce. He has no axe to grind. Unlike many from whom the Royal Commission has heard, he has no vested interests. Nor does he represent others with a vested interest. It was clear from the evidence he gave the Royal Commission in the October hearing in Melbourne that he's frustrated by a lack of progress on the implementation of the report that was produced by the Taskforce he chaired.

We submit that the evidence of Professor Pollaers should be given considerable weight. We submit the evidence paints a concerning picture of a government that does not see itself as a leader but is at best a facilitator. We note that was the language that was used by the Commonwealth Government in evidence that it gave to the Senate Committee Report in 2017 where the submission was as follows:

Aged care employers are responsible like any other employer for assuring that their workforce needs aligned with their business strategy as an essential component of organisational governance.

Commissioners, facilitator is, of course, one of those modern expressions of indeterminate meaning which in our submission says very little about the true role of the Commonwealth in this area. We do note, Commissioners, evidence before you that the government's position appears to have changed on the fundamental question of its role in relation to the aged care workforce. Challenges by senior Council Assisting described the Commonwealth aged care workforce role, Ms Glenys Beauchamp, the Secretary of the Department of Health emphasised:

We do absolutely have a leadership role in terms of workforce matters in the aged care system. Not just the Department, it's across the Commonwealth more broadly.

Commissioners, we note the evidence which we have sought to summarise in the submissions about the response that Professor Pollaers raised about the Federal Government responding to the work of the Taskforce. This, we deal with at paragraph 748 of the submissions. Mercifully perhaps the third last page of the document, if I can ask you to turn to. We note there are five strategic actions in the Taskforce report directed at the Australian Government, and we then quote the concerns raised by Professor Pollaers about what he considered to be an inadequate response by the Commonwealth Government to the strategic actions that were directed at it.

Professor Pollaers described the Commonwealth's response as "Profoundly disappointing". This is at paragraph 750. He clarified that he received an email from the Department of Health in response to his request that he had sent to the Minister but that he did not consider the response was sufficient and so he had asked for a step-by-step response. His view was the department in its response to him had not done justice to the brief they were given.

Commissioners, Ms Breamiam was asked about this by Counsel Assisting in the Melbourne 3 hearings. Her evidence was that the government has come out in broad support of the recommendations of the Taskforce. She also said:

The department doesn't embrace things publicly when there have been reports made to government. Our role is to support implementation and delivery and it wasn't our place to embrace it or not.

Commissioners, you will recall that Ms Beauchamp was asked about a briefing note which had been prepared by senior officers in the Department of which she was the Secretary. And in that briefing note the advice that was provided to the Ministers of Aged Care and Health respectively was:

Release of a formal response to the strategy would carry several risks to the government.

And the advice in that briefing note went on and said releasing a response would, and I quote:

Invite renewed criticism of the absence of similar responses to other aged care review reports, including the legislated review of aged care and the review of National Aged Care quality regulatory processes.

And it went on, and I quote:

A further risk for government is that a formal government response will invite public statements by key stakeholder groups, drawing renewed attention to sensitive matters such as staff ratios, aged care funding, access to health services for older Australians and service quality.

Commissioners, as was put to Ms Beauchamp at the Melbourne hearing this is not leadership. In my submission, it suggests an approach at the highest levels of the aged care bureaucracy that is timid. It's risk averse, more worried about political risk than making a contribution to the continuation of aged care reform. It's an approach we submit must change if the government is to fulfil the true role of a leader that is so necessary to the aged care sector to become an employer of choice.

Commissioner, they're the submissions we seek to make today subject to one thing I am about to be informed of. I just note that our submissions will be published on the Royal Commission's website today and the Royal Commission welcomes submissions in response to those submissions, which we would propose ought to be provided to the Royal Commission by 13 March 2020.

COMMISSIONER PAGONE: Yes, thank you, Mr Rozen. Thank you for those submissions, Mr Rozen and before I add to the thanks and in case there are others who will be eagerly waiting for these submissions to be published on the website, might I draw your attention to the need to do something about the numbering of the paragraphs. There seems to be a mismatch between some of the numbers that you referred to, most recently the last lot and those in the copy that we have. But some thing seems to have gone particularly at page 42, 43 and following. You will see that paragraph 42 has paragraph 191 and then that jumps to paragraph 244.

MR ROZEN: Yes, that's not ideal.

COMMISSIONER PAGONE: No, and yet another jump later on. So I think for the sake of the public, you might want to do that. I mention it only because there will be people who will be keen to get the document immediately today.

MR ROZEN: Yes.

COMMISSIONER PAGONE: And so I've put on the public record the fact that there might be some hopefully very short delay.

MR ROZEN: We are grateful for that indication. There are also, I hate to admit it, but some typographical errors which seem to have slipped through the otherwise thorough process of the Royal Commission. But I do know since I stood up and started my submissions, there has been people behind me hard at work addressing those matters. So the document that ultimately is on the website won't bear any of those flaws for which I, of course, accept complete responsibility.

COMMISSIONER PAGONE: Thank you, Mr Rozen. You have done a sterling job in outlining a long and complicated document. We thank you for that.

MR ROZEN: Can I just correct one matter which has been drawn to my attention.

COMMISSIONER PAGONE: Yes.

MR ROZEN: That is that during the course of the submissions, I indicated to you that Ms Holland-Batt was referred back and forth between the state regulator and the Aged Care Quality and Safety Commission. In fact, the evidence I'm now reminded from the state regulator was that they reached out to Ms Holland-Batt and have provided her with considerable assistance in addressing her complaint to the extent I said otherwise I do apologise for that.

COMMISSIONER PAGONE: Thank you. And do pass on our thanks to the staff who are doing all the work behind the scenes and, of course, thanks to the facility here who have been again very helpful in providing access and the relevant security. You've got another matter, Mr Rozen.

MR ROZEN: Just one brief matter I'm reminded. I'm going to do what my junior raised, I should seek to tender the tender bundle.

COMMISSIONER PAGONE: Yes, that will be exhibit 15-3.

MR ROZEN: If the Commission pleases.

COMMISSIONER PAGONE: Yes. Thank you. Mr Rozen, have you finished?

MR ROZEN: Completely, sir, thank you.

COMMISSIONER PAGONE: So let me complete my thanks to all those at the facility and to you again, Mr Rozen and to your team. I think we are now just adjourned until – what date?

MR ROZEN: 4 March.

COMMISSIONER PAGONE: 4 March.

MATTER ADJOURNED at 1.18 pm UNTIL WEDNESDAY, 4 MARCH 2020

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