Royal Commission
into Aged Care Quality and Safety

Statement of Professor Leon Flicker AO

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1. This statement made by me accurately sets out the evidence that I am prepared to give to the Royal Commission into Aged Care Quality and Safety. This statement is true and correct to the best of my knowledge and belief.

2. Where direct speech is referred to in this statement, it is provided in words or words to the effect of those, which to the best of my recollection, were used at the time.

3. The views I express in this statement are my own based on my education, training and experience. They are not intended to represent views of any of my employers.

4. I am currently the Professor of Geriatric Medicine at the University of Western Australia, and Consultant Geriatrician at Royal Perth Hospital. I have been in these roles since October 1998. I am also the Executive Director of the Western Australian Centre for Health and Ageing and have held that position since 2005. Prior to working at the University of Western Australia I worked for the University of Melbourne as Senior Lecturer in Geriatric Medicine based at the National Ageing Research Institute for the period 1989-1997. In 1998 I worked as a locum general physician in Alice Springs Hospital.

Aged Care in geographically remote locations

5. My predominant experience in the difficulties of providing care for older people in remote locations stems from my research with older Aboriginal and Torres Strait Islander peoples in these situations. However, many of the barriers that older Aboriginal people experience in remote situations also occur for non-Aboriginal people

For example see

1. Smith K, Flicker L, Shadforth G, et al 'Gotta be sit down and worked out together': views of Aboriginal caregivers and service providers on ways to improve dementia care for Aboriginal Australians. Rural and Remote Health 2011; 11: 1650. and

2. Logiudice D, Smith K, Shadforth G, et al. Lungurra Ngoora - a pilot model of care for aged and disabled in a remote Aboriginal community - can it work? Rural and Remote Health 2012; 12: 2078

Care services to older people in remote locations is subsidised by the Australian Government but is provided by Non-Government Organizations (NGOs). NGOs have difficulties with economies of scale and find the provision of services to small communities in remote regions to be non-viable. Travel, staff and infrastructure costs are more expensive in rural and remote situations further reducing the viability, effectiveness and costs for NGOs. This often means that many remote regions are not serviced by NGOs and in Western Australia, the Western Australian Country Health Service, becomes the provider of last resort. However, the choice of services may be extremely limited with many services that are readily available in urban areas (such as personal care like showering assistance), unable to be provided by NGOs in remote situations. The lack of personal care and home care may mean that disabled older people live in poor environments and circumstances, further discouraging social contact and support.

Residential care services also require economies of scale. Many small rural communities are unable to support stand-alone residential care facilities. Multi-purpose Services help fill some of these gaps, but the quality of service to older people is highly variable, depending on the training and interests of the staff. Attending to the special cultural needs of Aboriginal older people and employing suitable qualified staff also presents challenges.

General health services in rural and remote regions may not have specific training about the health needs of older people. There are many competing priorities in rural and remote regions, and care of older people may not be given a high priority in policy or by service managers or the practitioners themselves. This results in inadequate direct care but often there are no referrals to more appropriate specialised services

6. There are many barriers to access of aged care in rural and remote regions. The tyranny of distance often results in the lack of key trained staff in remote situations. This includes specialist and general staff in the areas of medicine, nursing, allied health and support workers. The lack of specifically trained staff and distances between small populations means that service needs are often overlooked. Even if problems are recognised, the lack of nearby key staff means that specific assessment and treatment services cannot be provided. Travel to appropriate services is often burdensome in time and money for consumers and similarly challenging for service managers/providers. Older people are often left to make stark choices about which services they will seek based on the amount of time and effort required and the funds they have available. The alternative is to move from the place that they have called home for all their lives. In general, these barriers are not nearly as pronounced in rural situations compared with remote regions, but there are still substantial problems experienced by older people.

7. There is a paucity of infrastructure in remote areas. There is a need to share other infrastructure found in health services to provide areas for assessment. There are often

difficulties outside of major regional centres in accessing even relatively simple equipment such as walking aids.

8. The costs of providing care are substantially greater in remote areas compared with either rural or urban areas. There are many contributing factors but a major one is travel. The costs resulting from major distances between client groups are the costs of travel and the time involved. These additional costs make assessments and care less accessible. Often services are provided on ad hoc basis, rather than regularly.

9. I am aware of the usual government programs such as Home Care Packages and Commonwealth Home Support Programme services. They have limited access in remote regions. Often there are some ad hoc services due to constraints mentioned above.

10. There are many barriers to developing a trained workforce. Because of lack of training and therefore understanding of aged care issues, many problems such as cognitive impairment, risk of falls etc are overlooked and the opportunity for prevention measures is lost. If there are insufficient clients then there will be no service because of feasibility issues but there will also be few referrals if there is no available service. The cost of providing management and administrative support to rural and remote regions also increases, making the service less attractive to non-government organisations. If there are no locally trained staff then it is often difficult to recruit trained staff from other regions to regional areas, and the difficulties increase with remoteness and smaller populations. Issues such as spouse employment and educational opportunities for children are very common. Training local staff is very helpful but often this requires staff to be trained distantly and trained staff are often preferentially recruited to larger centres.

11. The barriers for attraction and retention of Aboriginal and Torres Strait Islander aged care staff is similar to rural and remote areas but more acute. Even in quite large Aboriginal and Torres Strait Islander communities there is a paucity of trained aged care staff. Interested individuals may be discouraged from application due to inadequate literacy. Once staff are trained and for those who have high literacy, many alternative employment opportunities arise, frequently outside direct personal care, and often outside the community.

12. There are many challenges in providing home based care in remote regions predominantly due to the lack of economies of scale (please see above). It would be strongly advisable for small communities to have established home care services before embarking on residential services. Even so, there are often relatively few clients for aged care service in small remote communities. One possible solution is the Lungurra Ngoora Community Care model that was developed to enable Aboriginal people of all ages with disabilities and/or frailty to access the supports and services they require to stay at home and on Country. The model requires pooling of funding from the Commonwealth Home Support Programme, Home Care Packages, Mental Health Services, and Disability Services. An independent facilitator is required to ensure collaboration and assist with direction of common goals. It allows for formal partnerships, cooperation and collaboration between service providers and community.

Genuine community consultation, guidance and decision making is required, particularly for Aboriginal and Torres Strait Islander communities. There is a need for community based support, mentorship, training and development of staff. The service needs to be flexible and responsive to the needs of clients, caregivers, the community and the staff. Ongoing advocacy is often required for clients and families.

13. The provision of residential care in remote regions is more problematic than community care. Besides the issues associated with economies of scale, and recruitment and retention of staff, the maintenance of standards of care can be very difficult. Residential care facilities in remote regions are by definition small with limited beds and overall staff numbers are low. The loss of one or two key staff members can result in services being unable to provide basic care to vulnerable older people. A trained local community care workforce provides some redundancy, increasing the safety of residential care.

Aged care for Aboriginal and Torres Strait islander people

14. There are specific needs of Aboriginal and Torres Strait island people in accessing care. Firstly, Aboriginal and Torres Strait island people accessing aged care tend to be younger than the general Australian population (see below). Secondly, more Aboriginal and Torres Strait Island people live in rural and remote situations than the general Australian population and share challenges in accessing services associated with geographical location. Lastly Aboriginal and Torres Strait Islander peoples need culturally appropriate services. There is a requirement for cultural safety and proximity to family and their land. Many Aboriginal and Torres Strait island people have a close attachment to specific lands and dislocation from these lands has enormous negative impacts. There is a sense of loss in the community if an older Aboriginal and Torres Strait island person does not die on their land.

15. Many of the health conditions common in older people are experienced at younger ages in Aboriginal and Torres Strait island people. These include dementia, (Smith K et al High prevalence of dementia and cognitive impairment in Indigenous Australians. Neurology. 2008; 71:1470) falls, pain and urinary incontinence (LoGiudice et al Intern Med J. 2012; 42:e102-7) and frailty (Hyde Z et al Prevalence and incidence of frailty in Aboriginal Australians, and associations with mortality and disability. Maturitas 2016; 87:89-94). In addition, Aboriginal and Torres Strait Islander people are much more likely to develop Type 2 diabetes mellitus and renal failure. These premature health conditions result in disability many years earlier than in the general population.

16. There are barriers in Aboriginal and Torres Strait Islander peoples accessing aged care. For both residential and community care Aboriginal and Torres Strait Islander people find it very difficult to navigate what has become an extremely complex and convoluted system. Sub-optimal literacy levels are common and access to information technology can be inappropriately low. For residential care, Aboriginal and Torres Strait Islander peoples are more likely to live in areas that do not contain residential care facilities in close proximity. In addition, there are concerns regarding cultural safety. Most residential aged care workers have not had appropriate cultural training which also reflects the challenges of workforce shortage and financial models for operating services

in remote settings. Many do not understand the need for culturally safe practices for Aboriginal and Torres Strait Islander people e.g., for care to be provided by a specific gender. Unfortunately frank racism is commonplace. For these, and other reasons, despite the target group of Aboriginal and Torres Strait Islander peoples being approximately 3% of the population only 1% or residential care beds are occupied by Aboriginal and Torres Strait Islander peoples. For community care, other barriers exist, but the main one is navigating the increasingly difficult models of care associated with Consumer Directed Care (CDC).

17. The main obstacles to quality care are three-fold. Firstly, diminished health literacy makes it more difficult for Aboriginal and Torres Strait Islander peoples to navigate an increasingly complicated system. Secondly, many aged care and health workers lack specific cultural safety training. The use of inappropriate language and practices on vulnerable older people discourages Aboriginal and Torres Strait Islander peoples from utilising services. Thirdly, the financial resources of many Aboriginal and Torres Strait Islander peoples is very limited, and this hinders plugging the gaps that services cannot provide. For example inadequate housing is more common with Aboriginal and Torres Strait Islander peoples and this makes provision of community services more challenging. **17a)** All these obstacles are magnified in geographically remote regions. Trained heath and care staff who have completed cultural safety training may be non-existent or based large distances away from the client. The lack of choice in choosing staff members may further discourage seeking appropriate care. Inadequate housing and financial resources are more common in geographically remote regions.

18. I should emphasize this is my personal understanding of cultural safety. My understanding of cultural safety includes both understanding and a tailoring of practice. This understanding includes awareness and respect of the history, background and culture of Aboriginal and Torres Strait Islander peoples. The recent history is one of trauma and dispossession. An attachment to land for Aboriginal and Torres Strait Islander peoples is one of the important understandings. The local community of Aboriginal and Torres Strait Islander peoples is extremely important and community consultation is a necessary first step for provision of any service. Individual communities can be very different. Tailoring of practice to local community needs and responsibilities can be manifested in many ways but a really important proactive practical step is as far as possible the employment of trained Aboriginal and Torres Strait Islander health and care workers.

19. Cultural safety must underpin the provision of all aged care services to Aboriginal and Torres Strait Islander peoples. There needs to be the creation of genuine partnerships based on community consultation.

20. There are several challenges in providing culturally safe care. Training of non-Aboriginal and Torres Strait Islander health and community workers is time consuming and often not prioritised. There is usually a period of time that individuals require to adapt to local community conditions and requirements and a transient workforce will impede this process. Community consultation is often not straightforward and engagement takes a period as parties learn to trust and respect each other. All these

additional activities take time and the additional costs are often not factored into budgets.

21. There are two major consequences of not providing culturally safe care. Firstly, high needs clients will simply not use such services, assuming that a service that would be otherwise acceptable is available in their area. This then results in further morbidity, avoidable hospital admissions and early mortality. Secondly, Aboriginal and Torres Strait Islander people who use services that are not culturally safe will be unhappy and distrustful. This may be manifested in many ways, e.g. behaviours of concern in the client, angry family members who may not feel safe to visit unless in large groups etc. This is turn causes further break-downs in the relationship between the client, family and the care staff.

22. In general, the current aged care system has not performed well for Aboriginal and Torres Strait Islander peoples and one of the major reasons is the slowness of implementing culturally safe practices. One reason is that many health and care workers were unaware of the high prevalence of "ageing" syndromes in younger people (50 years and over) found in Aboriginal and Torres Strait Islander peoples.

23. One of the requirements to provide culturally safe care to Aboriginal and Torres Strait Islander peoples is that services must be tailored to local community needs and values. To adequately tailor such services staff members may be required to augment traditional roles or allow clients to accept "risks". These may include participation in important cultural practices whilst unwell, allowing sub-optimal personal care by untrained family members and other examples. These risks should be taken after appropriate consultation with the community and family members.

24. The KICA tool was developed principally by my colleagues Doctors Dina LoGiudice and Kate Smith but with many others including myself and it included considerable consultation. In 1998, whilst working at Alice Springs Hospital I observed there was no culturally fair tool to assess cognitive impairment in older Aboriginal people. Available tools that were used did not allow for cultural and educational differences. In 2003 Drs Dina LoGiudice and Kate Smith spent 6 months discussing the need for such a tool with local Aboriginal groups as well as local service providers including the Kimberley Aboriginal Medical Services and Kimberley Aged and Community Care Services. Local Aboriginal organizations were particularly important, including Aboriginal language centres. After the tool was developed it was extensively tested for acceptability by Aboriginal people in the Kimberley before it was then validated. The KICA was tested in both small and large communities after community consultation. One of the important properties of the KICA was it could be translated into the local Aboriginal languages and not lose its effectiveness. Although we made some mistakes along the way, there was a lot of good will for the project from local Aboriginal people and groups because they could see the importance of such a tool. It is one example where the principles of cultural safety were used to help develop an assessment tool. The KICA has been validated in other regions of Australia - urban, regional and remote - and is used extensively.

25. The quality and safety of aged care provided to Aboriginal and Torres Strait Islander peoples could be improved by a number of measures. Most importantly, the principles of cultural safety should be adopted throughout mainstream services that deal with substantial numbers of Aboriginal and Torres Strait Islander peoples. This will require considerable organisation of training of care staff. Not one size fits all, and differences in culture, languages, lore etc. must be accommodated. Secondly, assistance is needed in navigation of increasingly complicated pathways. At present this may be provided by Home Care Packages but this can be quite restrictive and coupled with administrative costs can leave little available resources for care. Substantial investment needs to be made in case management. Thirdly, there needs to be an expansion of specialist, targeted aged care services for Aboriginal and Torres Strait Islander peoples. Fourthly, there is an argument that expansion of advocacy services is needed and would be beneficial. Finally, these services should be underpinned by an evidence based approach and ensuring that investment is made in services that are effective.

26. I do not have direct experience of services that could be considered ideal. I have heard good reports of Jimbelunga aged care in Brisbane but have no direct experience. There are aspects of flexibility and cultural awareness to be supported from some Juniper facilities such as Ngamang Bawoona and Numbala Nunga in Derby but the overall care is highly dependent on key staff members. Remote services are particularly vulnerable to workforce turnover and the loss of key individuals.

Signed: _____

Date: 27/5/19

Witness: _____

Date: 27/5/19