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TRANSCRIPT OF PROCEEDINGS

O/N H-1140543

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

10.00 AM, TUESDAY, 11 FEBRUARY 2020

Continued from 10.2.20

DAY 75

MR P.R.D. GRAY QC, counsel assisting, appears with MS B. HUTCHINS and MS E. HILL

COMMISSIONER PAGONE: Mr Gray.

MR GRAY: Thank you, Commissioner. Our next session, the fourth session of this hearing, has a focus on the investment stream. That stream is concerned principally with restoration, reablement, respite and it's a centrepiece of the conceived program design in consultation paper number 1. Our panel for this session is constituted by Professor Julie Ratcliffe, Dr Gill Lewin, Mr Jaye Smith, Dr Henry Cutler, Ms Sue Elderton, Dr David Panter and Ms Patricia Sparrow, and I call those witnesses now. They are all in their seats along the panel desk. Ms Associate.

JULIE RATCLIFFE, AFFIRMED [10.00 am]

GILL LEWIN, AFFIRMED [10.01 am]

JAYE ALEXANDER SMITH, AFFIRMED [10.01 am]

SUSAN TRACY ELDERTON, AFFIRMED [10.01 am]

HENRY CUTLER, CALLED [10.01 am]

DAVID COLIN PANTER, CALLED [10.01 am]

PATRICIA LEE SPARROW, CALLED [10.01 am]

MR GRAY: Thank you. I will make brief introductory remarks about those of the panellists who we are hearing from for the first time today. Starting with Professor Ratcliffe, Professor Julie Ratcliffe is the newly appointed Matthew Flinders Fellow and Professor of Health Economics in the Flinders University College of Nursing and Health Services. Professor Ratcliffe also holds honorary professorial positions in the Institute of Health and Wellbeing at the University of Glasgow, and the School of Health and Related Research at the University of Sheffield. Professor Ratcliffe has previously held academic positions in the Health Economics Research Unit at Brunel University, the School of Health and Related Research at the University of Sheffield, and most recently in the Institute for Choice, University of South Australia.

Dr Gill Lewin. Dr Lewin has been involved in research in ageing since she joined Silver Chain as the research manager in August 1993. From 2008 to 2015, she

combined her role as research director at Silver Chain with that of Professor of Ageing at Curtin University. For the last 17 years the focus of much of Dr Lewin's own research has been the development and testing of care models that promote the independence of older people. Dr Lewin now works at Access Care Network Australia, a RAS provider, and a subsidiary of Silver Chain.

Mr Smith. Mr Jaye Smith is the First Assistant Secretary in the Residential and Flexible Aged Care Division of the Department of Health of the Commonwealth. This division is responsible for residential and flexible aged care policy operations, funding and allocation of places. This division also has responsibility for policy and programs for vulnerable or disadvantaged consumers, including people with dementia and people from diverse groups. Mr Smith has held this position since November 2017, and had not worked in aged care prior to this. But prior to that Mr Smith worked for the Commonwealth for almost 20 years in areas of policy development, implementation and program management.

Dr Henry Cutler. Dr Cutler is the inaugural director of the Centre for the Health Economy at Macquarie University, the MUCHE. Dr Cutler currently leads a team of 14 health economics researchers, three PhD students and support staff. Dr Cutler is an applied health economist with skills in evaluating real world problems having undertaken a consulting role to government and non-government organisations for 15 years. Dr Cutler also has research experience across a broad range of health care topics and these include, just to name one of many, aged care.

Ms Sue Elderton. Ms Elderton is the National Policy Manager at Carers Australia. Carers Australia is the national peak body representing Australia's unpaid carers, advocating on their behalf to influence policies and services at the national level. And I introduced Dr David Panter and Ms Patricia Sparrow yesterday.

I will begin the session with a recap of the format in which we're going to conduct the discussion today. Many of you have already heard this. It's a structured discussion based around a series of propositions and talking points which I will raise in succession. Each time I raise a proposition, I will nominate perhaps one, two or three of the panellists to respond to that proposition, and I would ask that perhaps you limit yourselves to three or four minutes in doing so. It's then going to generally be the case that other panellists, by raising their hand, can indicate whether they wish to respond in turn. Those responses should be very brief, if at all possible please, so we can move through the program and cover the topics in the notes that have been provided to you.

I will start by displaying on the screen an extract from consultation paper number 1, page 5, fifth bullet point, which is a description of this investment stream. It's intended to fund services, it will restore functioning, provide respite and very importantly delay or prevent the progression of an individual to more intensive forms of care, and there's an economic rationale underlying that last objective. That is, that in terms of fiscal defensibility this stream represents a very good "investment" of public funds. It's not only humane but it makes good economic sense if the

progression of people to more intensive and costly forms of care can be prevented and deterred.

This element in the overall design is a centrepiece in reorienting the programs in the aged care system in the direction of maintaining and restoring function wherever possible and pursuing wellness and quality of life for people in care. I will repeat something I said yesterday: that the overall principle of reablement is not just the role of this investment stream. All the services to be funded under the reconceived funding streams in the consultation paper should be reoriented this way. But this stream is the centrepiece in providing scalable and flexible responses to episodic deteriorations and also in providing respite.

The design objectives for having a separate funding stream for episodic potential deteriorations include being able to have differential ways, that is, ways that are different from caring for ongoing conditions, of producing agile and scalable responses and specialist responses and, as I said, ample fiscal justification can be demonstrated. And more than that, on that potential for specialisation, it might be able to foster incentives for innovation and specialisation in the services that best support people to regain function and to optimise their health while managing perhaps episodic declines in function or over time a deterioration in function and to learn new skills.

Respite is very important. Respite of all kinds, including more support for flexible forms of respite is to be included amongst the services funded by this stream. Sustaining the care dyad, that is, the caring relationship provided by informal carers, very, very largely, is not only humanely necessary but along the lines of the economic rationale I outlined a moment ago, it makes good fiscal sense. We know that informal caring relationships are hugely valuable to the economy and, in effect, represent a saving in what might otherwise have to be funded by public revenue. Informal care is necessary to sustain the overall system as well as being, one must presume, very often in the best interests of the person receiving the care. Regular flexible forms of respite planned out in advance in a systematic way are, the evidence indicates, one of the very important ways in which that caring relationship has to be maintained and sustained.

Now, after that introduction, I want to pose some questions at the level of principle and seek the panellists' responses. Are there good reasons for different funding and assessment of services intended to prevent progression of individuals to more intensive levels of need and more costly services compared with longer term stable care needs? I will pose that question at a level of principle and I will ask you, Dr Cutler, to respond.

DR CUTLER: Thanks Peter. So, yes, there are very good reasons for different funding and assessment of services. I suppose the primary difference between these types of services and more long-time types of services is the nature of the service itself. You have already suggested that there is an episodic nature to those services and that really sort of drives what type of funding model you would like to choose.

There are different funding models, obviously, to fund different types of services. We see that all throughout the health care system. Funding models also introduce different types of incentives as well and so those incentives interact with the characteristics of providers, so you want to make sure that any funding model introduces the right type of incentives and that will depend on how the service is structured and how the market operates.

In a number of areas, in health, for example, we see not just one funding system being used but multiple funding models which is a blended approach. That often helps with ameliorating some of the limitations with funding models. There will never be one perfect funding model. So there is the use of multiple funding models in different areas of the health care system and you can see something like that approach could apply to the investment stream. I suppose the other consideration is the trade-off that's required. So funding models can be complex and there is an administrative cost to funding, or to operating a funding model, so that also needs to be considered.

But I suppose the underlying principle for all funding models should be the same and that is to deliver value, so obviously improved outcomes for the best available cost. But also have an equity principle in there as well allowing people to access care when they need it.

MR GRAY: Do you have any particular funding models in mind amongst the mix that might be fit for purpose for this investment stream?

DR CUTLER: Yes. Look, it really depends on what type of service you're looking at. So, for example, respite is likely to be different than any sort of home modifications. So it would require considered thought. A block funding arrangement, which is a really simple way of allocating funding, may not necessarily be the right approach. It doesn't really provide any incentive to improve quality or maintain costs but other approaches such as a capitation approach where people are enrolled in a particular service and they can use that service in in an episodic nature may be appropriate. But it really comes down to a considered approach to looking at each service individually.

MR GRAY: Thank you. Ms Elderton, do you have a view on whether, at a level of principle, there are good reasons for singling out the scope of services that I've described and treating them differently, under a different funding stream which might provide for more scalable and flexible means of assessment and provision of funds?

MS ELDERTON: I think it's not only sensible, it's exciting. The fact is that respite has been considered the sort of tail end of aged care services for a very, very long time. And, as somebody remarked the other day, it's probably one of the most underdone areas of aged care. And looking at respite and the carer's constriction as an investment in the system provides a rationale – a strong economic rationale for it

being properly resourced and delivered, not just treated as the tail end of the aged care system.

And while I think – because very little thought has been put into it in the past, I think there's a lot of thinking still to do. And we're certainly not going to resolve it here today. It's the beginning of fixing respite at last. Yes.

MR GRAY: Thank you. Dr Lewin, could I ask you to respond and, in particular, given your expertise, to comment on whether this opens up opportunities for agile assessment, assessment of the needs to which this stream's intended to respond in a way that's different from and perhaps more agile and timely than general assessment might be.

DR LEWIN: I think it's essential that there is fast assessment and fast response when there's been a precipitating event or a sudden change in need. So, from that point of view, as has already been said, the funding mechanism has got to support that. But not only – assessment isn't at one point in time in a restorative intervention; it's ongoing, because as somebody regains capabilities and confidence, then the input that they require can be quite different and they can actually move on to completely different goals. So that it's certainly not a set and forget. It's a dynamic process when somebody is attempting to regain, relearn, be able to function more independently again. So I think that that's very important.

Another important thing that the funding has to allow, as far as I'm concerned, is I believe very strongly that these sorts of episodes of care should be free to the individual, rather than them having to choose to take it out of a package or whatever. I think that provides totally the wrong incentives. The other part of your question was about assessment. And I think that outcomes are the absolute key in this model, continuous measurement and monitoring of the outcomes to ensure that what is trying to be achieved – and this is not only in terms of accountability for the funder, but absolutely critical for the older person themselves to be able to actually visualise the gains that they're making.

And also for the provider. So many providers in health, they will do – intervene in some way. And if the individual gets better, they don't go back. So the provider is not getting that feedback and reinforcement about what's working and what they should continue doing and what they shouldn't. So measurement is a really critical part, I believe.

MR GRAY: It's been suggested by a former employee of the AIHW in a submission in response to consultation paper 1 that there are numerous gaps in data collection, collection of the data in a way that it's collected once and fit for use for all of the analytical purposes that are desirable. And it's suggested that there needs to be a wholesale national approach to collection and analysis of data in aged care. Is that a view you endorse?

DR LEWIN: I've always believed that there ought to be a minimum dataset that is collected across aged care. But I think it's really important and takes a lot of skill in terms of designing the measures that are actually clinically useful, because if workers on the ground or clinicians are being asked to collect data that they don't think is meaningful to what they're doing, to be quite honest, it's likely to be rubbish. It's just – they fill in the form.

MR GRAY: Are you aware of work being done, I think at an intergovernmental level, on data and a standard dataset of – we will ask Mr Smith in a minute, but a standard data set of some scope at least? I'm not sure exactly what the scope of it is. Do you know about - - -

DR LEWIN: No, I don't.

MR GRAY: Do you know about any work being done on - - -

DR LEWIN: My knowledge is out of date. It was when we first introduced a minimum dataset.

MR GRAY: Mr Smith, are you able to enlighten the panellists and the Commission on the status of work being done on an aged care dataset?

MR SMITH: So, look, I'll probably have to come back with some more detail. I don't have extensive understanding. I know that work around a minimum data set that used to exist under sort of the old assessment form and process moved on, I guess, when we moved to the new screening and assessment form. There is work being done around how the data that's captured in My Aged Care can integrate with the other data in the various systems that we have. But if it's okay, I'd like to come back with a more comprehensive answer.

MR GRAY: And we might be able to ask Dr Hartland. He gave some evidence on aspects of this topic at another hearing earlier.

COMMISSIONER BRIGGS: But might it also be helpful, Mr Smith, if, as well as that update, you provided us advice about what could constitute a really quality sound minimum dataset.

MR SMITH: Yes, please.

MR GRAY: Thank you. Now, before leaving that topic, at the level of principle, is the design concept of a separate investment stream motivated by the objectives that have been discussed, a good idea, an appropriate idea, fit for purpose or not a good idea? Do any of the other panellists wish to contribute at this point or should we move on to the next topic? We'll move on to the next topic.

Now, it has been suggested in submissions that the name of this funding stream should be changed in due course and Silver Chain's submissions suggest re-ablement

and restore. Aside from terminology, however, what are the key topics that need attention if this stream is to be implemented successfully? I'm not going to ask the panellists to come up with the solutions on all of the topics in detail, but let's identify those areas that need attention.

Now, can I just make the following suggestion as to the shopping list of areas that need attention and seek the panellists' responses. I suggest areas that need attention are the triggers for referral and the pathways that would lead to some form of assessment and eligibility allowing funding under this stream; the precise mechanism for opening up the funding, determining the eligibility for the funding. Now, presumably that has to be linked to assessment of some form. What would that look like? Attention needs to be given – and this was a topic I raised and Dr Lewin responded to – around the agility of the mechanism, the timeliness of the responses that are going to be delivered by the mechanism.

And the scope of the services is, obviously, also important and the way in which the system or this funding stream will respond to changes in condition. Now, I was conceiving of that as reassessment. After hearing Dr Lewin's evidence, I'm not so sure that that's the best way to consider how to address that matter. And I'd be interested in the views of the panellists on that topic. And should interventions from this stream always be sought and provided for ongoing care, from the care stream as provided? That's a suggestion raised in one or two of the submissions. What are the panellists' views about that list? Are there important omissions or are any of them inappropriate for inclusion? Dr Lewin, can we start with you again.

DR LEWIN: Thank you. In terms of triggers for referral, as I expressed when we last met, when an individual is first asking for help from the home care system, I think that, obviously, assessment is essential. And I think that if there is any ADL difficulties, most definitely - - -

MR GRAY: Activities of daily living, for those - - -

DR LEWIN: Activities of daily living – which distinguishes from the instrumental where somebody is having difficulties in their shopping or housekeeping. Now, often – sorry – I have to change that, because often when somebody has asked for help with shopping or housekeeping, there are actually underlying difficulties with mobility or other, what we call, activities of daily living. Now – and when somebody is experiencing this sort of difficulty, I personally think it's absolutely essential that they are assisted to optimise their functioning as much as they can.

Now – and as I have stated many times, I actually think that it should be the way in to receiving aged care services if you have that level of difficulty. And not – somebody asked when they're having difficulty, they've gritted their teeth, they've come to aged care and somebody turns around and says, "Well, actually would you like re-ablement, rather than a service?" I think that's an unrealistic question at that point in time and I don't think it should be asked. I think there should be a period of time when a specialised team work with the individual to assist them to optimise

their health and functioning. And then one considers what, if any, ongoing support they need.

Now, I know the question often asked is, "But it doesn't work for everyone." And that's absolutely true. That's what the research shows. But the research that has been trying to identify who does best with that sort of intervention at the moment is coming up with mixed results. So some studies showing one thing and some others. And so I see it, essentially, as a rights issue. Having worked with a team in this space who would say to me that when somebody was first referred they thought that this individual had Buckley's of making any gains at all. Two or three weeks later they were coming back and saying "You know, Mrs Jones, it's just incredible the gains she has made." And a lot of that was working with Mrs Jones around her own expectations, belief, confidence and just making significant changes in her life.

So I think that's important. But I do think that later events, when somebody who is receiving ongoing support then has a triggering event that causes significant loss of function, I think then, given the history of the individual has been receiving care, I think then there very much must be a discussion with the individual when they have a much greater understanding of the re-ablement opportunities and of the system generally, whether they think that a restorative intervention at that time is something that they want to engage in. I still don't think they should have to make a choice about cost, because if it's seen to be able to make a significant outcome that will affect their care in the future, I think that's a very valid free choice to be made. So, I mean, that's my thinking.

MR GRAY: Dr Panter, can I bring you in here, and I will just recap that suggested list of important issues that need attention in the specific design of the way funding is provided under this stream, the triggers and referral pathways and try to identify who might be the people who initiate that. If you've got any particular ideas on the actual substance, by all means share them. The mechanism for determining eligibility, perhaps assessment, how do we instil timeliness and agility in that mechanism. The scope of the services, how to ramp them up if they need to be or ramp them down. What's to be done; is reassessment needed or should it be left in the hands of the service provider. And is there any argument – I don't think Dr Lewin's comments would support, it but is there any argument for a requirement of a period of reablement before any ongoing care can be provided. Those are the topics.

DR PANTER: I mean I think the list here makes absolute sense in terms of the types of things that need to be considered. It comes back though for me to taking that holistic approach and making other sorts of assumptions. So even the whole principle of the investment stream is great in terms of thinking about it from a systems perspective but from the individual person accessing a service, it needs to be as seamless as possible. And they don't need to be worried about whether they are getting something from this pot or that pot. That is what frustrates people enormously at the moment and prevents them getting the service.

So I'm assuming from a user perspective, a client perspective, this is just seamless; they don't know these are different streams. And likewise, I think in terms of that assessment process, it's who within the system is carrying that watching brief for an individual in terms of their changing needs and we had some debate yesterday within the low entry services about that role and where it may or may not sit, but from our practice every day in my organisation, I know that it's the intelligence we're getting back from our front line staff going into people's homes who are spotting things, who are then able to flag internally that Mrs Jones might need to be thinking about something X or Y.

And increasingly through using new technologies and we use our home tracking system called Billy which works on movement sensors and is very unobtrusive but what it – and it's not an emergency system but what it gives us is data over time as to people's behaviour. And we can begin to predict what might be happening. Simple things like if somebody actually starts to go to the toilet more times than they normally do, that is actually a good indication they've got a urinary tract infection which we know is likely to be a precursor to a fall. So Billy enables us to intervene with Mrs Jones as soon as the toilet behaviour changes rather than wait for Mrs Jones to fall.

And we're going to see more of those sort of technologies. And that's the sort of intelligence that flows through to determine whether somebody needs to be reassessed and what the triggers might be. So we do need an agility in that system and we need to have somewhere in the system somebody who has got that stewardship for who is doing that assessment, gathering that intelligence.

MR GRAY: What is the current process, just say Billy gives you that information and an assessment with a small "a", not an eligibility assessment but within ECH a judgment is made that we need an intervention here.

DR PANTER: Exactly.

MR GRAY: Where does the money come from?

DR PANTER: So that will come out of – if people are on a home care package, it comes out of the package. If they are not on a package then we have to work with that individual to look at how they go back through the formal systems to get a change to their RAS assessment, etcetera, etcetera, if they aren't able to pay directly themselves for that service. So that again is part of the active process we have in working with an individual and their family is looking at what are the sources available for them. I would just also say at this point, just going back to the issue that we haven't spent a lot of time talking about home adaptations, I would just make the point that again we have to be mindful that the homes of older people are rapidly changing and are going to change over the next few years.

We are seeing more older people, particularly vulnerable older people, in rental accommodation, and we know from our – again, our experience, there are huge

challenges in getting landlords to agree to home adaptations and all too often we are seeing older people at the annual turn of the lease being moved out of that renal property because the landlord will not have handrails put in the bathroom. They won't have adjustments made and that, unfortunately, is an increasing part of – one
5 of the issues around home adaptations for older people finding themselves in rental accommodation. So I just make that point.

MR GRAY: Thank you. Look, can I open that up to any other panellists who wish to make a contribution on those topics. No? I will go to the next topic. How can
10 ongoing evaluation and incentives for improvement, that is, incentives in improvement, innovation in the way restorative services are provided, be affordably built into the way funding is going to be provided under this stream, and Professor Ratcliffe, I will ask you to consider this in particular. How can evaluation of the success or otherwise of the interventions funded by this stream, encompass and
15 address those very important wellness and quality of life objectives that the Royal Commission has indicated in the consultation paper that they wish to underpin the entire reform. Professor Ratcliffe.

PROF RATCLIFFE: Thank you. I would like to say initially that I think that
20 evaluation is absolutely essential for this new investment stream, which I think from fundamentally is a good idea. And I think that there are ways in which we can affordably evaluate a new stream such as this. So we know that there is a lot of data already that's routinely collected in the aged care system but it's not freely available. So I know that a lot of aged care organisations do collect a lot of data but they keep it
25 internally mostly. So I think what we need to do is to improve the evidence base for delivering timely and quality and cost effective services in this stream. And the way to do that is through evaluation, and this must include health economics and it must include economic evaluation.

30 An economic evaluation is really focused on assessing both the costs and the benefits associated with the provision of services in this stream. So an element that I would really like to stress is as a health economist, I often – I am often in conversation, casual conversation with other people. The focus tends to be on the cost side of the equation but I would just like to say that health economics has a long and very
35 established tradition of weighing up the costs and the benefits. So every decision to invest in a new stream of services such as this one, has a stream of benefits that we would expect would be delivered to older people and their informal carers and their families in terms of improvements in quality of life and wellbeing.

40 And certainly as a health economist, that is one of my main areas of research focus and that of other health economists in Australia, too. How do we quantify those benefits because they are very important. So for every cost there is a benefit and we need to weigh those two sides of the equation up very carefully. So I think we need to make better use of routinely collected data and we also need to introduce new data
45 collection mechanisms. So we're collecting the right data and we should have public reporting of that data. And I think it's very important, as Dr Lewin highlighted earlier, that we measure outcomes. But I think these should not only be clinical

indicators of outcome but they should also be outcomes that we know matter to older people and their families and their carers, which are really focused on quality of life and wellbeing.

5 So they are the outcomes that matter to older people and their families and I think we need to measure quality of life and wellbeing, and that's certainly a strong research interest of mine and we're developing at the moment a suite of instruments with older people in aged care to be able to do that and to be able to then use those instruments in the context of economic evaluation, so assessing the costs and the 10 benefits of new interventions. And I think that sort of evidence is really important and critical as we move forward with the redesign of Australia's aged care system.

MR GRAY: Thank you. We have got evidence – and we are going to get clarification and updated information about it – we've got evidence though that 15 there's work being done of some scope - - -

PROF RATCLIFFE: Yes.

MR GRAY: - - - on aged care data which would include at least some forms of 20 outcomes, and that this is a matter that the Department of Health is currently engaged in at some level. We have also – thank you – heard from you that you've got ongoing work in how to integrate metrics that might measure outcomes in the nature of quality of life and related matters. How far off are we from meaningfully being able to institute a collection regime that will be of use in evaluating the future 25 performance of the system and what can the Royal Commissioners do to speed those very worthy endeavours along?

PROF RATCLIFFE: In terms of our own work, we expect to have our outcome measures available, our final outcome measures, by the end of this year, so the end of 30 2020. I mean it's important to say that there are already a number of existing outcome measures available for assessing quality of life of older people but none of them have been developed from their inception with older Australians receiving aged care services here in Australia. Certainly no instruments that will be suitable and fit for purpose for economic evaluation have been yet developed with older Australians. 35 We tend to take instruments from other countries but we know that Australia is quite a different country to, for example, the UK and this is really where we're focusing our efforts to work with older Australians from the ground up, from inception in developing new quality of life instruments – older Australians who are accessing aged care services at the moment, both in home and residential care and it's likely 40 that those instruments will be different. They will have some commonalities but there will be some differences between the instruments, depending on the context in which the aged care services are being delivered.

MR GRAY: I want to return to another element in the question I posed which is 45 how could incentives for continuous improvement be built into the funding mechanisms that are employed in this funding stream? I might direct that question to you initially, Dr Panter: do you have any thoughts on that topic?

DR PANTER: Thank you. I mean, I think for me it goes to the core issue of what it is we're trying to do with not just the investment stream but the system overall and if our goal is about enabling people to continue to live independently and eventually have a good and respectful death at home, if that's their choice, then we need to be much more focused on incentives which are about those outcomes, rather than alternatives. And so for me, it's the thing that we track, for example, is migration from a home care package into residential aged care. Now, I think on the national data which is quite difficult to understand but what we can make sense of, then it's around about 45 per cent of individuals on a home care package of some sort will eventually migrate into residential aged care.

As an organisation, our goal is to enable to carry on living independently and we do our own version of that outcome measure and are currently tracking about at about 15 per cent of people in our home care packages migrating into residential aged care. We have a much higher number of people dying at home as a consequence, which is their choice which is what they wish to do. We also have a much higher utilisation in terms of that issue of the unspent funds where we travel at around about 95 per cent as opposed to the national average of 75 per cent. And I think for me, within the existing system there are data items that are perhaps collected that could be improved to provide an incentive because, say, if the goal at the end of the day is about enabling people to carry on living independently then how do you actually incentivise that and not some other outcome and how do you have the appropriate check to make sure, which comes back to for me the individual using the services, that they are satisfied with what they're getting to ensure that we don't have a perverse incentive where people are just kept at home, for example, unnecessarily against their will.

So I think it's a combination, but we've got to have a system, the funding system which does incentivise those outcomes, as opposed to counting the inputs, which is what we spend too much time doing.

MR GRAY: Has ECH come up with those metrics and those evaluation method off its own bat or was there an incentive provided by existing grant agreements or something of that kind externally that incentivised you to come up with - - -

DR PANTER: No. When we made the decision to move away from residential aged care five years ago, my board made the decision to invest in research in order to pursue the goal of enabling people to live at home independently. And so we have a small research team, literally two and a-half people, and we've come up with measures that we can use internally. We try and track data nationally. The whole issue about place of death – had long conversations with Kathy Eagar at Wollongong about this. You know, it's very frustrating.

In the basic national datasets and the ABS, we don't have actual information on place of death, believe it or not, because people mis-record, there's no consistency between jurisdictions about what counts as home, what's hospital. So just even to track some basic issues there are some deficits. So we try to make good for ourselves. And the

incentive is that we're mission-based and we want to deliver what our users, the people who come to us for a service, want to achieve, which is to live at home independently for as long as possible.

5 MR GRAY: Mr Smith, I'll give you a bit of a general opportunity to respond, but I suppose the pointed question is shouldn't there be incentives of this kind built into the funding arrangements presently? And, at any rate, whether there are or aren't – please, answer as you wish. Whether there are or there aren't there should be in future, shouldn't there?

10

MR SMITH: Yes, absolutely there should be. And the intention around a lot of the work we're doing is how you do build incentives into to re-able and to have sort of restorative care as part of an embedded in that service provision and not just through an investment stream but as part of what is delivered for what service providers are
15 funded for already. The work through the new aged care national classification system has an assumption that a person will come in, they will be assessed at a particular level and if the provider can re-able that person and that person sort of increases function and is able to, I guess, cost less to look after, frankly, in the facility, there's not a reassessment required that that sort of money – that additional
20 money can be, you know, reinvested by the facility and retained by the facility. So absolutely it should be part of the design.

It doesn't work as well in the current model as it should under the current ACFI, just talking about resi care here and note that we're not in the investment stream, but in
25 resi care. The ACFI sort of has a similar thing. You don't need to re-assess people, but there are other perverse incentives in the ACFI that kind of override that, I guess. So, fundamentally yes, I accept the point that there should be incentives built into the system and that we need to do more to achieve that.

30 MR GRAY: And that sounds like a worthy first start with the Aged Care National Classification Project AN-ACC. But Dr Panter has raised a number of other possibilities that are worthy of explanation, aren't they? Whether the person has actually been able to die in the place of their choice, etcetera. These are all worthy of exploration. And I suggest if they are worthy of explanation, is there a way to –
35 there must be a way – I suggest, a way to incorporate them into whatever the funding mechanisms are to provide a reward to those providers who can achieve improvements in those metrics.

MR SMITH: Yes, absolutely. And I guess the principle being and the principle that
40 we're pushing through the ANAC is one we should be pushing through the rest of the system, that there is reward for achieving the outcomes. And, you know, I note that the references to the use of the unspent funds. And that's about, presumably, engagement with the consumer in about how they, really, maximise the funding available to them and the relationship between the provider and the consumer to
45 engage on the use of those funds. So I accept the point and do agree that it should be part of the future design.

MR GRAY: Can I just open that up to the panellists. Dr Cutler, do you wish to make any observations about anything you have heard on this topic or from any of the other panellists?

5 DR CUTLER: Yes. Look, so I think there is an absolute need to incentivise providers to improve quality, particularly within the residential aged care sector. So, you know, there's some research that we're currently doing, which is around looking at how incentives are used in other aged care sectors in the US and the UK, for example. And we know that public reporting of performance in residential aged care
10 or long-term care, as they call it over there, can improve outcomes for residents. And so, therefore, you know, there should be some consideration around developing and publicly reporting a robust quality performance framework in Australia that not only looks at clinical outcomes, but all other areas that impact our wellbeing, so, for example, social inclusion.

15

The other point I would like to make also is that for a quality performance framework to work and to incentivise quality, there needs to be some other structural changes to the Australian aged care system. So the research suggests that there is less incentive for providers to deliver quality care through the market when there are
20 high occupancy rates, because they have access to residents and they don't necessarily need to go out and increase their quality to attract more residents. So I think there should be some consideration within the Royal Commission around removing supply side restrictions on subsidised beds.

25 MR GRAY: Thank you. Could I turn to a different but related topic, which is, going back to this point about the mechanism to determine eligibility for the funding that will be available under this stream and to delve into the question of what that eligibility mechanism should look like in a little more detail. I'd like to bring you in, Ms Sparrow, into the conversation, from the sort of ACSA and provider perspective.
30 We've heard from Dr Panter, but you could give us some other perspective.

We need it to be timely, we need it to be flexible, we need it to be scaleable. The consultation paper actually suggests that comprehensive needs assessment will be a unitary in a particular place. It may not look the same for every individual. It may
35 be scalable with reference to the apparent needs of the particular person. But, nevertheless, it will be one form of assessment which could lead to, in the care stream, an individualised budget in the form of a package, expenditure of which can be directed by that individual.

40 But in the case of these investment stream interventions, money that will be spent from other forms of funding and not taken out of the individual's package. The important point here is, for the purposes of my question, the assessment process that's proposed in the paper is, essentially, the same comprehensive assessment. What are the strengths or weaknesses you see in that approach and do you see scope
45 for the providers themselves to be involved in some form of triggering of investment stream funding and response?

MS SPARROW: So, look, I think the strength of it is actually that for the person there's one process that they're going through. And I think that should absolutely be our focus. And I think that's something we have heard really clearly from people. So I think having a comprehensive place where people are being assessed. It's a little bit, as Dr Panter was saying, you know, some of the mechanics behind that, the person that's going through that process doesn't need to be aware of; we just need make sure that works for the person. So I think that's a strength of it.

I think that what we also have to make sure – and we heard evidence – around the need to bring in specialist expertise, particularly around assistive technologies and also the restorative stream. So within that assessment we need to be able to draw in that specialist assessment that makes sure that people are identified who can benefit and that assistive technologies, in particular – I know if they're not assessed properly and then people aren't supported to use them, they're not as successful. That needs to be set up at the assessment piece.

One of the weaknesses that I would see, potentially, is if you have to go through a comprehensive assessment before you receiving anything, there may be people who are in dire straits or in really difficult positions. So I think there has to be capacity within the system. And I think we talked about this yesterday, as well, particularly, say, for example, on something like emergency respite. There should be ways of just referring people to that service. And maybe for some of the basic sort of entry level services and the assessment coming in after a point in time – it might only be a few weeks – to give that wrap-around assessment.

MR GRAY: So would you come up with a category of services that could be provided virtually on demand for some interim period with comprehensive assessment to come thereafter?

MS SPARROW: I would. I think that'd be a guide, because, you know, every individual's different. So there might be something that somebody really needs that can be provided easily. But there probably is a guide and certainly respite and meals and community transports are the ones top of mind for me that sometimes people can just be referred to, it helps them immediately and then an assessment can go in. But I do think this needs to be assessed more independently at the outset. There may be a different connection with providers. And I think Dr Panter and Dr Lewin have talked about where some of the – when changes happen, where some of those come from and how providers can contribute to that.

But I think at this point it's independent. People should be able to be referred to basic services or emergency services from a variety of sources with the assessment then coming in. And we have to make that in the assessment capacity that we have that we've got the specialist either in-house or to be contracted in to make sure that the restorative assessment and the assistive technology assessment and home mods to that extent are assessed by people who really understand and know what's needed in those areas.

MR GRAY: So let's just explore a little further how that might look. We've got that assessment body with the ability to draw in the expertise that's required. It's scalable, in light of the apparent needs of the individual. You don't need full interdisciplinary team if the needs are quite limited. If the needs are very complex, you might. That's fine. And, in terms of the role of the actual providers of care, they are not doing the assessing, which triggers eligibility.

MS SPARROW: Not at that point. They would be referring.

MR GRAY: They are providing - - -

MS SPARROW: So they might know that someone would actually be eligible and can refer for that assessment.

MR GRAY: And there might be, in effect, a list, not entirely prescriptive, but a guide, of the services that are, effectively, immediately available on call to provide that flexible scalability and to respond to episodes. And that request or that demand might come from the approved provider. Is that how you see it?

MS SPARROW: They may have a view that they're putting forward around that, yes, they may.

MR GRAY: There should be, in effect, expedited eligibility for - - -

MS SPARROW: I don't know if I'm saying expedited eligibility. I think I'm saying that providers are sometimes in a position, if someone's already in the system, in particular and they're working, to be able to – working with that person to be able to say this person may need something additional. So I think that should be looked at. I think – I know we've talked about the perverse incentives in the ACFI, but there is capacity within the ACFI for providers – with tolerance level to be able to recommend or provide some additional services. And I think there needs to be that capacity in the system with appropriate checks and balances in place.

MR GRAY: But what are those appropriate checks and balances in a very urgent situation?

MS SPARROW: Well, in an urgent situation – not in an urgent situation I'm suggesting there should be a referral and the person should get the service. And that might be from a service provider, but, equally, it could be a family member or it could be a GP who's actually saying if emergency respite's not provided – and emergency respite's probably the clearest example – if we don't put something in place to give emergency respite, then this situation is going to break down; someone might go into residential aged care who doesn't need to go into residential aged care or to hospital. And those are the situations where I'm saying we just need to provide the service.

MR GRAY: Mrs Elderton, is that a workable model from your point of view?

MS ELDERTON: Absolutely. And, especially as Pat's pointed out with respect to emergency respite. An emergency is an emergency. It's something that requires an instant response. You don't have time to go through all the forms and procedures. And if there is – if some post-facto accountability is required, it can be done after the emergency has passed. But, also, in terms of talking about comprehensive assessment, I think that actually should include a better assessment of the carer's needs than happens at the moment. In RAS, for example, at the moment, I think there are about eight questions at the back of the RAS that might involve the carer.

The carer is often not there and not encouraged to be there, so they don't get their side looked at. And yet it's through the RAS that you get referred to respite and we know that since the RAS was introduced, the number of referrals for respite has been – we know anecdotally has been going down and down and down and down, more referrals for respite actually come through the ACAT which is a more comprehensive assessment.

MR GRAY: Dr Lewin, can I just seek your response in summary to Ms Sparrow's description of a model that might work. It's key features seem to me to be that assessment triggering eligibility isn't to be conducted by approved providers or are other people who may be making referrals including health professionals, but in urgent circumstances, in effect, there should be what amounts to expedited provision – call it expedited eligibility, that was my expression, for those sorts of services with a comprehensive assessment by an assessment body to follow and that assessment body is to be able to draw in the expertise it needs. Is that a workable model?

DR LEWIN: I believe so. I think it's absolutely essential, certainly when somebody is first referred for support services, that the assessment is independent, that it is comprehensive, that it is face-to-face and that it is reablement-focused from the beginning and I strongly believe that people experiencing difficulties with the instrumental activities of daily living and extended assessment period with coaching and support from a trained assessor may well be sufficient. But for somebody who is experiencing difficulties with activities of daily living and actually need supervision and support to complete the tasks that they're having difficulty with, that is gradually reduced over time, then they need to be referred to a specialised reablement team that doesn't necessarily – isn't necessarily multidisciplinary at that stage but I do think there is a need for multidisciplinary teams for the more complex care needs that somebody has, especially as we know the very close relationship of health and functional needs.

And it's often a health event that has triggered the functional decline, and so I think that that specialist team, I think we discuss the need for specialist more later. But yes, so separate assessment, I think that maybe there are occasions when, for instance, somebody coming out of hospital and they are – there is an in-house specialist rehab team, then it might not be a full assessment. It would be – there would need to be contact with that independent agency, I think, whether it was a full-blown - - -

MR GRAY: In effect an endorsement of what the hospital specialist rehabilitation team might recommend?

DR LEWIN: Yes.

MR GRAY: Yes. Now, could I just briefly ask, with respect to what Ms Elderton said about reorienting the assessment process for the longer term respite needs to take into account the long-term sustainability of that caring relationship by giving carers a bigger place in the assessment; are those remarks that resonate with you?

DR LEWIN: I think for many, many reasons the significant others, be they considered carers by the individual or not, ought to be involved in the assessment process as the individual's advocate, as someone taking notes, as somebody who is also absorbing the information so that they can help the older person.

MR GRAY: That's not Ms Elderton's point, I don't think. Ms Elderton's point – tell me if I get this wrong, but is that we need to reorient the assessment process to sustain the caring relationship, not just for the carer to be a means of communicating with the person.

DR LEWIN: And I totally agree, but the point about respite from RAS having gone down, I think if you looked also at the functional needs of people going through RAS as compared to people now being referred for a package, that you would see that in the situation, the RAS situation, many fewer people are caring in a very extensive role, and except in the case of emergency, would often not sort of even think in terms of respite.

MR GRAY: Well, it's probably a bit of a distraction from the task at hand to get into a debate about that but I think - - -

MS ELDERTON: I take your point and that's why I think, actually, that respite assessment is misplaced in CHSP.

MR GRAY: I think we will move to the next topic but thank you very much for your contributions, unless there's any other burning issues that are on the minds of panellists on that topic. Right. I will move to the topic which is numbered 6 on your notes. This is a topic around reflecting what I call the fiscal defensibility of the stream, which is an important rationale for this stream being a more liberally available source of funding to meet needs that represent interventions that will prevent or deter progression to higher forms of need. Do we actually need to quantify a dollar value of the costs that are saved by the intervention? Is quantifying the dollar value of the "investment" represented by that funding necessary and does one need to compare that with the costs that have been avoided, in effect, conduct a numerical cost benefit exercise or a quantitative exercise, or can this be left to clinical judgment, or is the answer, well, it depends.

For example, if we're talking about a modification to one's home, that might lend itself to a quantitative cost benefit analysis better than, say, an episodic clinical response. I will open that up to the panel. Dr Cutler, I might start with you.

5 DR CUTLER: Yes. So the first point I want to make is that it's absolutely necessary, I think, to ensure that we are measuring the dollar value of any investment that the government spends. Any dollar that's spent in an area that is not producing good outcomes is a – there's an opportunity cost associated with that and if it can be spent elsewhere in the system to produce better outcomes then resources should be
10 shifted there. In terms of the detail, so evaluating an investment on an individual basis, I think is really difficult to do. It's easy to predict costs associated with the service but it's much harder to predict the potential outcomes for that individual. Not everyone will benefit from the service. There is some randomness associated with assessment, but I think that's okay within a broader program perspective.
15
What we do need to do is have some type of guidelines that – or guiding principles that allow people to determine whether someone should get access to services, based on the likelihood of them achieving better outcomes or avoiding costs down the track. And then, finally, I think there should be an assessment on a cost benefit basis
20 at a program level rather than at an individual level. And at that program level we can then start to say okay well, are we delivering better outcomes, is this cost effective, and if not start adjusting those levers through those guiding principles.

MR GRAY: Parts of what you said drive us back to the data question, so we have
25 that foundation in data for evaluation, and we don't know how many years off we are from being able to do that. Do you have any suggestions about interim measures?

DR CUTLER: Yes, I don't think data is an issue here. When we do introduce new programs, we should also be thinking about the data that we're collecting for those
30 new programs for the purposes of evaluation, and that can be done on a sample basis. So you don't need data for the whole of the program. You just need to focus on a representative sample within that program. And we see evaluations of specific programs at the state and the federal level all over the health care system that doesn't necessarily rely on administrative data to be collected. So I wouldn't see the issue
35 around administrative data collection a problem.

MR GRAY: I don't think you agreed with me that there would be any situations where an individual cost benefit analysis should be conducted, not even in the case of home improvements?
40
DR CUTLER: Well, it would really be difficult to determine whether that individual would – well, not benefit but – what we normally do in an economic evaluation is we don't look at the individual. We look at a group of individuals and we say, okay, for this individual group this is a welfare improving program, and I
45 think when we do look at a group of individuals, remove some of that randomness associated with an individual accessing a service. So I don't think there is a need for a formal cost benefit analysis on an individual, but I think there should be guiding

principles around the likelihood of a service being delivered to an individual being valued, being of value.

MR GRAY: Can I open it up to the other panellists and Mr Smith, do you have anything to say against any of Dr Cutler's responses on those topics?

MR SMITH: No, no, I agree with what Dr Cutler has said.

MR GRAY: Dr Lewin.

DR LEWIN: Whilst I totally agree with Professor Cutler in terms of restorative services I am aware that in the UK that they have to come up with, essentially, a cost benefit analysis on an individual basis for home mods and expensive bits of equipment. So it would be interesting to look at how that system works and whether it's considered to be fair by the community generally.

MR GRAY: Thank you. Professor Ratcliffe, are you able to bring a quality of life perspective into this? Can you do at a program level, a cost benefit analysis which encompasses quality of life metrics?

PROF RATCLIFFE: Yes, I believe you can. Strictly, when we think about cost benefit analysis we think about valuing all outcomes in monetary terms. But certainly as a health economist, I think that what we would aim to focus on would be cost effectiveness analysis. So I think you are entirely correct in the fact that we need to weigh up all parts of the equation here. So one very important aspect of evaluation is to think about the inter-sectoral effects so not only focusing on the aged care system but what the impact, for example, of home modifications might mean for an older person who is able to remain living more safely at home, therefore doesn't fall over and doesn't end up in the A and E department and an extended stay in hospital.

So that's also, I think, a really important element of the economic evaluation that we need to be very mindful of. That we do need to think more about the intersects, I think, between the aged care system and the health system and we know that, you know, it's very distressing for older people and their families to end up in the health system so anything we can do to keep people safe in their own communities is obviously very important. So in terms of cost benefit analysis, yes, we have the costs of the initial investment, for example, in home modifications but we also have the cost modelling in terms of the averted cost impacts of, you know, these types of events, for example, an older person falling and ending up in hospital with an extended stay which we know is also very costly and very distressing for the person themselves.

MR GRAY: Thank you.

DR LEWIN: We could also incorporate those costs and the costs averted with the quality of life in a cost effectiveness analysis framework. That's what I'm trying to – I hope that was clear.

5 MR GRAY: Yes, thank you.

PROF RATCLIFFE: Yes. I believe we can, in short, yes.

MR GRAY: And are there any other burning issues on the minds of the panellists?
10 I'll move to the next topic. Perhaps this question's largely unnecessary if it's in fact the case that there isn't a separate cost benefit analysis required on an individual level. If there were to be, and if a notional – a budget – not an individualised budget to be spent at the direction of the individual in question, but a budget generated by the cost benefit analysis on an individual for the purposes of comparing the cost of
15 the intervention with the costs avoided and, therefore, the benefit to the system of making ..... if that figure were to be considered a limitation on the services that could be provided, what are the weaknesses or strengths that the panellists see in that approach?

20 In other words, if a dollar value is calculated, should the funding of the services provided to the individual be treated as being limited to that amount? And, again, is the answer, "Well, it depends"? It might be different when one's considering a home modification. Perhaps a strict budget should apply. As compared with a clinical intervention, where there would be very powerful arguments against the strict budget
25 applying. What are the panellists' views? I'll just leave that open. Are there any views?

DR CUTLER: So I think there's a number of issues here. Theoretically, what should be happening is that we should be providing money to a service for an
30 individual so long as the benefit outweighs the cost, until the point when the benefit equals the cost. And then we say, "Okay. That's enough." In reality, what happens is that there are budgetary constraints within government. And so an amount of funding may be allocated to a specific budget and that stops the service delivery, even though there may be additional benefits to be gained by providing additional
35 services.

So I think it's, you know, it's a trade-off between the two. One way you may want to get around that is if you start thinking about, well, the government can provide a level of service and then there may be some co-contributions after that. But
40 theoretically what should be happening is that service should be delivered until that benefit – the marginal benefit equals the marginal cost.

MR GRAY: Any other contributions? Professor Ratcliffe.

45 PROF RATCLIFFE: Yes. Thank you. So, I mean, I agree completely with Dr Cutler's comments. So, you know, in the health system we make these sorts of decisions all the time. And it's not always about – it's not just about the least costly

intervention; it's an intervention may be more costly, but it may be delivering a much higher quality service. And, therefore, we need to be able to measure the outcomes, because if a new service is more costly but it's delivering, you know, much greater benefits in terms of quality of life and wellbeing outcomes and it's having a real improvement in terms of being able to avoid people having to go into hospital, for example, unnecessarily, then that might be a very good investment. So it's about weighing up the costs and the benefits. So it's not always about – you know, just about the cost side of the equation. I guess that's what I'd like to stress.

MR GRAY: Thank you. Ms Sparrow.

MS SPARROW: Yes. I would certainly agree with that. And I think there are – in the health system and the disability system there is information that can be used to inform what levels of funding might be provided to get a particular outcome. And I would see that that would be the case here and defer to Dr Cutler and Professor Ratcliffe about, you know, how that's done. But I think there would be reference. And we see that in health and we see that in disability and I suspect we'll see that in aged care.

MR GRAY: Thank you. Dr Lewin. Sorry.

DR LEWIN: Sorry. I just wanted to say that, given the restorative interventions are in the main time limited and intensive, that that by itself, if that is how the service is operating, will be a limit to the amount of funding. And what used to happen in Silver Chain was if somebody was making such obvious progress towards their goal still at the time limit, then there could be a discussion with the team leader to go over time. And so – because that's also over budget, if you like. So that perhaps a similar mechanism could work, because, also, I think if there's that intensity, people often need time to sort of re-establish a different level of functioning. And then you might want a later intense period of work again, when somebody is working on other goals, rather than it just sort of extending. I think you'd get more efficiency.

MR GRAY: And when that happened and there was a budget overrun for that individual - - -

DR LEWIN: Yes.

MR GRAY: - - - was the organisation simply absorbing that or was there an ability to get more funding from, in effect, the assessment body and a triggering of eligibility .....

DR LEWIN: The restorative services were funded in different ways at different times. And at one time it was block funded. So there was a nominal average amount per person. But – and we were funded for a number of people. And so you could – the provider could then adjust according to needs. You know, there was enough flexibility within that to allow there to be differences in terms of input according to need.

MR GRAY: Thank you. That's a very good segue into the next set of topics, if we can move on. Are there any other burning issues just on your minds on what we've just been discussing? I'd like to go into the funding mechanisms. At the one end of the available spectrum – I'm not saying that this is necessarily proposed by consultation paper 1. I think consultation paper 1 is just posing the question, "What are the appropriate funding mechanisms for this stream?" But at the one end of the spectrum one could conceive of some form of a directable package for at least some of these services.

Now, that's a topic that I'd like you to turn your minds to and whether there are any of these services that would be amenable to, in effect, consumer direction in the form of a package. And there are powerful arguments for and there are powerful arguments against the whole principle of consumer direction. A very powerful argument for it is that it's a way of reflecting the imperative of putting the person receiving care at the centre of being able to plan for and obtain the care in question.

That might extend to elements of the services intended to be provided under the funding stream. Is there perhaps, again, a different answer for different forms of services? For example, a much better rationale for putting that form of choice in the hands of the care dyad in the case of regular respite. What form of regular respite? Provided by whom? Compared with, in effect, an emergency response to a clinical episode. So I raise that for you.

And then can we have a more general exploration of the benefits of and the weaknesses of block funding; that flexibility with regard to overs and unders; activity-based funding, a mixture of block funding to ensure that some level of scale is achieved and some level of sustainability of an organisation is achieved with an activity-based overlay on top. These are the sorts of matters I wish to open for discussion now. And we'll start with you, Ms Sparrow. What are the appropriate funding mechanisms? Is it a mix? Does it depend on the service what you use?

MS SPARROW: I think it's a mix. And I think there are very different services within this stream. And, exactly as you were saying, in terms of a respite in an ongoing capacity, I think that is much more amenable to being part of a package for the person and their carer. But some of them, like the intensive short-term re-ablement services that we're talking about, probably a little bit different from that. There should always be an element of consumer direction and consumer choice, but there may be in those service – and it depends largely on the skill of the assessor and the skill of the people working with the individual – that there are some elements in that are fixed elements, that, you know, that's what this funding's being provided to deliver.

Different from how we see in home care packages, where people might be choosing to spend their money in one way and not doing some of the elements. I think there's a little bit of difference needed in this, particularly in re-ablement assistive technology, that that money needs to be spent on that product or on that.

Now, the other area to look at is what might work in metropolitan areas might be very different to what works in geographic areas. So we also have to look at how do you make sure in rural and remote services that people can get access to these services. And I do agree with you, whether it's block funding or activity funding which – you know, if you look at the way some activity funding works, it stills means that people have got a block of funding, because that's how you can ensure capacity in the system.

And we have seen with respite that we lost some of the capacity through the Commonwealth Care Link or care respite centres where they would block book beds in residential aged care to be available. When that stopped, the providers couldn't keep the beds vacant forever on the chance that someone might come in for respite. So we also have to look at it in terms of how you make sure there's capacity.

Not just in residential respite, but I also think there are other forms of accommodation that actually are probably preferred by individuals. So the smaller cottage or being able to stay in a day centre overnight, because they've got that capacity, where we also need to look at making sure that there's funding that helps them to be there and to keep the door open so people can use them when they need them.

MR GRAY: Well, can I go to Dr Cutler first. I have a feeling Ms Elderton might want to contribute at least on the respite point. Dr Cutler.

DR CUTLER: Yes. So, as I noted at the start, there is a need to have different types of funding models within the aged care system. I suppose the starting point, really, when you're thinking about funding models is what are your guiding principles around choosing a funding model? And there are several that you could choose from. So, for example, fairness, allocation to need, making sure that the funding model is administratively efficient and also sustainable.

The other area, I think, is around incentives and how do you use incentives to improve the wellbeing of an individual through a funding model, if that's what you want to do? So there is a list here which talks about activity-based funding. That, obviously, promotes activity. It doesn't necessarily promote improvements to equality. There is block funding arrangements, which aren't necessarily allocated according to need. That will, really, depend how the government allocates that funding and on what basis. So I think the importance is, really, around making sure you have a good understanding of what your funding model is trying to achieve.

I just wanted to make one more point, which is around outcomes-based funding. So in the last five to 10 years Australia, within the health care system, has been at least exploring the potential to use outcomes-based funding. One of the preconditions for that is to have a very good measure of outcomes and what is – what attributes to outcomes through a service, for example. So it gets back to your data issue, the administration data issue, around measuring outcomes and wellbeing, but then potentially attaching funding to those outcomes.

And we can see through changes in the independent hospital pricing authority, for example, that sets prices for – efficient prices for public hospitals. They are starting to look at an outcomes-based funding model type where they will no longer provide funding for certain events that shouldn't occur within a hospital.

MR GRAY: Thank you. Ms Elderton, do you wish to contribute on the respite point and the idea that there might be an argument for a different form of funding for at least the planned regular respite? That is, a different funding mechanism, such as packages.

MS ELDERTON: If capital funding comes in as a form of block funding, I certainly think there is a case. The money available for – Hammond Care says for dedicated residential respite, which is like cottages or any other form of dedicated residential respite, hasn't changed in so many years. And block funding – capital funding is not available to them at all. It is the preferred form – a residential place to go and stay where respite is needed. And I would hope that any changes to respite in the future would include capital funding for a preferred form of respite. I think - - -

MR GRAY: So you're saying that the package could be a hollow gesture in the absence of supply of the desired services.

MS ELDERTON: Absolutely.

MR GRAY: And really we should be focusing on building or incentivising the building of now forms of flexible - - -

MS ELDERTON: Yes, where you've got massive undersupply, absolutely, yes.

MR GRAY: And it's far too early to be considering any sort of package approach.

MS ELDERTON: In a way.

MR GRAY: This is block funding and capital funding, is that what is needed? What's the data like supporting that – underpinning that argument about unmet need?

MS ELDERTON: Well, the data available, I guess is in one case how few cottage respite or dedicated respite facilities are actually available in Australia and in 2017/18 I think there were 100 cottage providers across the whole of Australia, bearing in mind that some of those facilities were very small indeed. And the reason, one of the reasons they can't be expanded is that the up-front cost of doing that is not able to be covered by the providers. But I think Dr Panter might - - -

MS SPARROW: Could I just add - - -

MR GRAY: Yes, Ms Sparrow, and then we will go to any others.

MS SPARROW: I think it's two things. I think we need to have both. I think we need to have the funding for ongoing respite which is often delivered in home or in other forms of community settings, but there is a difficulty in getting some of the other more innovative and smaller forms of accommodation that provides respite because there is a lack of capital and for residential care providers, some of the ways they have to manage respite, there is quite a lot of an administrative impost on them. It's almost as if a person is coming in for ongoing care. So I think we need to make it easy for that form of respite to be available through capital and also through looking at how the administration, etcetera, is done to make sure that residential respite can also be available more easily.

MR GRAY: And are you referring there to the issues identified by ACFA in the 2018 - - -

MS SPARROW: Yes.

MR GRAY: - - - ..... distortions.

MS SPARROW: Yes.

MR GRAY: Thank you. Anyone else?

DR PANTER: Yes.

MR GRAY: Dr Panter.

DR PANTER: Yes, if I could just make a couple of comments. I mean, again it seems to me that there is potentially the need for a mixture but nonetheless that can still be consistent with the principles. So similar to the debate yesterday around the entry level services, you can have block funding and still individual choice because you can block fund 80 per cent of what an organisation has historically provided. 20 per cent is at risk depending how many people come through the door. And you can vary that year on year, so I think there are some mechanisms. But I really wanted to pick up and reinforce Dr Cutler's point about the health outcome type activity work because I think, again, overseas there are now a number of growing examples where, by pooling funds across historic silos, you get better outcomes, both for the individuals receiving the services as well as for the taxpayer.

I'm talking about the silos; it is across the whole of the government funded system, particularly around primary care and hospital care and aged care, because we may end up, as a result of the Royal Commission, some wonderful changes in the aged care system but unless we also have some impact on both the health system and the way in which primary care works, hospital, then we will still end up with people at the end of the day getting potentially a poor experience and taxpayers getting a poor deal. And so that sort of focused work – and there's work around children in need, there's work around homelessness, there is a number of different population groups in places like Scotland, the UK, Canada, Scandinavia where they've really

demonstrated by breaking down those silos and giving the ability to pool at that local level, you get better outcomes, and better use of the resources. I think we also need to bear that in mind in thinking about the funding and not just the plethora of pots that already sit within the different silos of the aged care system.

MR GRAY: Thank you. Can I go to the next topic, number 11 on your notes. Where the intervention in question is for a person who is already receiving care in an institution or residential setting of some kind, in the current system that would be a residential aged care facility. How is the relevant suite of interventions funded under this investment stream best to be integrated with the other care that's being provided? Should there be, in effect, a default provider presumption that the existing aged care provider is the provider of the interventions? Might that, again, depend on the specific interventions? You might need specialists but if they're interventions that are best adapted to integration with everyday care how are we going to achieve that, remembering that the consultation paper proposes a system in which unbundling of who provides care is possible in the future.

That's not to say it's going to happen very quickly but it's one of the principles being proposed in the consultation paper that by placing the individualised budget for ongoing care needs in the hands of the person receiving care, that person could conceivably choose to have nursing care of various kinds from one provider and different services from another person and that those services might be unbundled from the provision of all the services that are tied up in providing accommodation. How is the investment stream service to be integrated with the provision of overall care; are there any views on the panel about that topic? Ms Sparrow, have you got any views.

MS SPARROW: I think the unbundling issue in residential aged care is a really interesting one to explore and there are – and I know disability does that slightly differently but there are a series of increased risks where you have a whole range of providers coming in, in terms of who is responsible overall. So I think it is important to look at if the residential care service has the capacity to provide the service, and they're skilled and they've got – to do that, that that may be the most appropriate thing. That should be discussed with the resident and the resident's family. If they can provide that, I think that's a good model.

If they need to bring in outside expertise, some kind of coordination point needs to be in place to ensure that there is responsibility overall for the service that's being delivered and the person does indeed get the service that they need and it's going to be the most beneficial for them.

MR GRAY: Is that a return to the conversation about the potential services that could be provided by the care finder, if the care finder takes on the care coordination role or are you saying that person should be in the residential aged care facility, should be in effect in the current world the clinical care coordinator or the DON or the practice nurse?

MS SPARROW: I think there are two points I would make. I think there is a whole conversation that we need to have about the care finder, the case manager, the case coordination, and I think listening to the conversation yesterday sometimes we mean different things when we say that. So I think we're not having a clear conversation and we need to do some defining and working that through and then working through what the roles are. So, yes, particularly in the home care it could be there's the care finder or the case manager, whichever one we are talking about that has got an overall responsibility.

MR GRAY: It might be the same person.

MS SPARROW: It might be the same person.

MR GRAY: None of these things are set in concrete.

MS SPARROW: That's true, but I think that's where it's really important that we clarify what we mean and determine what the roles are and then look at where that sort of responsibility sits. With unbundling, I suppose I'm expressing some concerns about unbundling in residential care and the impact that that may have. If it is to pass that services can be unbundled in residential aged care and we're saying that there could be a case management person or a care finder that is going to actually have overall responsibility for what happens to an individual person wherever they're living and however many providers are coming in, each provider is going to be responsible for the quality of the care that they provide, and there's going to have to be a point somewhere overall where there's responsibility.

But I am saying I think that it's a more difficult thing to do in residential care to do well and that we need to look at the rightful role of the residential care provider as well as the choices of the individual. So I think that's just more difficult to navigate.

MR GRAY: Any responses? Dr Lewin.

DR LEWIN: I think that given that it is a specialist skill drawing up a restorative support plan, care plan, whatever you want to call them, it would depend very much, as Pat indicated, whether the provider has somebody with that level of specialism in-house. And if it's external and in reach then if, again, the provider has the capacity to provide the support staff for the extra time that is required to be spent with the resident to help them reable and regain skills because we know that it is more time intensive than it would have been when the person was more able before. So that – and they will work closely with the specialists so to make sure that it's actually happening, then very much so.

You want a coordinated, integrated approach in somebody's home. But you do need to bring to bear that specialist knowledge and oversight to make sure that it's happening. And I mean the other positive effect of having specialists working in to the residential care is the effect and influence that it will have on the other support staff. And the opportunity to reward their wellness and enabling types of behaviours.

MR GRAY: I think – thank you. I think we have probably covered point 12 in the notes and I would just like to open up what Dr Lewin said in support or, in effect, making sure that the system nurtures specialisation in this area for general comment by any of the other panellists. Do any of the other panellists wish to respond? I'll
5 move to the next - - -

MS SPARROW: Sorry, just – it's a good point and well-made but I would just raise again in terms of accessing rural and remote and regional areas we need to be looking more at how we make sure – and I think we've seen case studies through the
10 Commission where the quality of care has been compromised because they haven't been able to access that specialist support and I think we need to be looking at how we do that better.

MR GRAY: Time doesn't permit but there's also a proposition that has been
15 developed and tested in the hearing in Canberra about the possibility of a dedicated program for specialist inreach teams.

MS SPARROW: Terrific.

20 MR GRAY: Now, I'm going to move past point 13, I think it has been mentioned. I want to go to an aspect of respite and this will probably be our last point because I think the other points on the list have also been covered. Could we please display Carers Australia's submission at page 7. Ms Elderton, there's a point made here about submissions that Carers Australia is making for amendment of section 34 of
25 the NDIS Act. Section 34 of the NDIS Act provides a nexus between development of care plans under the NDIS regime and the development of a budget reflecting the supports that are reasonable and necessary in light of those care plans.

There's a clear analogy that one can draw between some of the ideas in the
30 consultation paper and those processes under the NDIS Act. Section 34 on the submission of Carers Australia tends to result in supports being formulated that take into account the presence of informal carers but in a way that Carers Australia doesn't agree with; is that right, Ms Elderton?

35 MS ELDERTON: Yes, that's true.

MR GRAY: Is that because Carers Australia sees the way the test is applied as tending to diminish the budget if there's an informal carer available from what it otherwise would have been?

40

MS ELDERTON: It can diminish the budget and, certainly, the nature of the supports provided. So if it was the case of aged care packages, for example, home care packages or even lower level supports and it were taken into the assessment, the amount of care currently being provided, and the fact that the nature of some of that
45 care is what under the NDIS would be what families would normally provide; that can constrain choice and control about the amount of paid care a person gets.

So, for example – I will give an example that's not a high care need. It's something like transport. You go in for an assessment and you say, "Actually, I need some more transport." And the assessor might say, "But haven't you got a carer at home that's been doing that for you? And, I mean, really, do you really need that? Can't they continue doing that. After all, families provide transport to other family members for all sorts of reasons."

And that may be true, except it may be the case that the person who's getting the support says, "Yes. I'm getting it from my daughter. I feel really bad about that. She's got a life. She's got three kids. And she has to take me everywhere, because I've lost my driving licence and – so she has to take me to all these appointments. So I actually do want transport. I want you to refer me to some assistance with transport." And the assessor says "Yes, but I don't think you really need it, you know, because" – yes.

MR GRAY: In short form, if the respite services that are provided – and perhaps that's not simply respite, but respite supported by other supports, including education, psychosocial support. If those sorts of services that are funded out of the investment stream are sufficient to sustain the caring relationship by really putting the carer just as much at the centre as the person in care, then does that have some sort of counterbalancing effect on the concerns you're expressing about the way section 34 is applied?

MS ELDERTON: It can, but respite's not everything. It's not everything in terms of the sustainability of care. It gives you a break every now and then from what can be an incredibly intensive role. And as the needs of the person you're caring for grow, as your health needs may decline, as you may have to take on caring responsibilities for someone else, respite just provides a kind of break, you know? It's a little holiday.

MR GRAY: Commissioners, subject to any other issues that you may wish to raise, I think that should conclude this session. If you wish me to go to any of the other matters that we did have scheduled, I can, but, in my view, we have addressed them sufficiently.

COMMISSIONER PAGONE: Yes. Thank you. Yes.

COMMISSIONER BRIGGS: I'd like to ask Dr Lewin a little bit more about reassessment and how this might occur across the continuum of care. So we've talked – or you talked earlier about the initial assessment needing to be comprehensive. I don't want to talk about a crisis situation. I get that. I want to talk about somebody at home or somebody in residential care, when their condition has deteriorated somewhat. How do you see a responsive assessment system, both identifying that and managing the situation and assessing as needs be?

DR LEWIN: In terms of, obviously, starting in the case of the person at home, when they or somebody else has contacted, the first thing is the telephone. I mean,

what happens currently is there's a telephone discussion and the assessor is ascertaining whether there's any change. And if there is a significant change, then they go to the home and they do a repeat or an update on the assessment that they did before. Within the RAS system, that is happening, my understanding, as according to plan. So there's not a huge waitlist or anything for the reviews.

At the moment, there is some discussion as to whether there ought to be everybody is reviewed an on annual basis or whether it should be on an as-needs basis only. And I think that decision can be made over the phone in discussion with the individual concerned. But I certainly think that it needs to be thought about and it needs to be open for people to come back at any time if their needs have changed significantly.

And particularly with the encouragement – and one of the things about – that I'm sure Rikki talked about yesterday in terms of the active assessment, I see a key element of that is helping the older person understanding that ageing is just not a downhill track from there, that, in fact, they can regain skills. They can learn to do things differently. They can live much more the life that they want to. And that helping people – because, I mean, there's heaps of research showing that that negative expectation then results in poorer mobility, poorer health and social outcomes across the board, including living seven years less.

So that changing that attitude, helping the older person acknowledge and know that if they do have the flu and are in bed for a few days, they're going to potentially have difficulties. Well, if they don't get over those quickly, come back, contact us so we can come in and get you back and thriving again. So it's having that – for me, it's sort of turning it around and trying to assure older people that it's not a system that sucks you in and never lets you out. What it's about is helping everybody live the best life they can, given that they have health conditions, given that their social conditions are not, you know, necessarily wonderful. But it's, yes, finding ways for individuals to be the best they can.

COMMISSIONER BRIGGS: I suppose I want to go back to Mr Smith, as well. I heard you were looking at incentives under existing package arrangements for restorative care. Have you got a sense of what those might be, because I want to look at this in the context of what we're looking for in the separate investment stream to try and understand how it might work or is that an early stage of work?

MR SMITH: Commissioner, that's in early stages. I'd be pleased to come back a little bit later, if that's okay.

COMMISSIONER BRIGGS: Sure. Thank you.

COMMISSIONER PAGONE: Well, thank you. Again, some of you have heard me say this before, but those of you who haven't, we do thank you for the time that you've put in, not just today, but in the submissions beforehand. It's a difficult and complicated matter. And your expertise and depth of knowledge has been very

helpful indeed. So thank you for joining us. Those of you who are not coming back later on, thank you.

MR GRAY: Could we release Mr Smith from his summons.

5

COMMISSIONER PAGONE: Yes. Mr Smith, you're released from your summons. 1 o'clock.

10 **ADJOURNED** **[11.53 am]**

RESUMED **[12.58 pm]**

15

COMMISSIONER PAGONE: Mr Gray.

MR GRAY: Thank you, Commissioner. Our next session, the fifth session of this hearing, relates to the care stream, also called the care and health stream. This is the
20 stream for the funding of services to be delivered, so the conception is, agnostic of setting, either in the home or over time in more flexible and less institutional forms of residential care and in institutional residential care, as well. And it's also conceived of as a stream of funding that would move to individualised packaged funding as a principal funding mechanism. This panel has been called to examine all
25 aspects of that proposal.

The witnesses are Ms Annie Butler, Ms Maree McCabe, Mr Nick Mersiades, Mr Matthew Richter, Professor Deborah Parker, Professor Mark Morgan, Ms Melissa Coad and Dr Nicholas Hartland. And all the witnesses are currently in their seats at
30 the desk for the panel.

COMMISSIONER PAGONE: Yes.

MR GRAY: Ms Associate.

35

DEBORAH PARKER, AFFIRMED **[1.00 pm]**

40 **MAREE McCABE, AFFIRMED**

NICHOLAS MERSIADES, SWORN

45

MELISSA COAD, AFFIRMED

ANNIE BUTLER, AFFIRMED **[1.01 pm]**

MARK MORGAN, CALLED

5

NICHOLAS HARTLAND, CALLED

10 **MATTHEW RICHTER, CALLED**

MR GRAY: Thank you, Ms Associate. I will make some brief introductory remarks about the witnesses. I'll start with Ms Annie Butler. Ms Butler is the
15 federal secretary of the Australian Nursing and Midwifery Federation. Prior to taking on this role in June 2018, Ms Butler was assistant federal secretary for four years. Prior to working in the federal offices of the ANMF, Ms Butler was employed by the New South Wales Nurses And Midwives Association as lead organiser, organiser and professional officer. Ms Butler has worked as a registered nurse for
20 more than 30 years.

Next, Mrs Maree McCabe. Ms McCabe is the CEO of Dementia Australia and a member of the organisation's board. In February 2017, Ms McCabe was appointed to the role of Alzheimer's Australia national CEO and led the unification process
25 from the Federation of Alzheimer's Australia to the unified national organisation Dementia Australia. Dementia Australia was established, therefore, in October 2017 in that manner. Within the federation, Ms McCabe served as CEO of Alzheimer's Australia Victoria from October 2010 to August 2016. Ms McCabe is a member of the board for the National Ageing Research Institute and a member of the Aged Care
30 Sector Committee, which provides advice to the Federal Government on aged care policy development and implementation. Ms McCabe is also a member of the Australian Commission on Safety and Quality in Health Care and is on the executive committee of the Cognitive Decline Partnership Committee.

35 Mr Nick Mersiades. Mr Mersiades has extensive experience in aged and health care, including 16 years in the Department of Health and Ageing, as it then was, as well as roles as manager of the department's Queensland and New South Wales State offices. Mr Mersiades' most recent role in the department was head of the ageing and aged care division, where he was responsible for the development of aged care
40 policy and for the overall management of the Australian Government's residential and community aged care programs. Prior to joining Catholic Health Australia in November 2008, Mr Mersiades had been general manager of strategic policy and communications in Catholic Health Care Limited. In 2012, Mr Mersiades was appointed to the board of the Aged Care Financing Authority.

45

Mr Matthew Richter. Mr Richter is the CEO of the Aged Care Guild. The Aged Care Guild advocates the development of sustainable aged care that delivers

consumer choice, represents a number of the larger aged care providers. The Guild's members believe strongly, according to the information that I think you've provided, Mr Richter, that a private group of major providers focused on advocacy is essential to delivery of the Guild's mission of sustainable quality aged care, delivering
5 consumer choice and affordability. Is that a fair summary, Mr Richter?

MR RICHTER: Yes.

MR GRAY: Thank you. Professor Deborah Parker. Professor Parker has been has
10 been the chair of the Ageing Policy Chapter of the Australian College of Nursing, ACN, since 2017. Professor Parker is Professor of Aged Care Dementia at the University of Technology, Sydney. Professor Parker's a registered nurse with clinical qualifications in aged care. Professor Parker holds a number of qualifications, covering a broad range of competencies: Bachelor of Arts
15 Psychology, Sociology; Graduate Certificate in Executive Leadership, Master of Social Science, Research; and Doctor of Philosophy. Professor Parker worked as a registered nurse in aged care for nine years, before assuming research and academic positions in Australian universities.

20 Ms Melissa Coad. Ms Coad is the executive projects coordinator at United Voice national office and has been in that role since 2016. Ms Coad has worked at United Voice since 2008. Prior to working at United Voice, Ms Coad worked as a case worker and policy officer with the Welfare Rights Centre. Ms Coad's qualifications include a Bachelor of Arts, Graduate Diploma of Applied Psychology and Masters of
25 International Relations. Ms Coad is a member of the Aged Services Industry Reference Committee. United Voice has recently been renamed, Ms Coad.

MS COAD: Yes.

30 MR GRAY: If you could give the new name of the union.

MS COAD: The new name is the United Workers Union.

MR GRAY: Thank you. And Professor Morgan and Dr Hartland I introduced to
35 you yesterday, so I won't do so again. Thank you for attending again. I will ask that consultation paper number 1, page 5, the sixth and seventh bullet point under the Fundamental Change heading be displayed for reference. As I mentioned in my introductory remarks before calling you the witnesses, I focused on the role of this funding stream in meeting ongoing needs in a way that puts consumer or care
40 recipient choice at the centre by using comprehensive care needs assessment to, in due course, develop individualised budgets, the spending of which can be directed by the person receiving care.

There are a number of key components to that proposition about how this stream
45 would work. One of the important things to focus on is the fact that the purpose of the funding stream is to meet – or to fund the services that will provide for longer term and more stable needs, as opposed to episodic deteriorations, episodic clinical

needs that can be met by perhaps more flexible, agile scalable responses funded by the investment stream. That topic's been the subject of detailed examination this morning.

5 This is, in effect, a funding stream intended to provide funding for the services that provide that base level of ongoing care. And it's to be done according to the concepts in the consultation paper in a way that places individual choice at the centre, in the manner I've described by the development of individualised budgets. Another important feature of it is that in time this could lead to innovation through
10 the unbundling of services and the provision of services of the choice of the care recipient in different settings.

Now, all of those issues raise important matters for consideration. And that's the task ahead of you, the panellists. My first question at a level of principle for the
15 panellists is - is the proposal for a different funding stream for longer term care needs, compared with basic support providing by a basic support stream that's also been the subject of separate consideration, and restorative and re-abling urgent interventions and respite – that's the subject of the investment stream. Is that proposal for separate funding streams to enable differential approaches an
20 appropriate one at a level of principle or not? Professor Parker, can I start with you. What are your thoughts on that issue?

PROF PARKER: Thank you. So the Australian College of Nursing is not supportive of the separation of personal care from nursing and allied health or
25 medical care, which is not mentioned in the redesign in the earlier two streams – the previous two streams. So I don't think that will then lead to comprehensive care for older adults.

I think we have to look at the assumption that people who are assessed as requiring
30 the Commonwealth Support Program now versus older people ageing without this. Seeking this assistance, just from a social need or whether there's a functional underlying issue. So the delivery of meals, assistance with gardening, etcetera are occurring potentially due to a loss of function. And this is the point at which re-ablement and healthy ageing programs should be deployed and to identify in fact the
35 help ..... for social care is looking at an underlying concern.

So the notion of separate funding streams, assuming that no nursing or allied health or medical support is required until you get to the care stream, I don't think is the current reality that we've heard from older individuals giving evidence to the
40 Commission. And it doesn't appear to be supported by a number of other submissions to the Commission.

So in the opening pages of the document, it's clearly articulated that people are not in a box or a stream for individualised care, care needs should be assessed at entry,
45 relevant supports put in place, regular reassessment should then identify reduction or increase in support. For the client, there should be no need for them to know which stream that they have been assigned or that they are now in or out of their designated

stream. This will mean providers will need to either provide comprehensive services or broker those services, but this should not be left, I don't think, to the individual alone.

5 Choice is around what sort of support from what kind of person or organisation you want. Choice doesn't have to be that, "I find and pay for my own services." Choice can be built into a coordinated case management service that should be offered from entry into the system.

10 I also just want to make a note about language where, in this stream, we are noting that it is for longer care needs. And you've just mentioned the word stable for longer care needs. But it actually is about complex care needs. And that may not be stable and it may not be long. In our current system, 25 per cent of people entering residential aged care die within the first six months of entering that sector. And a
15 proportion of those actually die, unfortunately, within a matter of days or a matter of weeks. So that is neither long or stable care within that – what we are calling the care stream.

But we also have about 23 per cent of people on home care packages, where death is
20 recorded as the discharge reason, have also stayed for less than six months. So I think we just have to be careful around envisaging that people in this care stream are stable, they're the long-term stayers, where we have time to be able to put in a plan of care. They're complex, they're dynamic and so the services need to be wrapped around very quickly for many people.
25
MR GRAY: Thank you. Professor Parker, just to take up one of the issues you raised, it's the conception of the consultation paper that a person might well be receiving services that are funded from all three streams at the one time. They might have basic needs for travel to social engagements or other replicable high volume,
30 but low value, services of that kind, at the same time as perhaps receiving quite complex personal and nursing care, which might be funded on an ongoing basis under the care stream. And, indeed, they might then have a need for episodic restorative care funded at the same time out of the investment stream. Does that alter any of the propositions that you advanced about the inappropriateness of segregating
35 care and the impact of that on holistic care?

PROF PARKER: Well, I think the devil is in the detail in the delivery of it, and so it depends how the services are set up. So if we are setting up services where we are – literally I'm delivering just the personal care services and somebody else is
40 delivering the re-ablement services and somebody else is delivering the nursing and allied health services – and we haven't mentioned the medical services, well, we've heard so far in the Commission is that people do not get a seamless service across different providers where we have compartmentalised these funding streams. So I don't have a problem with the fact that you can be technically across multiple strains,
45 but I think we have to be very careful when we're redesigning a system that we're not just recreating the current system that we have where people aren't getting the coordinated care. So I think it's the coordination of care. But often the funding

drives the care that people get and the services that are set up. So I think that's the issue. I think it's, you know, we do agree that you would need a higher level of – a stream service for people with what I would call the complex needs. But it is around the delivery of how the system is coordinated and I'm sure that will come up.

MR GRAY: I am sure it will. If that coordination was very, very strong, do you accept that at least at a level of principle, if there are economic efficiency drivers which suggest there should be a different approach to high volume, substitutable services such as low level domestic assistance – laundry, gardening, things of that kind – on the one hand and a different approach between those and personal care integrated with nursing care and potentially allied health and, indeed, medical care on the other; do you accept that there could be efficiency drivers, administrative reasons for treating those two areas separately?

PROF PARKER: I can accept that on the notion of efficiency drivers and volume but I just caution that we do want to make sure that people are getting the right assessment, the right care delivered by the right people at the right time, and so just caution in that high volume efficient service that people are still there for a reason. They are still entering the aged care system for a very good reason and, you know, the pathways in care that we know occur, people can go from the current Commonwealth Home Support Program and end up in residential aged care. Now, you know, that means that you've got somebody in, you know, what you would call the efficiencies of care high volume service but at some point something happens and they end up in the high complex care needs.

And it's about the oversight of people within that high volume service that I think we have to be very mindful of and how do people get flagged, how do people navigate to step up into the other care streams. Who is responsible for that?

MR GRAY: One other thing I want to ask you to expand upon, you mentioned choice. The proposals in consultation paper 1 could be rightly regarded as an endeavour to ensure that the people receiving care are able to be armed with the information necessary for them to make informed choices. That's the emphasis placed on the care finding and navigation roles and improved information. To make those choices and communicate them, and there will being decision support available on the conception in the paper, and to exercise those choices not only as to the setting in which they receive care but whether certain forms – whether they wish to receive certain forms of care or whether they wish to spend the individualised budget that is generated based on their needs in some other way.

What do you say about the balancing of choice and, indeed, dignity of risk, the right of people to take risks in the way they live their lives even if they are older Australians, compared with the issues you have raised about the need for a continuum of care, holistic care and, I would add, the need from a clinical standpoint to provide safe care. Are you able to see a compromise?

PROF PARKER: I think that choice should be absolutely a fundamental of the redesign of the system. But choice is a relative thing depending on your health literacy, the support that you have available. You may belong to a marginalised group where, in fact, choice doesn't appear obvious to you. You may be in a
5 geographical region within Australia where choice is limited. So I think the fundamental notion of choice, of course, should be at the forefront of any redesign of the system, but I think there is a level of health literacy that is required to navigate people through that, so that people can make that assessment between, you know, the dignity of risk versus choice. Dignity of risk is around having the conversation with
10 somebody to outlay what are your options so that you can make an informed decision about those options.

And so we have to have people in place to do that. But I think, you know, choice is, as I said, fundamental but it is a problematic concept for many people within the
15 current system.

MR GRAY: Ms McCabe, can I bring you in, what do you see as the strengths or indeed the weaknesses of the proposal under the care stream concept for providing that choice principally through the mechanism of individualised budgets for those
20 ongoing care needs; what are your views?

MS McCABE: Well, I completely agree with Professor Parker's view around choice is – it is iterative – or it not necessarily available in all settings and I think that one of the things is that certainly funding should follow the care recipient, and one of
25 the challenges that we have with dementia as an example of the complexity is that it is a progressive disease and regrettably as people progress through their dementia pathway, they will be – there will be a time when they're unable to make those choices. And I would like to pick up, too, on the dignity of risk issue. So for people living with dementia, the choice may be restraint or the opportunity to walk freely in
30 their environment and risk falling. And, unfortunately, dignity of risk is not something that is well understood in the aged care industry. And I think that it's an area that we need to elevate people's awareness and understanding so that we can provide choice in these areas, that is so important to people.

35 MR GRAY: Dr Hartland, can I ask you what's your reaction to the proposal for a separate funding stream for ongoing care needs so that there can be a differential approach. There may be efficiencies involved in doing so and the ability to place choice at the centre of the funding mechanism.

40 DR HARTLAND: So yes, we would be supportive of that. I think if you are going to move to a needs based system which is what you are envisaging in your consultation paper, you are going to have to give separate consideration to the funding of care because it will be the most expensive part of the system. So investments and what you have called basic support will – I mean, they're obviously
45 very important parts of the system but the major costs are likely to be in this stream and so you will have to think about how do you make sure that what you are funding

is a genuine reflex of need in the way that you have defined need so it's important - - -

MR GRAY: I think there's – there might be a problem with your microphone. If you're able to move a little closer - - -

DR HARTLAND: Or me. One or the other. Is that better?

MR GRAY: Much better.

DR HARTLAND: Yes, we agree you would need to give detailed consideration to care within a three-stream model because it'll be where all your costs lie. I think in the in-home setting, the model you are proposing does maximise choice and I don't see any fundamental way in which it would jeopardise dignity of risk and choice on the in-home side. I think there's one thing that you will need to cover and it might be better that we talk about this in question 6 and there's a question, I think, about how far are the personal care models that you are envisaging different to what we do at the moment. So at the moment in-home care, personal care is pretty simple. Sorry, that's not to underplay it but it's a form of getting someone showered, getting them dressed, if they need other assistance providing that.

In the new system you might find very different models of providing that care and in those circumstances you might have to think about what is the cognisant safety and quality arrangement that allows that innovation. But that depends on how far you think these choice models – these models are going to be different to what we do at the moment. I think – and again, you will come to this later, in the residential settings, there is another set of kind of principles that do rub against each other and I think the Catholic Health submission has made that clear, and it's for me, really, about the extent to which if your guiding principle is funding the efficient cost of care, and that's calculated in relation to care delivered in a congregate and therefore bundled setting, what does that mean if you then unbundle that care in a congregate setting, and you would have to work through that issue. You know, it's going to be a necessary part – the short answer is yes, it's an important part of your system.

MR GRAY: Professor Parker has already mentioned, as part of her list of concerns, the potential segregation of personal from nursing care, you made a brief mention of that. I want to bring the ANMF perspective in, too. I will just pose a proposition, and I will ask you, Ms Butler, to respond and we can have a discussion around it. An important element of the consultation paper proposal consistent with the direction of the 2017 Tune report and the Aged Care Sector Committee Roadmap of 2016 is that there should be a move to funding that is agnostic of setting, as the expression goes, that is, where the choice of setting in which to receive care is left in the hands of the person who is going to receive the care and this will enable them to choose to stay at home longer, which is an important imperative for many people.

On the evidence before the Royal Commission there seems to be a large degree of unmet complex health care needs for people who would prefer to stay at home rather

than going into residential care. That's an indication that there's unmet demand in this regard and there's other evidence before the Royal Commission that the preference of people is to stay at home rather than to move into institutional care wherever possible. Now, Ms Butler, the ANMF has raised concerns about a move to provision of, in effect, a budget or a package of money that can be directed at the choice of the aged care recipient if the indications are that that person should be receiving care in a residential setting. Is there a compromise where we can accord the maximum choice possible to people without compromising safety; what are your thoughts on that matter?

MS BUTLER: Thanks very much. Obviously, I think the best thing is for us to find a compromise but I just – before I come to the question of funding being – or care delivery being agnostic of setting, just to support the earlier comments – and I think we have made it plain that, of course, we strongly support the need for all people, older people, to have choice and greater control and we support the concept of a universal access to a continuum of care and support categories or services to meet assessed needs in a timely manner. We are just not convinced that a system built on individualised funding via whether it's a voucher mechanism or a debit card mechanism is the way to achieve it, for three key reasons, and then I will move on to the specifics of what you are talking about.

But my three key reasons go there. The paper doesn't present evidence to show that this particular increased focus on choice and control through this mechanism of individualised funding will lead to increased quality and safety. We also think that there's a very great risk that many people won't be able to manage the system well and that it will continue to advantage those who can, those who have strong supports, those who have advocates, those who have the capacity, those who live in areas with access to the bundle of services that they might want to package up. Therefore, we think there's a risk that it won't meet the equity and access objectives that the Commission is trying to achieve.

We also think that it has very significant risks for an already compromised workforce. And I think we might come to that in some later situations. In terms of agnostic of setting, it's very difficult to conceive of the care as individual – it's not difficult to conceive of an individual wanting the sorts of care services and they should be able to have access to their preferred bundle of care services. But how is this particular – the way this particular system is laid out, how is that going to ensure that somebody – so somebody who is in inner city, Melbourne, inner city Sydney, probably has a good range and a good choice of people they might be able to package up and be able to get into their own home. Conceivably, a worker who has people who are in a nice neat array of suburbs in inner city Melbourne, inner city Sydney might be able to deliver – or sets of workers might be able to deliver those particular care – or aspects of care as desired by the person.

What if the person is in Cobargo or what if the person's somewhere else where choices are limited? How will this system – how will that system ensure that that person, when we say agnostic of setting, has access to all the other services that are

available to those people where services are concentrated? We can't see that this system is going to deliver that. So fundamentally, before even digging down to the concepts of dignity of risk and how does it work for managing that with managing duty of care and clinical governance obligations of providers, I mean in the
5 Eurobodalla Shire or Cobargo or one of those areas, what's the responsibility of the provider to maintain an individual's choice across a range of disparate sort of settings, environments where, say, somebody wants 24 hour nursing care? That's their choice and they want to access it. And say that – I mean, that's probably – it's hard to imagine how somebody would be assessed with that. But would this system
10 somehow allow for that to be provided?

MR GRAY: Could it achieve that if there was appropriate market monitoring and if there was no functioning market on the supply side for the provision of the relevant services? There would just have to be a different mechanism, presumably activity-
15 based funding, even block funding for the relevant services, market – a market mechanism in the nature of the consumer direction of the expenditure of an individualised package wouldn't work if the market was too thin. There could be an alternative mechanism for those areas. Does the fact that those areas might not have deep enough markets to enable that market mechanism to work in those places mean
20 that it should be withheld from other areas of Australia where it might well work and might provide more choice to the person receiving care?

MS BUTLER: That may be the case. I'm going to have to just be honest with you. And my special subject is not the discussion of thin markets or describing particular
25 – I just have to be frank.

MR GRAY: Sure.

MS BUTLER: Because the way we conceive of that is that these are people. These
30 are particular groups of people who still have the same need for care, potentially, and have the right to have that care provided. So there may be – we don't think that that the market-based system and what you're talking about is the way to achieve it. We think that perhaps – I think you're trying to suggest that there needs to be another mechanism of funding that understands that there need to be additional supports to
35 access those particular groups who are in those – you know, particularly whether they're geographically disadvantaged, disadvantaged in other ways. So, yes, we would support that particular concept.

MR GRAY: Yes. Thank you. I will open that up to the panel more generally. Is
40 there anybody who wishes to respond to what's been said?

MS McCABE: If I may.

MR GRAY: Ms McCabe.

45

MS McCABE: I think one of – what's inherent in this is that people have the capacity to make that choice. And if we consider that it's a market-based force, then

what we're assuming in that is that people can vote with their feet. Well, for people living with dementia, that's actually not possible. So I think it's really important to consider that there are groups of people where that isn't available and it's not available either through capacity or through access or availability of other services.

MR GRAY: So, for those people, should the response be better decision support, better support for their informal carer, who may be their spouse even or in some other loving relationship with them, or should it be, in effect, a, just a uniform centrally-planned response, not a consumer-directed response?

MS McCABE: Well, we absolutely support consumer-directed care. The challenge is that many people living with dementia actually live alone and don't have carers or an advocate to speak on their behalf. So I think that we can't have a system that is either/or. We've got to have a system that is flexible enough to take into account the unique challenges that many people are faced with.

MR GRAY: Yes. Dr Hartland?

MR HARTLAND: Just very quickly. Sorry, Professor Morgan. I just think on the relationship between choice and safety and quality, we also need to remember that part of the whole reason why aged care for a long time has been looking at the control and choice, consumer-directed care is because it does have a positive impact on the wellbeing of the people getting services. And COTA has had a trial where there are positive results from giving people control over their lives. And it's a pretty intuitive result, really, isn't it, that if you have control over what happens to you, you're going to be happier. So we want to make sure that these issues around clinical governance and safety are important, but we just need to keep in sight that there's a link between having control over what happens to you and your sense of wellbeing.

MR GRAY: Professor Morgan.

PROF MORGAN: Just a piece of clarification which I think needs to be made. And that's whether these individual budgets for care and continuing care are based on needs or based on unmet needs. So if – the difference might be if somebody is receiving a lot of help from a carer or family, then there may not be as many unmet needs for that person. Whereas if you just took the person as an individual and said, "Right. What can and can't you do?" and allocate budget on the basis that, you'll get a very different result. With that in mind, I struggled with how you would make some equity here. And I think if you were to consider the unmet needs and include the unmet needs of those providing care, the informal carers, then you start to get some – a way to equitably assign individual budgets.

MR GRAY: Is a compromise – again, this is a balancing exercise and this was the subject of some evidence in the previous session, where Carers Australia CEO Ms Sue Elderton gave evidence on this topic. One perspective is that it's only the unmet needs that should be budgeted for as a result of the comprehensive assessment in the

individual budgeting process. But the qualification to that is there needs to be good support for those providing the informal care.

And Ms Elderton's evidence on this – I won't put words into her mouth, but it was,
5 "Well, respite can only go so far and it's actually more equitable or a more appropriate position if the assessment doesn't take into account provision of informal care, because that would tend to have a diminishing effect on the individual budget that's allocated." Do you have a view on this difficult topic, Professor Morgan?

10 PROF MORGAN: I think there are risks in both ways. I think a broad view of unmet need of the carers is the more logical way to go, otherwise you run the risk of driving informal care away, because it affects the size of an individual budget. And that's the last thing that the system needs or wants. So I would say respite isn't the only solution to unmet needs of people finding care; a more broad suite of supports
15 is what might be needed. I think the - - -

MR GRAY: Could you just - - -

PROF MORGAN: - - - unmet ..... the carers' input into this this needs to be valued,
20 not necessarily in a pure dollar terms, but does need to be strongly valued.

MR GRAY: All right. Mr Mersiades, do you have a contribution on this topic? I had down you as a potential contributor.

25 MR MERSIADES: Thanks, Peter. This is a difficult topic. I mean, choice is fundamental and I agree with the comments to my right about for some people they'll need a lot more support than others. So I think the system needs to be calibrated to be able to respond to the different capacities of different people. It doesn't mean that you set up the system for those who – around the assumption that
30 everyone needs an awful lot of support.

When it comes to informal carers, I mean – the reason we support the government traditionally has supported informal carers through respite and carers allowance and those related issues is because it's more efficient for the government to have people
35 cared for in their own home, but it's also where people want to be. But there will come a point when the pressures on the family carer will be such that some sort of congregate care arrangement will be necessary. So that's where I would come from.

MR GRAY: What about the issue of the clinical governance obligations of a
40 provider providing care in a congregate setting that was alluded to by Ms Butler? How are we to grapple with issues such as that, which are arguably, essentially, organisation-wide issues, if the provision of the funding is, essentially, to be individualised and consumer-directed?

45 MR MERSIADES: I think there are ..... for individuals to make. There's no – I think the evidence is that in a congregate living arrangement the costs of delivering a given amount of care and personal nursing care will be less than if the care is

delivered to locations which are distributed and dispersed, because there's a lot of travel time that's involved. And people will make judgments about the level of risks that they accept in that, by going down that path. They will value – and different people have got different degree of resilience, different degrees of informal support
5 and different values in terms of the things that they – how much they value their independence and the living environment that they're currently in.

And so what there has to be is a really strong relationship between the professional caregiver and the individual to talk through the issues. I mean, there's no regulation
10 that sort of says there's a tipping point where this has to happen or that has to happen. It's a negotiation that happens based on a fully informed situation. It's a bit like a GP. A GP tells you – gives you a prescription to take medications. He can't force you to take those medications. It's still, basically, your decision to choose what to do. So, you know, there's no easy answer to that question; it's a question of
15 negotiation around people's preferences.

MR GRAY: Just before I move to you, Ms McCabe, I'll just ask one more question of Mr Mersiades. In the consultation paper there's an emphasis on the potential care coordination role that could be handed to the person that's been variously described
20 as care finder or navigator. Is that going to assist in trying to reach a solution to the compromise between increasing the ability for individuals to direct the setting of their care and the need for these safety concerns to be met?

MR MERSIADES: For some people, that will be very important, particularly those
25 who don't have other supports or given their life experiences. But I think in many cases it won't be necessary – it shouldn't be necessary to have an extra third party that's involved. A provider who has responsibility for assessment, care planning and person-centred care should be best placed to actually be responding to the changes and fluctuations in care needs of an individual as they wax and wane.
30
If you have to then always go back to another third party, it's just not going to work. It may be necessary in some cases, but, even then, and the navigator is more likely to say, "This service over here is the one that's going to seek your needs." For example, if you're a homeless person, I mean, there are recognised providers that
35 specialise in those areas.

MR GRAY: In other words, you're saying the role really reaches it's sort of useful extent at the point of linkage with the service provider and shouldn't really extend into care coordination.
40
MR MERSIADES: And then it's a question of having the systems in place where providers are incentivised and have the professionalism about delivering quality care. And that's another debate.

45 MR GRAY: Ms McCabe?

MS McCABE: I would just like to pick up on the point around clinical governance and I think it's absolutely essential. It is very different in aged care. In aged care the relationship between the doctor, for example, is between the doctor and the resident. In acute care it's between the doctor and the hospital. And in a hospital setting, what you would have is you would have a medical advisory committee. They would define and determine the standards that are acceptable and a code of conduct for doctors within that setting, and also the clinical pathways for particular diseases or particular surgical procedures.

In aged care, we don't actually have that and so to set the standard of clinical governance is absolutely essential to ensure that caregivers such as registered nurses or carers have a framework in which they can operate where there are clinical indicators and certainly there have been three that have been mandated by the Commonwealth recently, that there is a process of reporting incidents, that there is a framework where people are supported to - - -

MR GRAY: Ms McCabe, understanding that all of those things are necessary - - -

MS McCABE: Yes.

MR GRAY: - - - what's the impact of the care stream proposal on that, that you are seeking to identify?

MS McCABE: Well, I think that it's essential that we make sure that clinical governance is a high priority as part of the care stream proposal, and that it's something that really facilitates the care of residents and particularly people with specialty needs such as people living with dementia.

MR GRAY: Mr Richter, do you see any difficulty – any tension between individualised consumer-directed funding and the need to meet the clinical – have the clinical governance framework and actually implement it and embed it in the provision of care, meeting the continuum of care needs of the individual?

MR RICHTER: I don't see a challenge in having a clinical governance framework in place. The challenges are, as have been talked about, you know, what is the care that's being delivered, how complex it is and making sure we're maintaining that workforce to deliver that care in various settings. So I know this is not health care but we are talking about pretty complex care and so as it gets more complex, there does become, I think Nick said, a tipping point where there will be trade-offs because we want, you know, certain volumes of, you know, that type of care being done by certain cohorts of registered nurses or whoever it is in the workforce.

To use a health care example, many hospitals around the country don't deliver babies any more, particularly in rural New South Wales, because they don't deliver enough of them, and so the staff don't maintain those obstetric skills at a high volume, and that's health care. But I think we should recognise here that we are dealing with complex needs and there will be a tipping point at some stage where there needs to

be a discussion with the family and the consumer about, you know, what might be the best location to deliver that care but all of that can be done within the appropriate clinical governance framework for sure.

5 MR GRAY: A couple of hands have gone up at that end of the table but, Ms Coad, I just want to ask you what's the perspective of the United Workers Union, is there – wearing your hat as, in effect, a spokesperson for those members of the care workforce who provide personal care, are there issues you see around the individualised funding model proposed in the care stream concept around, perhaps
10 not clinical governance but aspects of what personal care workers do that are important to the provision of complex care?

MS COAD: Absolutely. And I think sometimes we conflate consumer-directed care with individualised funding and I don't think they have to go together. I think
15 you can have consumer-directed or person-centred care without an individualised budget attached to that.

MR GRAY: Would that involve the problem? If, for example, the amount of money that was handed over to the care recipient to spend as they choose was not an
20 individualised budget but say, as Catholic Health Australia has suggested, a classification package level. Would that make a difference to the concern - - -

MS COAD: I think that does make a difference. Our concern really also stems from our experience with the NDIS where the – particularly from the workforce
25 perspective the individualised budgets there do not allow for anything other than face-to-face support time with people with disability. So our members in the disability sector no longer have paid team meetings, paid training or supervision, buddy shifts, all of those things that are integral to them being – having quality jobs and being able to deliver quality supports all disappear because the individualised
30 funding only pays for that direct one-on-one support and it misses all of those other things that are really critical to workers being able to do their job properly.

MR GRAY: Well, is there some way that a compromise could be reached where the promotion of choice could be balanced by having some element of individualised
35 funding or consumer direction of a package at a particular dollar amount according to Catholic Health Australia's proposal on the one hand, with support and subsidy and appropriate funding for those, I will call them overheads but they are more than overheads, those sort of organisation-wide costs that are so important to the building of a stable workforce, a trained workforce, activities that build a resilient and agile
40 workforce, and all of those sorts of matters that you alluding to; is there some sort of compromise?

MS COAD: I think there could be a compromise and there could be a balance. The risk from our perspective would be that when costs get squeezed, those costs – as
45 you call them overhead, they're what get squeezed and that's the risk. So even if you set it up from the beginning that all of those things are subsidised and paid for, as

costs increase over time and budget pressures from governments are felt those are the things, in our experience, that go first.

MR GRAY: Thank you. Now, I think it's only fair I go to Mr Mersiades, because I
5 might have misrepresented the Catholic Health Australia submission.

MR MERSIADES: No, not at all. A compromise position would be that you have your classification system and you allocate an amount of money as you indicate, but instead of that being dealt with as a separate budget for which you purchase
10 individual services and you get an invoice and you pay with a debit card and what have you, an alternative approach is once you have been assessed at a particular level and classification, you actually enrol with your preferred provider. And in that case, the provider and you work together to meet your care needs as they fluctuate over time. So that's an alternative compromise. You still get a degree of choice in there
15 but you don't have the complexity of individual budgets and everything that goes with it.

But at the same time, personally, I would still prefer to have a system where people can opt out of that system and choose to use their individual budget in the way that a
20 home care package works at the moment. So there will be people who will be attracted to that. It won't be everyone's cup of tea. Then you can get providers sort of competing with each other. The other thing about the current system is that we've got a couple of thousand home-based care providers, many of whom just deliver a limited range of services, they are just contracted for those. Whereas if we had a
25 complete restructuring so that in each region there was two or three large providers who can meet your across the board requirements, you are going to end up with a far more efficient system than you have got at the moment and I think one that meets people's needs much better, rather than having to shop around and just deal with – just receive the services that the provider happens to have been contracted to deliver
30 for you.

MR GRAY: So just to seek some clarification on that very last point, that would involve, pardon the expression, but a degree of central planning. It would involve a deviation from the idea of leaving it to market forces to determine which provider
35 should thrive in a particular region, but in return there'd be a coverage obligation; is that what you are saying?

MR MERSIADES: I wouldn't see that that's a role for government to be picking winners. I think it's a question of you open the system up so that individuals and
40 their families have a genuine choice as to which provider they go to. And you will find over time that will work itself out as to those who are – that people want to use.

MR GRAY: And you say through that natural process and evolution there will be two or three large providers.

45

MR MERSIADES: Obviously, providers will have to meet accreditation standards. The other advantage of going down that route is that it's going to be much easier for

governments to performance manage what happens with providers. There was a big discussion earlier about data collection. It's very difficult when you've got thousands of providers out there. If you've got a number of large providers who are well organised, have good governance in place and have the support systems, you can end up with a far more efficient system and it can be more evidence based and get much better data.

MR GRAY: Thank you. I need to go to Professor Morgan.

PROF MORGAN: Just briefly, and we've heard about governance frameworks and accreditation of providers, but the tension seems to be between people having choice to self-direct and purchase their own services or to have bundled services provided from choice of a few providers, and whether that's going to be appropriate and safe care in both circumstances. What I would like to strongly recommend is that as part of the assessment and initiation process that goals are set and that the person receiving care is asked how is it going for you at predetermined intervals and use that as a feedback mechanism to make sure that the bundle of care they're receiving, either self-purchased or through an organisation is appropriate to their needs. I've not heard much to enshrine that patient – person feedback to shape their ongoing care needs.

MR GRAY: Yes. Who do you see as best placed to do that or isn't there a one size fits all?

PROF MORGAN: The person receiving the care or their closest advocate.

MR GRAY: I mean, who do you see as the person who is best to receive that information and conduct that follow-up proactively and make sure that that information then influences the provision of care?

PROF MORGAN: So where there's a problem identified that can't be solved by retailoring the system, then it's clearly going to be the ultimate funder that's going to receive that feedback, that the package is not meeting needs and have to work with the various providers to reshape it.

MR GRAY: Okay. I want to go to the next topic. It's related. It's about what are the limits that can or should be placed on choice as to setting. This has really already come up in a number of the responses that you, the panellists, have given. There's that preference that I've mentioned, evidence of the preference for people to remain in their own homes and age in their own homes. There's the fact that Australia's rate of entry into permanent residential care is high by world standards. These are the sorts of considerations driving the redesign principle that more choice needs to be allowed for people to remain in their own homes. But does the system need to recognise that there's a limit to choice as to setting, and at what point does that come into play.

Submissions from various organisations, I mention Uniting Care and Anglicare, just to name a couple, have been to the effect that there must always be explicit recognition of a requirement in the future for 24/7 residential care for people with complex needs or complex and intense needs. And there's a submission from the CPSA about the need to begin a conversation around perhaps providing encouragement to individuals to start planning about appropriate ageing-appropriate accommodation earlier in their lives than they do, and to perhaps even factor this into the responses that the aged care system provides on this topic of permitting a degree of choice as to the setting in which care will be received.

Should it, for example, be the case that a system would subsidise a home modification no matter what, or does some consideration have to be given to whether the person in question should move to another form of accommodation that's perhaps closer to the services that they need and where they can be more efficiently and appropriately cared for, even if that's short of residential institutional style residential care. So the questions for the panellists: is there room for a principle that receiving aged care may have to require moving to appropriate accommodation for the delivery of care, whether that's some form of flexible accommodation where the person is more proximate to the services they're going to need or, indeed, 24/7 institutional residential care.

Should incentives be built into this care stream framework for varied accommodation to foster as much independence as possible in that grey area between staying at home in the traditional family home and moving into fully institutionalised residential care? Can this be left to market forces to drive innovation or is there a role here for a capital grants program? I will open that up to the panel for your responses. Mr Richter, do you want to start.

MR RICHTER: Sure. Thank you. And there's a lot of questions there, isn't there. I think in the paper you mention is the dichotomy a problem, and it is. Home care, residential care and the two don't interrelate at all. They're almost independent systems, in my view, and there's not much in between. And that's a real problem. So should there be incentives to, you know, grow and develop something in the middle? I think absolutely. Should there be incentives to coordinate everything better? There should be. So home care, we could be missing great opportunities, for example, like I don't think it should just be about mowing someone's lawn in that stream because we could be missing an opportunity to talk to that person and realise that they really enjoy gardening and want to maintain their function or capacity as much as they possibly can and instead of mowing the lawn we might replace their front lawn and put a native garden in there with three or four plants that they can manage during the week as a different solution. And that works towards their functional capacity and their wellbeing. So I think it's critically important that there is a coordination role in all this.

In terms of where I see is there a tipping point, I think that's the word that has been used, and I think there is a tipping point as complexity of need, if we call it that, across a continuum increases, there becomes an increased relationship between your

built environment and your ability to deliver great care. It becomes more and more important as complexity increases all the way up until you get to the hospitals and surgeries and things like that. So it does point to a necessary role for purpose-built 24/7 environments still. Should they grow as fast as other arenas? No, I don't think so. I see growth in that – I think you might call it an intermediary setting which your research papers have pointed to different styles; your cottage type homes and different shared accommodation and lots of options in there which Australia really hasn't grasped yet, and that's where I would see that growth in there.

So retaining a 24/7 residential setting is, I think, very important but it doesn't need to be the primary part of the system but I think it does need to be there. And we need to incentivise the system to grow the bits that are missing. In terms of can we leave it to the market, I don't think it can be left to the market alone. I think there is a very important role for capital grants in this space, particularly if we need to, you know, develop a market or particularly in rural and remote areas or if we want to try and have a particular focus on something, we might need those kind of interventions. We also need, and coming out of all this, some relative policy stability for whomever it is that is going to come into those intermediary settings to come in there and have the confidence that the policy settings are going to remain relatively stable for some time to come in and actually build – develop those services, you know, build the workforce they need because that all takes quite a long time.

MR GRAY: Ms Coad, can I ask you with specific reference to the point about whether there's a limited choice here, whether – and ugly word perhaps, but whether there's an element of compulsion that's needed in certain circumstances about the form of care that's going to be provided.

MS COAD: Yes, look, it's a really tricky area and I wouldn't want to use the word "compulsion" but a flipside of the coin of people staying in their homes a lot longer, is that while that is the person's home it's also other people's workplace and those places can become unsafe if they deteriorate. There's a whole lot of issues related to people staying at home longer if they can no longer maintain that home in a way that is safe for people to come in and provide them with care and support. So I think where the point is it's really hard and I wouldn't want to, as I said, bring in an element of compulsion but I do think there is a need still for more that residential style 24/7 care. Does it have to look like it looks now; no, I don't think necessarily but I think there is going to be for some people a limit.

MR GRAY: We don't have it yet, we don't have it in abundance yet. For some time we're going to be faced or many Australians are going to be faced with a pretty dichotomous option here, and if it's not compulsion, what is it? If it's really the judgment of clinical assessors in an assessment team that this person needs residential aged care, how is the system supposed to respond to that?

MS COAD: I'm afraid I don't have an answer for that, I don't think. I think this also opens up the whole debate about affordable accommodation more generally in Australia which is obviously outside of the aged care system. As you have

increasing rates of non-home ownership and all of those things as future generations age, that will really impact on how these systems are designed as well. There might not be a choice for people into the future to stay in what is currently their own home if it's in a private rental market unless our, you know, rental and housing systems change dramatically as well.

MR GRAY: Thank you. I'm going to move through – I'm going to skip the next point that was on the list, and I'm going to now ask some questions about assessment and whether comprehensive assessment can practically speaking be used as a means to develop an individual budget. Now, I know that not all the panellists agree with an individualised budget approach and there's the proposal that Mr Mersiades spoke about by which one might have classification to package levels flowing from an assessment. And Professor Parker, I just want to quickly get your response to that proposal. Does that meet some of the concerns you had about the fact that these are not really stable needs that we are talking about, these are in fact very dynamic needs?

PROF PARKER: Yes, so I think – you know, I have no issue with the independent comprehensive assessment being undertaken and reassessment I think is critical as well. I think it's, again, around the training and skill of the workforce in completing those comprehensive assessments. I know in the AN-ACC study that Professor Eagar has conducted they looked at the different skill sets that were required to get the quality and reliability of the assessments and came up with the registered nurse allied health model and not a lower level of worker, you know, to make that comprehensive assessment. So I think as I said, I have no issue with the assessment being independent.

MR GRAY: Can I just seek the panellists' positions on whether the comprehensive assessment is something that should be used for people in this cohort, older Australians, for their ongoing care needs, even accepting the point made by Professor Parker that those care needs are going to be more dynamic than perhaps the care needs of people in general in the NDIS scheme. Can I just seek the views of the panellists about whether it's an individualised budget approach that's optimal here or allocation to – it's an ugly word to use for people but classification to a number of package levels along the lines of Mr Mersiades' suggestions earlier. Is there anybody who wishes to speak for individualised budgeting?

DR HARTLAND: I don't think it's a simple as choice as you might be posing it.

MR GRAY: Dr Hartland.

DR HARTLAND: I think that the NDIS approach is an individualised plan which gives you a budget allocation but as Mr Lye said yesterday, sitting behind that, some structured packages about what you would normally expect to pay for that person. The proposal that Catholic Health are ventilating is that you would have an individualised care plan but you would have more to the foreground an understanding about the kind of cost categories that a person was falling into. And

so I actually think the choice is not between a completely individualised and atomised system with no structure to it, because that's actually not what the NDIS; it has structure to it but it's in the background.

5 So it's not a choice between that and a structured system. It's actually a choice between where does the care plan actually get done. Does it get done in a central agency, and if it gets done in a central agency like the NDIS, the funding categories can sit in the background because the agency understands and controls it. If the care planning gets done in, say, a service delivery agency, then it's hard to think of a 10 solution other than having a more structured and visible approach to the expected categories that a person will fall into. So it's not a dichotomous choice between complete individualisation and a package approach. It's much more complex than that and I think actually that issue about where does the care plan get done - - -

15 MR GRAY: That's the real question.

DR HARTLAND: - - - centrally or diverse is actually a threshold question about how you would design the legislation and funding arrangements as well. So it's one of the most important threshold questions that you have got in front of you, and 20 you're going to have to tackle it head-on.

MR GRAY: What's your view, where is the care plan done; is that done by the provider and not by the assessing agency?

25 DR HARTLAND: I think my instinct at the moment – I don't think you'd even say it, not only is this not a Department of Health view, it's not even a personal view yet because next week I might be arguing the opposite, right, but as of today, I think if you look at the NDIS relatively stable population of 450,000 people, lifetime relationship with the agency, if you think about aged care and what people have been 30 saying, about 800,000 assessments or reassessments each year, 1.3 million people staying in the system two or three years; I think that the physics of that mean that it is likely that you would come to the view that service delivery agencies have to be their care planning. I don't think they should do the care assessment - - -

35 MR GRAY: The service delivery agency meaning in our world the approved provider - - -

DR HARTLAND: They wouldn't be doing the assessment. That would be me arguing against myself from yesterday but they would have to do that planning. I 40 can't see how a central agency is going to have enough scope to do that.

MR GRAY: Now, if we go into the detail of how – if individualised budgets were to form an element of funding under the care stream, if we go into the detail of the criterion on which that individual budget would be generated, the consultation paper 45 suggests that the reasonable and appropriate criterion, similar to section 34 of the NDIS Act, would be an appropriate criterion. Are there any panellists who wish to comment on that aspect of the proposal? Dr Hartland again.

DR HARTLAND: Thanks. I've always wanted to quote legislation at senior counsel. If you look at section 34 of the NDIS Act, the bits that do the work aren't – reasonableness is a very important part of that concept, obviously, but effectively I think it seems like putting that you do need to answer the question of reasonable and
5 necessary for what.

MR GRAY: Reasonable and necessary supports.

DR HARTLAND: For what. No, you – it's – so if you look at section 34(1) of the
10 NDIS Act, the bits there sections (a) and (b) talk about reasonable and necessary supports to assist the person pursue their goals, objectives and aspirations and that the support will be to allow the participant to undertake activities to facilitate social and economic participation.

15 MR GRAY: Clearly there would be adaptation as necessary.

DR HARTLAND: So the really important point – so, again this is one of your crucial issues you'll have to come to is that effectively defines, and I think LASA draws this out quite well, those two sections, not just reasonable and necessary but
20 the "for what" define a standard of care. So they define a care around full social and economic participation and what is crucial, I think, in terms of the way this whole system will operate is, is that the standard of care you're funding for and if that is, you get – you will end up with quite different needs assessments so - - -

25 MR GRAY: That's a submission you have mentioned suggests there should be a plan B because that level of budgeting might be not accepted by government. Are you, in effect, giving the Royal Commission a hint that that might be quite a high level of - - -

30 DR HARTLAND: No, not at all. But thank you for clarifying that. I definitely did not want to end up with that impression so it's a good opportunity to clarify that no, that wasn't the point I was make. I think that what I'm saying to you is this level of the normative standard is something that bureaucrats are not well placed to provide advice on and it's something that the Royal Commission will have to come to. And
35 it's a really important part of what you do.

MR GRAY: I will open this point up for any general responses from others on the panel, as well. Mr Tune's recently provided a report on aspects of the operation of the NDIS legislation. And one of the aspects he's looked into is the consistency with
40 which the "reasonable and necessary supports" criterion's been applied and whether other things need to be done to achieve more consistency in that approach. Are there particular lessons that we can learn from that aspect of the NDIS experience? Are there any views on the panel about that? Dr Hartland is suggesting that the test might be liable to a broad range of variable applications by those charged with the
45 obligation to develop budgets. I might take that up with the final panel, if there are no panellists who wish to comment on that.

Now, can we move to the topic of unbundling and just address that in a little more detail. And I might look for the perspectives of Ms Butler and Ms Coad on this in particular. The consultation paper envisages unbundling of care services. Professor Parker's mentioned her concern that the proposal in the consultation paper might
5 lead to a separation between personal care and nursing care. The consultation paper also, while underlining the point that the system would allow the person receiving care to construct their own bundle of services, also caters for the possibility that one provider might deliver all the services.

10 And it may be the case that a provider is simply, in light of safety or clinical governance requirements, just not in a position to provide for unbundling and might only offer bundled services. So that's also within the scope of what's proposed in the consultation paper. What are the pros and the cons of potential unbundling? Unbundling would provide enhanced choice, but challenges for the proposition of
15 holistic care. Ms Coad, do you want to start the ball rolling?

MS COAD: Yes. I think from our perspective the risk of unbundling, as I understand the proposal here, could lead to greater fragmentation of jobs, so if there's a provider that is just providing one bit and I can choose to get that bit from
20 the provider, from the perspective of the person doing that, it becomes a very fragmented task-based job, potentially, which, you know, goes to all those workforce issues that we have now of attracting and retaining suitably qualified and trained people, if jobs are really fragmented into tasks.

25 The other issue for me – or for us is that if they are fragmented and if you're providing them within an aged care system, that risk that Professor Parker mentioned is real. So if someone wants a domestic service, food laundry, cleaning and that's brought in from outside the aged care system, that person doesn't have the skills and experience to know that the person whose house they are in might need some
30 additional care or assistance. Whereas, trained and experienced workers who go in and do that are able to link that person back to the other elements of the aged care system that they might need to have access to at any one time.

And I think there's a risk, if those services are provided within the aged care system,
35 they have to be provided with that framework that they are in an aged care system and that you're not just providing that cleaning service or that whatever; you're also providing something within a care and support system. And I think that fragmentation of jobs is a real risk in that potential unbundling, if providers – it would work, potentially, if a provider was large enough to have a whole range of
40 services that then a worker could, you know, work across all of those many things, but if there continue to be sort of smaller providers, that potentially does fragment it.

MR GRAY: Ms Butler.

45

MS BUTLER: Well, I would support what Ms Coad had to say. And because the fragmentation would be at risk of appearing both in the community, but also in

residential care. It's hard to conceive of exactly how this potentially could work if an individual can bundle services and be pulling – they may be in – is conceived that they may be in a residential care service?

MR GRAY: If the residential care provider chooses to allow unbundling, because presumably that provider has considered the environment in which the services are going to be provided and considers that it can cope with that, it will be, at the option of the provider, whether to allow for unbundling or just to only offer a fully bundled residential care service. That's the concept of the paper. That's the proposal.

MS BUTLER: So, potentially, a residential provider could stop that choice anyway, is what you're saying, because - - -

MR GRAY: Yes.

MS BUTLER: So already choice is limited - - -

MR GRAY: Yes.

MS BUTLER: - - - by the way the system that might be conceived to work.

MR GRAY: The proposal is that in that case the person who wishes to receive care just might not choose that provider. If they're so keen on unbundling, they will go to another provider. And in that way over time market forces will drive innovation.

MS BUTLER: If they have that option. If they exist in a place where they have that option - - -

MR GRAY: Yes.

MS BUTLER: - - - and they have somebody else to go to or, as Ms McCabe pointed out, they have the capacity to vote with their feet, as it were. So we see a lot of risks. We see, as mentioned by previous people, but also that it doesn't appear to make a lot of sense to unbundle in residential care necessarily and then have people repurchase to make their own bundle. It has potential – because I think where Ms Coad is going, particularly, the whole is worth more than the sum of the parts in some ways.

So for a worker just to do a task and then disappear and not have the capacity to have the holistic assessment and be able to spend that better time with a person and do all of those things, it doesn't seem that that's going to be supported by this system of individualised funding and bundling. So that has – it appears that it's going to have risks for the workers being – well, providers being able to have oversight and capacity to actually deliver these ranges of services and remaining attractive in a market to people who are able to access them.

It would seem to have significant risks for workers who aren't going to be satisfied and aren't going to have meaningful work and meaningful jobs. And a safe and satisfied worker generally leads to a safe and satisfied care recipient. There also seem to be inherent risks for those care recipients who, unless they're extremely well-informed, aren't necessarily going to be able to access the continuity of care that they need, even if their assessment has been good and their care planning has been good, to be able to deliver what we generally need. So it seems to be a significant risk in what we have seen through what's happened in the evidence in the Royal Commission so far, in terms of – and I think Mr Richter said it earlier. One of the big things that we've seen is that health needs are not being met, significantly for older people, particularly in residential care. And it seems that this could compromise that situation even further.

MR GRAY: Can I go to Professor Morgan on that last point.

PROF MORGAN: I think there are potentially some wins to be had from unbundling care when you're talking about people at the high end needs in residential aged care facilities, for example. Already we unbundle most of the medical care, because the visiting GP is unbundled from the service. And I've been playing around the with the concept of unbundling nursing care in the same way and what the advantages of that system would be, in that you could – effectively, nurses' employers would become different from the owners of facilities.

MR GRAY: Potentially.

PROF MORGAN: Potentially.

MR GRAY: If the provider felt ready to move - - -

PROF MORGAN: And the potential for some cycling through of nurses with hospitals and closer connections there. We know that ..... services from hospitals provide – if they're not multi–disciplinary, don't make much difference, but, looking at options where nurses were actually working and rotating through nursing homes, residential aged care facilities would offer some opportunities for more seamless care and even funding streams for those people that are at high risk of hospital admission and trying to prevent that. So I just see some benefits of perceiving of nursing services in the same way that GP medical care is provided in an unbundled way.

MR GRAY: How does that - - -

PROF MORGAN: But there's a bunch of risks, as well.

MR GRAY: Yes. Well, how does that sit with clinical governance and the new requirement in the single quality framework for there to be implemented clinical governance framework for each approved provider?

PROF MORGAN: So the potential is that some of the clinical governance systems that exist in our hospitals can spill over and work with the care provided to those people that are very high risk in residential aged care facilities. So I think the hospital-based clinical governance systems are well tried and tested and robust and
5 have been quite poorly replicated in aged care.

MR GRAY: So those risks identified by Ms Coad and Ms Butler, should they be manageable or would they be unmanageable if unbundling proceeds?

10 PROF MORGAN: So the risk that I've heard is the fragmentation of care and the fact that – and I think people that are in their own home, for example. Ideally, you want a more holistic approach to care needs with everyone working at their full scope of practice, rather than doing just one little piece of a jigsaw puzzle to look after a person's needs. That's a recipe for disaster. The only – in your own home, the
15 only bits that are easy for you to purchase and commission yourself are those services that you've always been purchasing and commissioning, such as, you know, if you've always had somebody else do your gardening, why not continue. If you've always had somebody doing the laundry, why not continue? So it's at both ends of the extreme of care needs where I think unbundling might work well.
20
MR GRAY: Both Ms Coad and Ms Butler, and I think probably to some extent Professor Parker, are identifying a danger of separation between personal care and nursing care. And, in fact, it's in the written submissions to some extent that already the aged care system seems to propagate a separation that is contrary to good practice
25 and that this model might entrench or perpetuate or even exacerbate that problem. Professor Morgan, do you have comments on that aspect of - - -

PROF MORGAN: Well, some of the other submissions have been around the fact that the care has been suboptimal in residential aged care facilities and not – because
30 of the governance of the care and the substitution of nursing care and medical care for cheaper providers of care. So I think one of the ways – one of the potential advantages of some unbundling is to actually make those health care needs something that happens as a priority.

35 MR GRAY: Would another advantage be the ability to ensure accountability, in effect, acquittal, that particular forms of care that have been assessed as needed and have been funded actually are provided to that individual?

PROF MORGAN: Rather than the money going to a melting pot and then being
40 managed in a kind of uncontrolled way.

MR GRAY: Indeed. Professor Parker.

45 PROF PARKER: I think what we need to remember, that – the residential aged care setting – that 70 per cent of the workforce are currently unregulated care workers. I can't imagine, given that they're supposed to work under the supervision of a

registered nurse, how that would work in reality in this unbundled world where we're suggesting that registered nurses would come in an in an episodic way to do a particular task. We've spent many years in the aged care system looking at the model of person-centred care, holistic care.

5

And for me this is just going – this is a retrograde step to going back to this task-focused. But without a skilled workforce, 24/7, we've already identified that people who are going to be entering into the 24/7 residential aged care setting have probably already made the choice or the choice was made for them that staying at home was
10 no longer an option. Potentially three reasons for that: housing is an issue, lack of the informal support for – lack of support for the informal carer, and then the complex needs that simply cannot be funded around the clock in the home.

And so within these settings – and I agree they need to change structure and form
15 from potentially what we 've been building over the last 10 years to look at something that is more person-centred, you know, like the smaller sort of household-type models that we've seen, particularly overseas. But these people require extensive care. These are people with advanced dementia. These are people who require end of life care. Episodic care does not work for these – for this group of
20 residents. People with advanced dementia, the reason we have an issue with restraints and psychotropic medications is that we need a skilled workforce there that knows the residents, knows their needs.

Similarly with end of life care, episodic care is not the answer for us. I can see – you
25 know, GPs are unbundled, but they are professionals in their own right and they are – they do have the opportunity to come in and come out. Nurse practitioners could come in and come out and certainly provide a level of supervision and complex care needs, particularly for people with dementia and end of life care. So I see that as a possibility in an unbundled system. But I think we have to be very clear about
30 having a certain level of care delivered by a comprehensive team, including allied health. We've not mentioned much about allied health, but it is incredibly important within that team.

MR GRAY: Thank you. Commissioners, subject to any questions you have,
35 although we haven't dealt with every single one of the enumerated items in the list, some aspect of each of those matters has been covered.

COMMISSIONER PAGONE: Yes, they have, Mr Gray. Thank you to the panellists. This has been a very lively session. The propositions that were in fact put
40 to us are in the process of being tested. And I think you have done that admirably. Thank you very much for your time and efforts. Thank you. I think we've now got to reconfigure the panel, so we might adjourn for 10 minutes.

45

ADJOURNED **[2.33 pm]**

RESUMED **[2.45 pm]**

COMMISSIONER PAGONE: Mr Gray.

5

MR GRAY: Thank you, Commissioner. The sixth and final session of this hearing is perhaps somewhat ambitiously titled transition and implementation. One might ask transition and implementation to what and, of course, there is still uncertainty about precisely what the new system will look like and that has been very much the
10 task of the previous sessions to examine. However, there are things that can be done and that should be done in relation to transition and implementation in the final session we have for the hearing, and that consists principally of identifying those topics that will need attention, even if it's not possible at this point to flesh out the detail of a transition plan. The witnesses are Mr Sean Rooney, Mr Robert Bonner,
15 Ms Sandra Hills, Dr Henry Cutler and Dr Nick Hartland. I'm informed that there's no necessity for any further affirmations or oaths to be taken.

Ms Hills is our only new participant. So I will make a brief introduction about Ms Hills. You have already heard introductions about all of the other panellists,
20 Commissioners. Ms Hills joined Benetas in 2009 with career experience in health, business management and public policy. Under Ms Hills' leadership Benetas has diversified its services to meet future demand with a specific focus on innovation, research, workforce development and sustainable fiscal growth. Benetas has a strong presence in international research and advocacy through its role as foundation
25 member of the International Longevity Centre Australia, and has implemented beneficial outcomes across its services and workforce through programs such as the clinical leader orientation program. Ms Hills has leadership roles within other community organisations including executive member of peak body group Leading Age Services Australia, and also Anglicare Australia, National Aged Care Alliance
30 and various other government and community boards.

A major redesign of the aged care system will involve complex, interdependent changes affecting the older Australians who are the intended beneficiaries of the services provided by the system – or subsidised, I should say, by the system, the aged
35 care providers, the aged care workforce who, of course, are instrumental to the activities that constitute aged care, multiple government agencies, not just the Department of Health which has stewardship of the system but interrelated agencies who have related responsibilities and, indeed, the broader Australian community. Another important factor in that is the number of players who make up our complex
40 health care system.

The topic of implementation and transition is being considered more fully by the Royal Commission in its work program and it's intended it will be the subject of detailed attention and probably a future hearing. This session today, as I mentioned
45 at the outset, is an opportunity for you, the panellists, to identify your positions as to the work that should be included in that program, particularly in light of the proposal in consultation paper number 1. What are the issues arising from that proposal that

raise specific areas for examination on the topic of transition. Could I display, LASAs submission at page 1 in its submission response to the consultation paper. LASA said:

5 *The introduction of location agnostic care subsidies is likely to cause significant disruption to the aged care services sector. Accordingly, careful consideration must be given to transitional arrangements including appropriate timeframes, intermediate steps and support for structural adjustment.*

10

Now, under the heading Implementation and Transition on page 22, LASA identified a number of objectives and topics. Do the panellists – I hope you received your notes and had an opportunity to reflect on these matters, I beg your pardon, this is consultation paper, page 22. Do the panellists agree that this is a reasonable set of

15 objectives and topics for specific consideration in the context of transition and implementation? Mr Rooney, we will start with you. What are the objectives that you see have to be considered when one is formulating a plan for transition and implementation to a new set of programs along the lines of consultation paper 1?

20 MR ROONEY: So I think the starting point that we took was if we look at the track record of delivering large scale policy reform to human services systems in Australia, that the implementation has been fundamental to getting that right and I think whether it's in primary care, NDIS, Living Longer Living Better, there's a number of lessons to be learnt with respect to what we need to get right to realise the intent of

25 all the heavy policy work and thinking that goes into coming up with a new set of reforms. And so when we thought through what was being proposed in the discussion paper, we started thinking about what are the things that we know that we could do to make the system better right now and in our paper we have identified those.

30

MR GRAY: I will ask them to be put up on the screen right now. If we go to LASAs submission, page 5, heading 3, Fundamental Reform and Immediate Priorities, beginning with the introductory paragraph, paragraph 21, there are then a series of headings that follow around the waiting times for home care, the gap

35 between residential care costs and funding and care practice improvement in specific areas.

MR ROONEY: Yes. So those three specific areas are things that we already know are issues in the system today and are having an impact on the outcomes for older

40 Australians who are receiving care or service. So the point we were making is that where we can act to make the system better right now, we should. And so reducing the home care waitlist obviously is a priority. Getting the right amount of funding into residential aged care to ensure that the quality of care, the number of care hours and the sustainability of the organisations that support older Australians is assured

45 whilst we go through the further reform process with the Royal Commission is a priority, and notably in some locations that's an even more urgent issue. And then finally the workforce support.

We have gone through all the work of the Royal Commission and identified a number of competency and capability issues that have been identified with regards to clinical care or governance issues or response to complaints. These are things that we can act on immediately with regards to upskilling of staff, but also looking at the
5 numbers of staff or the care hours available to staff with respect to specific needs in the system. So I guess our starting point was to say, well, if we're transitioning, there are things we can do right now. Secondly, whilst we want to pursue that, we are also looking at how are we laying the foundations to prepare the system, and that's not just workers and providers, that's the government services, whether it's
10 assessment, whether it's regulation, etcetera, but also on the demand side for consumers, how are we preparing them to then transition to what comes next.

And then, thirdly, once we know what comes next, having clear objectives for that system, what are the elements of that system and then how do we measure its
15 performance because once we have that clear, we can then work through, well, how do we get from where we are, to where we need to get to. What's the timetable to do that and who is going to be responsible and accountable. So that was the thinking that we put into our response to the paper.

20 MR GRAY: Thank you. We will break down some of the elements of that and I'll open up the discussion to other panellists. At the level of what we are trying to achieve here, are we agreed that continuity of service is absolutely critical. These are essential human services. I take it – there's nods. There's broad agreement on that. Appreciation of the likely impact of the changes, if they're high risk changes there
25 needs to be some sort of appreciation of their impact, possibly a staged implementation of some of them. Is that a point that is agreed by this panel?

MS HILLS: Yes. Can I say I think that one of the first things I wrote when I looked at my notes and I read the paper was looking at the undertaking of a risk assessment,
30 and there's various ways you can do that but I think that will expose what the risks are and then looking at what the mitigation strategies are and I think, yes.

MR GRAY: Thanks, Ms Hills. Mr Bonner.

35 MR BONNER: I think that we would agree that there's work that can be done immediately and needs to occur immediately and work that will be required to be done over time. So we wouldn't disagree with the idea of let's work on the things that are able to be tackled up-front. I would note that in the last response I don't think there was anything specifically around workforce. There was a ..... workforce
40 in terms of what was required to tackle practice improvement and the like but we would argue in addition to the sorts of issues that have been raised there, there needs to be urgent action beginning now in terms of workforce supply and workforce reform.

45

MR GRAY: Thanks, Mr Bonner. There might be a problem with your microphone. Could I ask you just to – thank you very much.

MR BONNER: I will try.

MR GRAY: Thank you. Now, related to continuity of services, is it the case that there needs to be consideration given to – not the viability of providers at all costs but some sort of assessment – prudential assessment in the transitional phase as to the financial viability of providers so that there is an understanding of any sort of risks to continuity of service. Is that an agreed principle? There are aspects of the consultation proposal that involve - - -

MS HILLS: I think one of the things that providers need as much as possible is to know where are we going. Now, of course, a lot of that is not available, obviously. But to have some idea rather than stabbing in the dark. Not everyone is brave and wants to make some predictions and go forth but I think to have some idea as to where things might go and that perhaps answers some of your later questions about who's in, who's out.

MR GRAY: Yes. Mr Bonner, I think you were shaking your head.

MR BONNER: Yes, I mean, I think that we need to make sure that the services overall are able to survive and provide care and support in the way that we need them to. Does that mean that every provider needs to be sustained into the future; we would argue not. And they need to be sustained in a way that supports the shift in focus and change, not just to do the job that they are supposed to be doing now.

MR GRAY: Thank you. Dr Cutler.

DR CUTLER: Yes, so I would support those comments. Really, you know, there's a change that's going to occur within the aged care sector and in some ways the government needs to let that change occur and resources to shift as they respond to any structural reform that comes out of any reforms from the Royal Commission. So I agree that as a system there needs to be sustainability of providers and there needs to be continuity of care and that may be having some sort of model within government to determine okay, well, if a provider is going under and it is in an area that doesn't have another service provider that's easily accessible, then what's the transition arrangements in that specific situation just to make sure that, you know, people aren't left out in the cold.

MR GRAY: Thank you. That seems to be getting broad approval from this panel. Mr Rooney, did you raise your hand.

MR ROONEY: The point I was going to make is in residential aged care we are already seeing that transition. I mean, we've gone from around 1250 approved providers, you know, six or seven years ago now to probably just over 800. So there is already consolidation and transition. I guess the thing – picking up on the point that Sandra Hills was making, stability and certainty is one of the big challenges particularly in residential care with respect to the capital cost and the investment that

is required to actually have service available and in the absence of that, it just increases the risk and costs of capital and all of other things that come with it.

MR GRAY: Thank you. Finally, two things. I will try to deal with them together. Clearly defined roles and responsibilities and accountability for meeting those goals in the transition, whatever the transition ends up being, and oversight of the progress – independent oversight of the progress of the implementation with transparent reporting of that, perhaps to Parliament. Is that – what's the reception of those proposals by you, the panellists?

DR CUTLER: So I think there is an absolute need for independent oversight and transparent reporting of progress, particularly around quality within the aged care sector. So we obviously have a quality indicator program that's operating at the moment. It has a limited number of clinical indicators. There's three; two more are being explored. But we know that wellbeing within a residential care facility, for example, is much broader than just those indicators. And we also know that if you measure a particular component of an aged care – of a provider, for example, then those parts that aren't being measured may not get as many resources as what they otherwise would have. So I think the first and foremost need within a reform agenda or a transition agenda is to make sure that there is a robust quality performance framework to pick up on any trends that may be occurring due to structural change.

MR GRAY: Mr Rooney.

MR ROONEY: I absolutely agree and I think what we were thinking is really two areas of focus. One is around having an agreed timetable for implementation of reform and an agreed set of sequenced steps that would be clearly understood by all the actors and roles and responsibilities and then, I guess, co-dependencies worked through. So being able to measure the performance and the execution of that program of reform is one area. The second area is a matter that I have raised previously is looking at that performance measures and, I guess, holding to account the system at various levels. We will set out on this reform journey with clear expectations around what we want the system to deliver but we need to have indicators and measures so we can track what's happening at the system level so we have assurance that we have a high performing national system that's delivering good value for money.

MR GRAY: Thank you.

MR ROONEY: We need then at the service level - - -

MR GRAY: I remember the evidence and we will be able to refer back to it. Thank you. Mr Bonner.

MR BONNER: I think the point that Sean was just about to move on to was that I think that there is evaluation and measurement of performance at the system level,

whether or not the reforms are delivering the outcomes that are sought from it, and then there is the performance of individual providers and constituent bodies. So we would say that there is a clear line of sight and transparency of reporting that needs to be cut across both of those systems.

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MR GRAY: That's indeed what Mr Rooney said on that earlier occasion. Thank you.

MR BONNER: You've been quoted.

10

MR GRAY: Now, could we go to this proposition of Mr Rooney's, and it's expanded upon in the LASA submission, heading 3.1, 2 and 3, for urgent action for certain elements of what needs to be done, at the same time as developing a more staged process for longer term reform. Dr Cutler, can we ask you to provide us with
15 the conceptual tools that are necessary to decide when that can be done and when it's not a good idea. There's some caution that's needed, is there not, in implementing what might be regarded as urgent incremental reform if one doesn't have careful regard to what the long-term agenda is?

20 DR CUTLER: Yes, that's right. So I suppose there's always a risk that if we start to significantly change the system now, ie, picking up on things that are urgent, then it may lock us into a specific direction which may be harder to turn around once the recommendations from the Royal Commission are implemented over the longer term. So, for example, you know, we all agree that there is an unmet need in home
25 care but increasing significant amounts of funding to home care packages when we don't really know what home care is going to look like in two or three years time, there may be some issues around whether it is then harder to change the system.

The other thing I wanted to say is that there are many reforms that rely on each other
30 to be effective. So in the prior session I've talked about quality and quality performance frameworks, in particular report cards, but for those to work properly we also need to ensure that individuals have choice, and in particular within residential aged care where in some areas there is high occupancy rates. Without choice, people can't vote with their feet even if the performance framework was
35 much better than it is now with the report card – the report card is much better than it is now. So there needs to be consideration as to how reforms interact with each other and once that is done, then the timing of reforms should naturally fall out.

MR GRAY: If we take Mr Bonner's point about urgent need to address a range of
40 workforce issues and the ANMF, for one, has put in detailed submissions following the third hearing in Melbourne, which was the workforce hearing; there has been an identification of a need for improved training. There has been an identification of a need for, on the ANMFs case, careful attention to be given to the skill mix that is deployed in residential settings and the ANMF advocate for ratios. There's more to
45 it than that, but I will leave it at that at this point.

DR CUTLER: Yes.

MR GRAY: Now, are those sorts of reforms or any of them, for example, the training element and the labour supply element of those proposals, are they the sorts of issues that can be addressed urgently, irrespective of the shape of the system to come?

DR CUTLER: Yes, I think so. I think there's a number of areas that you could continue to improve upon without regard, really, to the outcomes from the Royal Commission, because there is a fundamental structural need within the aged care system for change. And I think the skills and the training of the workforce has been identified on a number of occasions over the last 10 years, and in prior reviews for that to continue to increase. So I do believe that there are some changes that can be made now.

MR GRAY: Can I open this up to the other panellists both at the conceptual level of whether we need to be taking particular care about incremental change and with any particular suggestions. Mr Bonner.

MR BONNER: There's another level of consideration, I think, in terms of the area that was described in the home care packages example, of the unintended consequences of not dealing with that urgently now. So the unintended consequences are risks that flow from not addressing areas of undersupply now. So whilst we might not want to implement massive reform in that area ahead of other final destinations, if we do not act now, then there are people either trapped without services and deteriorating without care and support at home, or alternatively, they are escalating because of chronic health breakdown and turning up at the emergency departments, stuck in our teaching hospitals and incurring massive cost and human suffering through that process.

So whilst I accept that you don't want to be sort of turning the system upside down twice in short order, if we don't deal with some of the issues that LASA have raised in their submission, it seems to me that we are going to be further behind the eight ball by the time we actually get to the time of major reform.

MR GRAY: Yes. Dr Hartland, then Mr Rooney.

DR HARTLAND: So certainly I agree with what people have been saying that the phasing is really tricky. I won't put a personal position about the order of priority because I think that's a normative judgment. I'm getting a bit tired to do that today. So it's certainly true. So you know, if you uncapped residential care you would push more people into that system if you kept home care capped, and that's not – you know, the Royal Commission has observed that we are already too focused on residential care so you do need to be really careful about that phasing. You need to be really careful about planning, the timelines of doing some of this complex work are really horrendous so, we started - - -

MR GRAY: You mean they're very long?

DR HARTLAND: They can be very long, yes. So you know, we started work on single assessment in May 2018 and the concept had been discussed before that and the current timing is to have that delivered in April 2021. Now, you know with a more solid authorising environment by Royal Commission recommendation, things – barriers get cleared and a lot of the timelines are about taking the sector with you, but these are no trivial tasks about these complex reforms. You have got to think about stakeholder engagement and co-design, legislative design, micro policy, IT design which is its own, you know, developing specs, choosing technical solutions, building and then workforce implications being changed. So you know, careful planning is really important in this.

I think in terms of your immediate priority, I don't want to put too much of a substantive view but I think we should be looking through that from the lens of the consumer and what would be of most immediate benefit to them. It does strike me in that context that the investment side of what you were talking about in your streams is an area that – you know, without having done a full risk assessment doesn't appear to have a downside into more investment so that might be an early gain. And finally, and you know, when I do job interviews occasionally and they ask me the thing that I got wrong about things, I was involved in the NDIS design and what I always say is we really underestimated the incentives that actually applied to providers once the system was announced.

So you know, day 1, you know, we were doubling the money effectively, and people were obviously very enthusiastic about that prospect but day 2, all the established providers could see was risk to their business models. And so getting the providers in to the system and wanting to change actually proved to be much harder than it kind of looked like in the abstract. So I think there are some lessons to be learned about what are the kind of behavioural economics aspects of a provider that's basically got its books full, kind of pretty well off, nice business model, pretty stable; all of a sudden a new system. All they can see is where am I going to get my clients from. You know, how do I have to change.

So I don't think personally I paid enough attention to that when we were doing that, and it's worked through the system. I don't – you know, I don't think you'd say that it has been terrible, but it's something that did strike me about how complex that can be and worth thinking about it now.

MR GRAY: Mr Rooney, back to you.

MR ROONEY: Look, I'd just up on the theme of workforce. When we were preparing our response we were thinking of workforce in two areas: one is around competencies, so what are the identified current gaps or soft spots that we need to upskill the current workforce with in regards to issues identified through the Commission's process. But we're also thinking about capacity, and that's about increasing workforce supply both in the very near term, in terms of more care hours delivered but also through the work of the aged care workforce taskforce which was given the role to, you know, consider what is the workforce requirements into the

future and we have a strategy there that we're all working together with the workforce council to execute.

There has been some challenges in that execution which have been picked up in
5 previous hearings. But certainly our view is both the competency but also the capacity of the workforce.

MR GRAY: Commissioner.

10 COMMISSIONER BRIGGS: No, I think ..... thank you.

MR GRAY: I will move on to another topic unless Ms Hills, you want to join in.

MS HILLS: I was just going to say, as a member of the workforce council, I have to
15 say something. So our actual plan – I mean, we've been meeting for nine months now so we are getting on with things regardless of where the Royal Commission is at and, in fact, our work plan goes over five years so we are in year 1 now, I think. We have identified a number of projects and we are actually moving on them. So looking at engagement surveys, staff satisfaction surveys, the voluntary code,
20 looking at issues around micro training, online training; there's a whole range of things that we're starting to have a look at and we actually are progressing quite well.

MR GRAY: If the council is able to provide us with the up-to-date work plan that would be of assistance.
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MS HILLS: We meet on Thursday so we can give you one after Thursday.

MR GRAY: Thank you. Next, I will go to – well, actually we've probably dealt with point 3 to some extent. Let's move on to point 4. I think we have probably
30 dealt with point 4 as well. Unless there are any other contributions from the panellists about specific areas for urgent attention in addition to the LASA list, and obviously the workforce issues? No?

COMMISSIONER BRIGGS: While you are thinking about that, I might in fact ask
35 a question. It arises from the - - -

COMMISSIONER PAGONE: You've turned it off.

COMMISSIONER BRIGGS: I'm sorry. Thank you. I'll start that again. I'll ask a
40 question. I'm sorry about the mic. It follows from the evidence of Mr Hartland and Mr Rooney and it's around locking in service providers to deliver on change. We've heard evidence in this Royal Commission at various times around how governments have provided additional funds for particular outcomes, and the industry has taken the funds and not delivered on the outcome. This is a pretty serious issue when
45 we're considering workforce issues more generally and how that funding gets to the

appropriate place. So I'm a bit nervous about rushing in to just provide extra funds to the sector without the quid pro quo. And the question from me is how does the industry sign up to provide the quid pro quo?

5 MR ROONEY: So I think you've hit the nail on the head insomuch as there has been investment in the system where it's been loosely termed, "Well, here's some money to do something." But there never really – in my short period of time in the system, there's never really been an appropriate or an effective mechanism to monitor and determine whether that investment has delivered on the intended
10 outcomes.

And, you know, you see this in lots of areas of government where, you know, we can be very loose about what the government wants, we can be very tight about, "Well, you must spend the money this way" and then very loose about measuring the
15 outcomes, where in actual fact I think my observations of where the system should go is that we want to be really clear up front what is that we want the outcome to be and what are the metrics we would measure that. We would then resource the providers to be able to deliver those outcomes and get them to be able to do that innovatively, efficiently and effectively and then measure their ability to how they
20 performed.

That's a very different model. And I think, getting back to your point, in the absence of that, it's been very difficult to determine, "Well, what's the value for money? What's the return on investment?" So I absolutely acknowledge that if there was
25 more investment coming into the sector, that would come with clear expectations around what performance and what outcome would be delivered. And that needs to be measured and monitored. And, you know, if you're not meeting that, you need to be held to account.

30 MR GRAY: Mr Bonner wants to - - -

MR BONNER: Can I just say that Mr Gilbert's evidence, I think at the Victorian hearings, was illustrative of the point that you're making, Commissioner. And I think that our position would be that we would want to see, in terms of workforce
35 reform, very clear tying of funding flow to particular workforce outcomes. So visible and transparent arrangements for the money to actually lead to improvements in the wages and working conditions of people in the sector. And the industry had that available to them in the early 2010s through the workforce strategy that was being implemented by the then government, but baulked at the accountability
40 measures that were attached to that in terms of making enterprise agreements that ensured that the money arrived in the pockets of the workforce. So we would like to see those kinds of enforceable mechanisms built in to any system before the money was flowing.

45 MR GRAY: Can we go to Ms Hills.

MS HILLS: Commissioners, if I can just use an analogy for us. If I want to undertake some large project or transition or something like that and I go to my board and I say to them, "I want a lot of money to do this", I'm going to have to do a few things. I'm going to have to put up a good business case that actually says,
5 "This is my goal, this is the purpose, here's the cost/benefit analysis, here's the risk, here's the risk strategy, here's how I'm going to monitor, here are the resources, here are my skills", etcetera, etcetera. And I don't get the money unless I do that. And I think – and if we use that analogy, I think you'll understand what I am saying.

10 COMMISSIONER BRIGGS: I agree, Ms Hills, but the problem is that if a government asks that, it's called red tape and there's an immediate rejection of the approach. And, frankly, I think if the sector expects to get a lot of money, there are some hoops it's going to have to go through in order to see that money delivered, because the ultimate issue is the outcomes for elderly people and how we get them.

15

MR GRAY: Dr Cutler, did you raise your hand earlier?

DR CUTLER: No.

20 MR GRAY: Can we – I want to skip to point 8, which is, really, directed to you, Dr Hartland, which is about barriers to smooth implementation and monitoring and, indeed, evaluation, to circle become to the point the Commissioner is making, including evaluation at a provider level, flowing through to evaluation at a system level, to pick up Mr Rooney's point and Mr Bonner's point.

25

What are the barriers? We've had a previous session in which data collection and analysis came up. It's also been the subject of your evidence on a previous occasion. I think it's sort of, really, an uncontroversial position that data collection and analysis is in a poor state in the aged care sector and, indeed, across the interfaces with health
30 care. The Commissioners have asked for an update from the Commonwealth on the progress of data improvement projects and initiatives that the Commonwealth is involved in. And, perhaps, rather than asking you for an update now, we'll just hope to see that .....

35 DR HARTLAND: There is some positive news, so I don't have to jump out a window.

MR GRAY: Commissioners, do you want to hear a brief synopsis now? We've got about 10 minutes.

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COMMISSIONER PAGONE: Sure.

MR GRAY: I mean - - -

45 DR HARTLAND: ..... 30 seconds - - -

MR GRAY: - - - we don't have 10 minutes on this. We've got about 10 minutes left in the session.

DR HARTLAND: Okay. Good. No. We have been able to link between the data
5 systems and we're expecting the data to get into a warehouse that you were seeking, so there's some good news there. Look, I think those three points, as you say, are uncontroversial, but they're important preconditions for being able to reform - - -

MR GRAY: The other two points, for those - - -
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DR HARTLAND - - - interfaces - - -

MR GRAY: - - - on the web stream, complexity of interfaces ..... to engage with transformation.
15
DR HARTLAND: You know, undoubtedly, aged care needs to get better data. You know, we're doing stuff on CSHP to try to understand data and we're trying to understand what's happening in home care. And that does – that will require investment in ICT. I'll go back to the NDIS experience.
20
MR GRAY: Will it include better tools for understanding the true demand for those services? Because, as I understand it, the approach to demand projections has been, essentially, a population-based one, based on assumptions that go back many, many years about the services that a given population will require. And there's not a lot of
25 subtlety – not a lot more complexity to it than that. It's not a detailed demand analysis, as I understand it. Will these new data analytics approaches assist in understanding demand?

DR HARTLAND: Yes. Yes. And, again, I think of the NDIS experience. They
30 did a lot of demand modelling. And it took a decade to get to a level of sophistication to be able to assert to government that they knew exactly what would happen if you went to a needs-based system, so - - -

MR GRAY: Well, that's disturbing news for us. Is that - - -
35
DR HARTLAND: .....

MR GRAY: ..... aged care?

40 DR HARTLAND: But we do have – sorry. Yes. That was probably a bit overly pessimistic. So we're doing some work. It's just a way of saying these things are complex. I'm not – I don't want you to – don't focus on the decade. Sorry. We are doing some work about what we think the needs groups are in the population, you know, groups with similar characteristics, costs and risks. And we're also doing
45 some work on demand-supply modelling. And if we can connect those two, we'll be able to project what a needs-based system would look like. But we talked about that

yesterday and we think we'll be able to complete that to get you some information to assist you and whatever ..... you do internally.

I think it's, obviously, important to be able to say what the cost of changes were and we need better data and analytics to do that. The interfaces with related human services are clearly important. I think, as the Tune report identifies on the NDIS, that that's been a big deal in the NDIS. It might actually be a bit simpler in aged care, because aged care is not, essentially, a Commonwealth-State program. And one of the problems with NDIS, it was a jointly funded program, and so people got very, very anxious about the boundaries between Commonwealth and State programs and whether there was cost shifting between the two. It's an issue in aged care, but it might be simpler to solve.

Look, the third point about the capacity ..... as a sector, I actually think that goes to the Commissioner's point about quid pro quo and how do you manufacture a situation where people are willing and active and, indeed, enthusiastic participants in the reform agenda? I don't have a definitive answer on that. I just observe – it goes to some of the workforce material, too, but it's wider than just the nurses and people providing the care. You know, there's a cultural element to change and how do you make people feel that a reform agenda focused necessarily on the needs of the receivers of the care, which is where we should always be, how do you create a cultural – almost like a cultural movement within the sector that that's what they want to be involved in? And, you know, cultural change is hard.

MR GRAY: I understand. I think, just in the time we've got left – and I understand both Mr Bonner and Mr Rooney want to comment on this topic. Perhaps if we have any time left at the end, we might come back to it, but, just to get through the agenda, I might move to another topic. I apologise.

DR HARTLAND: No.

MR GRAY: I want to turn to the longer term part of the agenda and reiterate, look, we don't know exactly what that looks like, but assuming it involves such things as a move to uncapping of supply, a move to, at least where it's possible, subject to the thin markets issue and there's a possibility of a sort of a two-speed model here, where we have a default position looking after regional coverage and people who don't wish to opt for individual packages or consumer-directed care, there may be one model. And there may be the added overlay of individualised budgeting and consumer-directed care on top of that to harness market forces in those places where a market exists to drive innovation.

Now, assuming those two things are brought in, they are going to need a staged approach, I propose. And they're going to need some degree of understanding of the implications of uncapping supply, some appreciation of demand and whether there's a sufficiently deep market in a particular place. This is probably going to have to be dealt with on a region by region basis. What are the panellists' views on those propositions? Do you agree with me? I'm seeing nods. Dr Cutler.

DR CUTLER: Yes. So, as I said prior, I think one of the – or the most important starting point in moving down this path is having a quality report cards for providers. So any identified change in transient quality can be picked up through the reform process. I think the government also needs to be prepared for potential closures. So you start opening up the aged care market, there's greater competition. There may be new entrants into the sector. And so the government needs to ensure that there is continuity of care that's delivered and it can accommodate closures in regions where there may not be other available services.

The other point I want to make is, you know, what is the reason for removing supply restrictions? Well, obviously, one reason is to create greater choice for individuals, but the second reason may also be because offering greater competition can lead to potential improvements in quality as providers try to ramp up their quality to attract residents or people with home care packages. So providers need to respond to that incentive. And they can only do so to the point whereby their revenue covers any increase in costs associated with increased quality. So I think there needs to be an evaluation, also, of the funding regime to make sure that any increase in quality is potentially covered by the funding mechanism, as well, because otherwise providers will be constrained.

MR GRAY: Mr Bonner, can I go to you on this. There have been clear concerns raised by the ANMF around what you perceive as the implications of individualised budgeting. Putting – understanding that those points are being made, what about the proposal that there needs to be a staged approach to this, so that the impacts are understood?

MR BONNER: I mean, I think the starting point that everyone that I've heard giving evidence is supportive of is consumer-directed care. And, as part of that, I think if we disentangle the individual budget holding bit of it for a minute and talk about moving to a system of client-focused consumer-centred care planning, assessment and then service provision, then, to some extent, if there's a need to look at budget attachment to that, at an individual level down the track, that can be added in as a complexity.

But I think that that's the kind of progression that is relatively well understood in terms of all of the positions that I've seen and heard. So I think it's about how do you progress that debate over time. And, from our perspective, it's the attachment of the money and what happens in terms of that accountability that is the fundamental problem with the model that's on the table now.

MR GRAY: Is the real problem – well, the most significant problem – seen by your union the capacity for unbundling at some point down the track, because of the potential challenges that poses to providing holistic care?

MR BONNER: Yes. That would be one of them. But there's also the cashing out potential. I mean, I think that there's an argument that if there is an assessment process that is shared – genuinely shared involving consumers and assessors that

says, "This is the outcome in terms of care interventions that should be provided", for the consumer then to have another go at that and be able to say, "Well, I want to use that for something completely different" is potentially a misuse of the public funds. So we would argue that it's about building those steps in an aggregated way
5 that might be more appropriate in the longer term.

MR GRAY: Dr Hartland, the Commonwealth submission at pages 6 and 7 speaks not only about the need for understanding demand for uncapping supply, but also refers to demand management. Now, of course, there is supply management at
10 present under allocated places, packages, the national prioritisation system, the limited scope of particular grants under CHSP, etcetera. What do you mean by demand management in a needs-driven system?

DR HARTLAND: So I think it is a slightly confronting phrase. And if you were to
15 go to a needs-based system where, effectively, you didn't limit the service response by reference to caps or population ratio, you would want to be quite certain that the service offer was a reflex of someone's need. And you'd want to be certain a that person hadn't got to a need for a specifically funded service if there were other things that would better suit their purposes that you could get for in the community.
20

So there's a nest of functions that a needs-based system will – should have that you can group under demand management. There might be a better term for it, because it sounds a bit authoritarian, but goes to things like rigorous needs assessment, to make sure that you're certain that the subsidy is right, actively linking people to
25 mainstream services, you know, primary care and social support is what we pointed out. And that's an issue both at their first contact with the system, so you don't queue for a funded package, if actually all you needed was social inclusion.

You know, I was struck by the evidence in the investment section about what a good
30 provider that understands a person's changing needs can do if they're aware of that and linking them to primary care. So that's an important aspect of it. We've talked about ..... approaches, which is both about how you do assessment, specific service intervention such as short-term investment approaches, but also the way you provide care, support for informal caring, so that that can continue. And then, obviously, as
35 the Tune report in 2017 observed, you want to get means testing right.

So there's a whole range of interconnected functions that you would need in a needs-based system to make sure you were certain that the system was meeting needs, but that it wasn't – effectively, over subsidising needs. And these roles, I think, some of
40 them exist in the system, some of them simply don't and would have to be created. And they'll need consideration as we go forward.

MR GRAY: Commissioners, can we take an extra - - -

45 COMMISSIONER PAGONE: Sure. Yes.

MR GRAY: Thank you very much. Mr Rooney.

MR ROONEY: I was just going to follow on from the conversation. I think from a demand side, the notion that the system needs to be person-centred and I think more and more place-based and then outcome-oriented, that's something that is coming through, I think, more and more as the process has progressed. And then when I look at the link or the list that you've provided around the staged approach, picking up on Dr Hartland's point - - -

MR GRAY: Is there the list under the various features - - -

MR ROONEY: Sorry. Uncapping supply - - -

MR GRAY: Yes.

MR ROONEY: - - - implementing individual .....

MR GRAY: So, for example under transition to individualised budgets for care - - -

MR ROONEY: Yes.

MR GRAY: - - - ensure the presence of assessment resources, market testing, etcetera?

MR ROONEY: Yes. And then, in item 5, the staged approach to uncapping supply, a staged approach to implementing individualised budgeting and consumer direction and agnostic of setting.

MR GRAY: Thank you. That's not available to the public, but thank you for reading it out so the public can follow. Thank you.

MR ROONEY: Sorry. The point I was going to make is, I think, listing from that list is the integration with the health and social services sector, because it then, from a consumer perspective, they're not really concerned whether it's the aged care system or any other system; they have a suite of needs which can cut across primary care, acute care, social services, aged care. At the end of the day, they just want something that's going to meet their needs in their community. And the system needs to be able to deliver that. And we need to be ensuring that we're delivering the outcomes that that person is actually requiring.

MR GRAY: So, as a sort of a step back, consider the perspective of consumers, is there going to be a seamless provision of - - -

MR ROONEY: It is. And I think the place-based piece – you know, we had the national infrastructure with the primary health networks. And, again, interesting listening to the discussion about demand. You know, each of those organisations, they have national coverage, they do population health plans, they look at the current set of needs across health needs in those communities. They then look to service map what services are there. And you can extrapolate that out to say, "Well, what

does that look like over time?" You know, I'm just not sure do what degree those plans are being applied to consideration of aged care services.

MR GRAY: I want to move to a final topic. It's very important that we get this in.
5 And the Commissioners have given me a few extra minutes. I want to ask the panellists to step back and consider the broader societal context in which this transition will be occurring. Every Age Counts is charged with responsibilities to increase social awareness about the current ageist tendencies in Australian culture, in society. Consideration needs to be given to what concrete steps the Royal
10 Commission should be taking to accompany – that is, by way of recommendations – to accompany its recommendations about system transition in this regard. Is that something you the panellists, agree with? There needs to be an element of system transition that is allied with initiatives that are aimed at the broader community and aimed at ageism in the broader community?
15
MS HILLS: Yes.

MR ROONEY: Yes.

20 MR GRAY: Thank you. There's also been broader contextual points made by National Seniors Association about making better use of existing resources, existing contact points in community and in primary health care. I take it that there should be – well, I propose that there should be, built into the transitional model, attention to that existing resource, so that that is nurtured and sustained and improved in
25 whatever ways possible. That seems to have broad agreement. And there has been a broad consensus – perhaps consensus is too high a word, but there has been a broad pattern of support for something that looks like local, sort of a local network of face-to-face resources that can provide – and then it gets difficult – a spectrum of services that have been variously called care-finding, navigation and the like. This is
30 obviously something that needs to be built and that should also form part of the transition plan, I take it.

DR HARTLAND: ..... a really important point and it has got that element to linking to services already available but it's interesting that you put it in this because in the
35 original concept of NDIS local area coordination there was an idea of making communities more disability friendly, and that goes to the point you're raising about cultural change.

MR GRAY: Now, in the minute that remains, are there other very important
40 contextual matters of that kind that need attention in a transition plan that occur to any of you, the panellists, in this session?

MR BONNER: I think that just in terms of that last question, there are issues just in terms of equity that flow from those local community discussions around financing
45 and housing and the like. And there was a discussion yesterday that talked about superannuation and how that might be moved into the future and we know that women have very low accounts in terms of their superannuation because of

employment and related matters, their engagement in the workforce, their proportion of part-time work than do men. So if we're going to get into financial planning as part of this system we need to deal with some of those wider social equity issues as well as the issue of ageism.

5

MR GRAY: Thank you. Any other thoughts about how else governments should be working with older people, their families, providers, health professions and the broader community in a way that would be a coherent aid and augmentation to transition to a new system. Mr Rooney.

10

MR ROONEY: I guess one of the things that strikes me is that we do have an ageing population, and we know this has been going on for some time. Yet everywhere we look there what I would call the inconvenient truths of ageing in Australia. There are a number of things, whether it's homelessness, whether it's

15 poverty, were it's people at risk to suicide, ageism in employment; there's just a number of things where you go that's just not right. I'm wondering whether a national score card approach to be able to report back to the nation on issues of importance to older Australians that would demonstrate progress in improving some of the outcomes that the growing numbers of older Australians are experiencing. I

20 would have thought that would be a useful thing to promote further respect and care.

MR GRAY: To draw on what has been done in some other areas, a national action plan - - -

25 MR ROONEY: Yes.

MR GRAY: - - - with identified goals, measurable targets, timelines and the like.

MR ROONEY: Yes.

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MR GRAY: Thank you very much. Unless there is anything else from the panellists, do the Commissioners wish to raise questions?

COMMISSIONER BRIGGS: Thank you for that. I want to change tack and go

35 back a little bit to Dr Hartland's comment about a social movement for change, and it tees off when you just said then, Mr Rooney, I think. When we delivered our interim report, I think I was asked the question by some providers about what should we be doing, and I can't remember exactly but I think I said "Preparing for change", or words to that effect. And I think that's what the sector needs to do. But on top of

40 that, I think we need to think about what might some of the core elements of preparing for change be. I think leadership is clear on that, governance, stewardship of the change is pretty important, catalysts for change, new players in the system who aren't the same people who talk to governments all the time, and how those new players or new workers or whatever can be brought in to keep a process of reform

45 going.

Similarly, research about leading edge activities and how that is institutionalised and spread across the system are things we might talk about. So what I'm saying is can we raise the discussion up to that level, and anyone in the panel who wants to talk at us about these things, I would be pretty happy to hear that.

MS HILLS: I would suggest that the sector is already looking at many of those areas but we really do need to come together and be far more united. I think it's unrealistic to think that we are ever going to get everyone following in the one trail. I think that's unrealistic. And I think that there are – we can all talk about movements and things but – and I'll talk about – I've already spoken about the work of the workforce council, but certainly the work of many of the peaks, the work of NACA. But it's not enough. I understand that, but we are talking about culture change. That's one of the things I would also add to your list, Commissioner.

And, you know, people are tired, you know. They've gone through reform. Will they be ready to do more reform? Many of them are and some of them aren't, and that's probably one of the things that's going to separate the wheat from the chaff, etcetera, which may or may not be a good thing. But strong leadership is absolutely needed in the sector and I think people need to speak out more, perhaps be a bit more, you know, a bit more risky about what they're doing and what they want to do. I could speak a lot on this subject but I will stop now, but I think it's up to the sector. We have to lead.

MR ROONEY: I think my reflections would be, as I have said previously, the issues of ageing and aged care are issues of national importance. I'm not sure that they are seen to be that. If you look at the current discourse, whether we're talking about aged care – and we've got a lot of focus on quality and safety, and rightly so. But we're seeing spot fires, I would argue, around retirement ages and retirement incomes, around employment for older people. There's just any number of issues that all – the root cause is that there are more older Australians today than ever before. And I don't think, as a country, we have actually acknowledged that, and when we come to those conversations as spot fires, more often than not the discussion is around this is a problem or this is a burden, and it's in the negative.

When in actual fact the starting point is, hey, isn't this a success of our society. What are we going to do as a society to support and enable those growing numbers of older Australians to continue to contribute to their families, their communities, the economy, in whatever way they choose, that is, basically drawing down the dividend from their long lives contributing to this country. And I think that is a piece where we really need to elevate and that's the opportunity, I think, as afforded through this process is to start to deal with those issues as well.

COMMISSIONER BRIGGS: Thank you.

MR GRAY: Thank you, Commissioner. Commissioners, that concludes the session and, indeed, the hearing. Can I just say that it's the intention of the counsel assisting team, ably supported by solicitors and other staff, to distil what has been learned

during the course of this hearing and to make a presentation to you, the Commissioners, in about the first week of March, drawing on that material and on further analysis.

5 COMMISSIONER PAGONE: Thank you, Mr Gray. And I should begin, I think, by thanking this group of panellists as I have the others separately. The issues that have been raised in this session and, indeed, the others are really very important. We are very grateful for the depth of experience and knowledge that you have brought to this discussion. It has been very significant, and we thank you for the work that you
10 have done before the presentation today as well as your presentation today.

Counsel, may I thank you for your hard work right throughout the last two days. I know that there have been a lot of people behind the scenes doing a lot of the work as well for you and with you, and if you would pass on our thanks to all of those,
15 some of whom are sitting at the table, others who are not.

MR GRAY: I will, thank you.

COMMISSIONER PAGONE: Thank you to all of them. I repeat the thanks to all
20 of the people who have been participants, and to all of the staff of the convention centre which has been absolutely wonderful in every respect. The matter has gone very smoothly. We have been able to get in and out very easily. The layout has worked out very well indeed. Our staff that have prepared the layout and all of the other things that you can sort of see and some of the things that you can't see. So
25 thank you to all of those. I think we now just adjourn until - - -

MR GRAY: Would you please release Mr Hartland from his summons, Dr Hartland.

30 COMMISSIONER PAGONE: Should I?

MR GRAY: We may need him back.

COMMISSIONER PAGONE: Yes, of course. You are formally released.

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DR HARTLAND: I had forgotten about that, too.

COMMISSIONER PAGONE: Thanks for that, counsel.

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ADJOURNED **[3.47 pm]**