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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

CANBERRA

10.02 AM, THURSDAY, 12 DECEMBER 2019

Continued from 11.12.19

DAY 72

MR P.R.D. GRAY QC, counsel assisting, appears with MR R. KNOWLES SC and MS B. HUTCHINS
MS L. WARBEY appears for WA Department of Health
MR I. FRASER appears for the State of New South Wales
MR GOLDING appears for the State of South Australia

MR KNOWLES: Good morning, Commissioners.

COMMISSIONER PAGONE: Mr Knowles.

MR KNOWLES: Professor Len Gray and Professor Leon Flicker are the first witnesses today. They are esteemed professors of geriatric medicine with longstanding and extensive experience working in the health and aged care systems. They are eminently qualified to give opinions about the interfaces between those systems. They are presently in the witness box, if they might be administered the oath or affirmation.

COMMISSIONER PAGONE: Yes. Thank you.

<LEON FLICKER, AFFIRMED [10.02 am]

<LEONARD CHARLES GRAY, AFFIRMED [10.03 am]

MR KNOWLES: Professor Flicker, could you state your full name for the Royal Commission.

PROF FLICKER: Professor Leon Flicker.

MR KNOWLES: Yes. And you prepared a statement dated 25 November 2019.

PROF FLICKER: I did.

MR KNOWLES: Yes. And that bears the document identification number WIT.0616.0001.0001.

PROF FLICKER: That's correct.

MR KNOWLES: Yes. Have you read your statement lately?

PROF FLICKER: Yes.

MR KNOWLES: And are the contents of the document true and correct to the best of your knowledge and belief?

PROF FLICKER: They are.

MR KNOWLES: Yes. And are the opinions expressed in that document genuinely held by you based on your expertise and experience?

PROF FLICKER: They are.

MR KNOWLES: Thank you. I seek to tender the statement of Professor Leon Flicker dated 25 November 2019.

COMMISSIONER PAGONE: Exhibit 14-25.

EXHIBIT #14-25 STATEMENT OF PROFESSOR LEON FLICKER DATED 25/11/2019 (WIT.0616.0001.0001)

MR KNOWLES: Professor Gray, can you tell the Royal Commission your full name.

PROF GRAY: Leonard Charles Gray.

MR KNOWLES: Yes. And you've also prepared a statement for the Royal Commission dated 25 November 2019.

PROF GRAY: That's correct.

MR KNOWLES: And that bears the document identification number on the front page of WIT.0619.0001.0001.

PROF GRAY: That's correct.

MR KNOWLES: Have you read that lately?

PROF GRAY: Yes, indeed.

MR KNOWLES: Yes. And are the contents of the statement true and correct to the best of your knowledge and belief?

PROF GRAY: Yes, they are.

MR KNOWLES: And are the opinions expressed by you in the statement opinions genuinely held based on your expertise and experience?

PROF GRAY: They are.

MR KNOWLES: Yes. I seek to tender the statement of Professor Leonard Charles Gray dated 25 November 2019.

COMMISSIONER PAGONE: 14-26.

EXHIBIT #14-26 STATEMENT OF PROFESSOR LEONARD CHARLES GRAY DATED 25/11/2019 (WIT.0619.0001.0001)

MR KNOWLES: Thank you, Commissioner. Can I start with you, Professor Gray. You are the Director of the Centre for Health Services Research and Professor in Geriatric Medicine at the University of Queensland.

PROF GRAY: Yes, I am.

MR KNOWLES: You have qualifications in medicine, business and health management.

PROF GRAY: Yes, indeed.

MR KNOWLES: Since 1982, you've been a consultant physician specialising in geriatric medicine working in acute, subacute and aged care settings in Victoria and Queensland.

PROF GRAY: Correct.

MR KNOWLES: From 2001 until now you have been engaged in various aged care policy informing research for, among others, the Commonwealth Department of Health and its predecessors.

PROF GRAY: Yes.

MR KNOWLES: Prior to 2002 you held various positions in health management in Victoria including responsibility for management of a number of aged care services.

PROF GRAY: Yes, indeed.

MR KNOWLES: And since 2002 you've held various academic positions at the University of Queensland.

PROF GRAY: Yes.

MR KNOWLES: Your current role involves a wide range of research programs in, among other areas, aged care, geriatric medicine and telehealth.

PROF GRAY: Yes.

MR KNOWLES: The centre has considerable expertise in biostatistics, health economics, clinical informatics and behavioural science.

PROF GRAY: Yes.

MR KNOWLES: You are also a board member and Fellow of interRAI, an international research collaborative.

PROF GRAY: Yes.

MR KNOWLES: I will come back to that work in due course. Your current practice otherwise includes weekly telehealth sessions into a rural Queensland community which include a 24-bed hospital, an 80-place residential aged care facility and primary care practice.

PROF GRAY: Yes.

MR KNOWLES: As well as regular telehealth into other residential aged care facilities in metropolitan and rural Queensland.

PROF GRAY: Yes.

MR KNOWLES: Turning to you, Professor Flicker, since 1998 you've been the Professor of Geriatric Medicine at the University of Western Australia and Consultant Geriatrician at the Royal Perth Hospital.

PROF FLICKER: That's correct.

MR KNOWLES: And before 1998 you were a senior lecturer in geriatric medicine at the University of Melbourne.

PROF FLICKER: That's correct.

MR KNOWLES: Since 2005, you've been the Executive Director of the Western Australian Centre for Health and Ageing.

PROF FLICKER: That's right.

MR KNOWLES: Can you briefly describe what that role has entailed?

PROF FLICKER: I help coordinate and lead research, largely translational research in geriatrics and ageing generally, and we're looking at interventions that may be useful for older people across a wide range of conditions and we also have quite a prominent role in looking at Aboriginal health and older people.

MR KNOWLES: Yes. Now, can I start by going to a particular proposition that at this hearing some witnesses have been ask asked to consider, and that is that the Australian and State and Territory Governments should agree on the introduction and funding of local hospital network-led outreach health services for people in residential aged care facilities or receiving higher level home care. Professor Gray, you've previously worked for such a service being CARE-PACT.

PROF GRAY: Yes.

MR KNOWLES: And I think in your statement you described that service as a fine innovation.

PROF GRAY: Yes.

MR KNOWLES: Yes. Can I ask you both, and I don't mind who goes first in this regard, what are your views on hospital-led outreach services of this kind for people living in residential aged care facilities? It's a big question but - - -

PROF FLICKER: Okay. I will go first. So it's something that I think has been necessary for many years, and not just for residential care but – for residents in residential care but also for people who are using high level community care services. So the problem we have is that older people in residential care in those other – and who have advanced frailty is that they find it very hard to access routine specialist care by any other means. And so often travel is almost impossible, outpatient care is very difficult to access for them, particularly timely access – timely outpatient care. Private specialist care is extremely difficult for them to access, so older people are essentially denied specialist care in any reasonable format.

The only thing that's left for them to access specialist care is through the emergency departments in major teaching hospitals where the staff there feel – often feel aggrieved that they have to provide such care because they cannot see why it should be done in that situation.

MR KNOWLES: Professor Gray?

PROF GRAY: Yes, the – there are quite a number of very good outreach services into aged care facilities and to a lesser extent hospital geriatric departments provide community support really on a one-off consultancy basis rather than providing ongoing support. They're very valuable services for what they are, and the outreach to RACFs is designed to really avoid unnecessary hospitalisations and they do that reasonably well where I think they're set up correctly. And where a regional geriatric service can provide a home-based consultancy service, again, that's reasonably good. However, what Leon has referred to is continuous support for complex problems that crop up week to week, day to day where other folks would be able to go to see somebody in their surgery, or go and see somebody in a private rooms or to an outpatient department.

For a frail older person who needs an escort usually, special transport, somebody to be with them, probably some nursing support even, it virtually means they don't have access. So in one way or another the service has to come to them to give them the equivalent access that an average citizen would be able to secure. So that paradoxically, the most needy people have the worst access to these capabilities.

Now, in modern times we've got ways of doing this better. And, obviously, I'm interested in telehealth because that's part of a solution to provide advice to folks without them having to travel, but there is an array of things that we think we could do to support such people that are in such difficulty. And that locally, and I agree there is a – it's particularly an issue in our aged care facilities but also there is a small but important group who are frail living in the community supported by family members who are in the same level of difficulty.

MR KNOWLES: Well, I will come back to the issue of telehealth - - -

PROF GRAY: Yes.

MR KNOWLES: - - - in due course, Professor Gray, but just having regard to what you've just said, each of you, could I ask you, do you think that programs of this kind, outreach services for people living in residential aged care facilities or otherwise receiving high level aged care support in the community should be available nationally?

PROF GRAY: Yes.

PROF FLICKER: Yes, I agree.

MR KNOWLES: So do you agree then with the proposition that I put to you at the outset about the need for the Australian and State and Territory Governments to agree on the introduction and funding of such measures?

PROF FLICKER: Yes.

PROF GRAY: Yes.

MR KNOWLES: And how might those outreach services, the introduction of them, be systematised across Australia? Can I start with you, Professor Gray, on that particular question.

PROF GRAY: Well, I suppose you would think about it in terms of – at one level regionally but also in relation to hospitals and aged care facilities that are kind of proximate to them. So you have to think of some kind of footprint, so there's a geographical imperative perhaps might be the best way to think about that. The issue of importance, I think – so there needs to be some kind of funding structure to support that, some kind of model. Imagine that a budget sorted out. The issue in my mind is governance and ownership of such matters. You know, they clearly risk falling into one camp or another where one, if you imagine the RACFs, do they own or what control of the quality and the responsiveness of such a service would they have if it's kind of run by a public hospital, for example.

If you run it the other way then there's a sense of not really being committed to it. So we've got to try and set up an arrangement where there's a shared governance and

shared responsibility for making this interface work effectively. So that's a challenge; but, yes, I think regionally with some kind of notional allocation of funds that support that activity and then some kind of payment structure for the various actors that would be involved.

MR KNOWLES: Yes. Can I ask you, Professor Flicker in that regard, how might sufficient flexibility be retained to account for those regional or cultural differences particularly in regard to rural, remote and Aboriginal and Torres Strait Islander communities perhaps?

PROF FLICKER: That's a big question. Firstly, I agree with Len that the governance is crucial and the funding streams and how they're run is important. But if you think about this in regions and probably at local hospital networks, there are three – in urban centres at least there are three groups that are involved. There are the people who provide care in the nursing home, the providers, who have the nursing staff responsible to them. There's also the general practitioners or the primary care practitioners, and there's also the in-reach service.

And – which would be specialist-driven, probably, and would come from the local hospital network and would work in that situation. Clearly, there has to be a partnership between all those groups. They have to be able to work together; clearly defined governance arrangements, as Len has said, but they obviously need to work together, to try and maximise the outcomes for the individuals that they have in – within those nursing homes and probably in the community care. So those are discussions that have to take place.

The discussions would probably take place in primary health practitioner networks as well. There needs to be clear delineation and responsibilities. When you go to rural settings, you may not have as clear-cut boundaries in some of these areas. For example, the general practitioner might be a very important part of a local hospital and might be – or the local hospital might be a mixed-care facility and, therefore, actually be providing the residential care. So the arrangements have to be flexible enough to account for those differences where people might be fulfilling multiple roles. With the very important question about how we provide this sort of service for Aboriginal people is even more complicated.

So one of the problems that we have on a national basis is providing appropriate health care and residential care for Aboriginal people in general – Aboriginal and Torres Strait Islander people in general. So we would have to – again, probably have to look at separate models for that. And one of the things that – one of the few things that I know very well is that you cannot establish any Aboriginal model of care without local input from the local Aboriginal and Torres Strait Islander people; it would have to be negotiated and it would have to be clearly attuned to those local needs. So it's another layer of complexity.

MR KNOWLES: Just in relation to local needs that you refer to, Professor Flicker, Professor Gray, part of your qualifications or experience entails conducting rural

telehealth sessions into communities in rural Queensland. Can you describe how you would see this type of service working, in that context, yourself, from your own experience?

PROF GRAY: Well, telehealth is an enhancement to the basic everyday service. The huge advantage with telehealth is the elimination of travel and, therefore, the ability to – the travel for the residents, obviously, but also for the practitioner. So there are – in some instances, it's important to go to the facility and be aware of the environment. And one should be familiar – you can't just do everything remotely. You sometimes need to lay hands on the resident and examine them and so forth. But once that familiarity is established, there's lots of issues that can be dealt with. You know, with simple transactions that may not take an hour – you know, simple things that might take five minutes of advice, and, yet, if you were to go there it would be an hour of travel.

So, effectively, that five-minute window to get some advice is, kind of, eliminated. So the beauty of telehealth is that you can do follow-ups very quickly. For example, if you start up a resident on a new drug that's got side effects, you need to watch it very carefully. If you're regularly interacting with that facility weekly, adjustments can be easily made; you'd only need five minutes to, kind of, keep tabs on it. So that then starts to cause a relationship to form with the staff of the facility; that would be impossible if you had to travel out there all the time. So you can create a much more interactive and informed relationship with residents, staff, in particular – I think the staff interaction is the most crucial part of telehealth.

They start to regularly interact with people who have specialist knowledge and that results in knowledge diffusion and, ultimately, in them being more capable to look after complex problems. So there's lots of advantages with this enhancement. In the context of an outreach service from a hospital, of course – in the service we run, it's quite apart from the service. You have a mix of visitation and telehealth. And getting that blend right produces a really good service.

MR KNOWLES: Just in terms of – I will come back to the visitation in a moment, but can I just follow up on that in terms of telehealth. Do you see, beyond what you said about the need just to lay hands on people at times - - -

PROF GRAY: Yes.

MR KNOWLES: - - - are there other limitations or places in which you see scope for improvement, in terms of the way in which telehealth currently operates?

PROF GRAY: I think the largest – two major problems. One is access to background information, code for medical records that are coherent, integrated and easily accessible to an outside party. The records in aged care facilities are, kind of, largely inaccessible, digitally or whatever. Half of the record sits with the GP practice. They may also have hospital records that one can't access. So you need a combining of information from all of those places to really understand the problem.

Secondly – so you need somebody at the facility to put it all together for you, just basic things like gathering this information and transmitting it to you somehow so you can read it. It's a really messy, disorganised business and it shouldn't be happening in the modern age.

The second major issue is the – it's somewhat related, but when you consult a person in an aged care facility they've more than likely got cognitive impairment, unlike the people in this room, who would be able to give a very good account of themselves about their medical history and so forth, the residents can't. You need somebody there to host the conversation. And that means capable, informed nursing staff. When you make recommendations, they have to be executed. Someone's got to talk to the GP, to the relatives, and to the resident and make sure that things happen.

My experience is that some nurses are excellent and some are not good at all and you can't get the right information. They don't seem to know the resident properly; they don't know the background. You give advice and you're not quite sure they're understanding what you're suggesting. If it gets to that situation, you may as well not consult. So there's a really fundamental issue about the capability in-house to give and receive information. And I think the Commission is already aware that there are issues in the facility. And without that capability being there, it's a serious problem. As I said, once you interact on telehealth, you can diffuse your capability across that person, but there's a limited – you have to start with someone who's reasonably well trained before you begin that process. It's a big issue. Big issue.

MR KNOWLES: Yes. Professor Flicker, is there anything you wish to say in relation to that particular topic?

PROF FLICKER: Only just to underline what Len said, that it's really important for telehealth – every time, really, no matter where it's performed, if it's complicated patients there really has to be somebody at the distal site that has done adequate preparation with that patient, often administered simple tools, like a Mini-Mental State or some other simple tool, has talked to the family, has brought them in, talked to other parts of the staff out of a residential care facility to know what the background is. If you're talking about complex and challenging behaviours, you want to know exactly what they are and when they're occurring and, if anything, what are the triggers.

So you need quite a lot of information at the distal site. You need people to prepare that so that the telehealth becomes much more effective and valuable. If you don't have that, telehealth becomes almost useless. So you really need – and, again, it's that partnership between the provider and the service – whatever outreach service this is, you need a partnership model where people feel it's part of their job to support that service and that it adds value to their residents.

MR KNOWLES: Are there any – perhaps you were going to say something.

PROF GRAY: Can I add to that? I mean, one should – I would like to emphasise also that if you visit a facility and you can't find the nursing staff or they're not available or they don't know what's going on with a resident, you have the same problem. So it's not just about telehealth, it's about trying to help people in the facility in general. Same issue.

COMMISSIONER PAGONE: So, Professors, if I'm understanding you correctly, what you're saying is, whether it's telehealth or physical visitation, there really is a need for some form of coordinator?

PROF GRAY: Well, I think it – the capability in the facility cannot be nothing. You cannot have – you know, the idea that there are no properly-trained health care staff in a facility. They basically provide the day-to-day care, make the day-to-day observations and, really, are the people who make that person's life as good as it can be. And if they're not there, no matter how many outside specialists and, you know, kind of shouting at them to do things, you're sort of wasting your time. You really have to have a core of people in the facility who can take and use advice.

PROF FLICKER: And the coordination from any proposed outreach service from the providers and the nursing staff within the residential care facility but also it's still primary care as well which is usually provided by general practitioners, so the coordination has to be between all those groups for the resident. Because the resident – the people in residential care are some of the most complicated medical case patients in the system. They have the most profound disability of anywhere in Australia and they have very complicated health issues. And you're trying to coordinate the primary care, the providers and also an outreach service. So it's very important that that coordination is being done.

COMMISSIONER PAGONE: And if I'm hearing you correctly, the need to have that person is to have that person present at the time the specialist is dealing with the patient?

PROF GRAY: Correct.

COMMISSIONER PAGONE: And otherwise the service of the specialist is fundamentally compromised.

PROF GRAY: Correct.

PROF FLICKER: That's correct.

MR KNOWLES: That role of coordination, Professor Gray, you've referred in your statement at paragraph 42 to a medical director. Is that something that that medical director-type person would undertake, or is that a different role?

PROF GRAY: I think I was really speaking to the idea that – a number of reasons why I think – I'm a doctor and I advocate for what we do, of course, but I'm trying

not to, you know, present that kind of way of thinking. So medical care is quite important to people who live in aged care facilities. It's provided by individuals who don't actually get employed by the facility. Their relationship to the facility is kind of almost like a favour, "I come". Some – you talk to the nursing administrators and directors of nursing, they – some of them really struggle to hold people to account. They can't. "Why don't they come when I need them or why do they come at 7 o'clock at night when nobody's here".

So there's a very difficult relationship in some facilities around the relationship with medical practitioners and for that matter medical practitioners don't seem often to have any role in how the facility delivers its health care as a whole, you know, a lot of the programmatic things that are done in the facility that need medical input. There's no involvement. So I'm suggesting the role of some kind of person appointed by the facility who is accountable to the facility that coordinates the medical care, both at a day-to-day level, not necessarily offering the care but making sure that the medical care is delivered correctly and has a role in quality improvement and other activities that you would see, for example, in a hospital environment.

In terms of the matter that we were just talking about, I think well-trained registered nurses who have skills in aged care are the kind of people we're talking about, that maybe a nurse practitioner or you would hope that every facility has several nurses that have had proper gerontological nursing training who are actually there day to day. It shouldn't just be a specialist function. That's what I'm talking about in terms of the consultation process.

MR KNOWLES: Yes. So there's a distinction there between the person who is involved in the consultation as such but you see there being a place for some sort of supervisory or coordinating role - - -

PROF GRAY: Yes, a governance role.

MR KNOWLES: - - - above that - - -

PROF GRAY: Yes.

MR KNOWLES: - - - a governance role in terms of this medical director type role that you've just described.

PROF GRAY: Yes. And that's the situation in North American nursing homes, it's the situation in the Netherlands, so there are examples already where this model works. It's not an unusual idea.

MR KNOWLES: Yes. And that role, do you say is best placed by someone who is employed or engaged in the facility, the residential aged care facility, or should it be somebody outside of the facility?

PROF GRAY: Well, I think diseconomies of scale mean you can't have a full-time medical director in a relatively small facility but it could be done at a multi-facility level, or it could be a part-time role for someone who's already attending the facility. I think it's the role that we think about would mostly be at a facility level part-time.

MR KNOWLES: Professor Flicker.

PROF FLICKER: Or it could be part of the role of the geriatrician employed by the local hospital network to fulfil that role, because we're talking about a part-time position that that person would then have, be the medical director at the facility but would also have some responsibilities within the hospital network as well, which means that facilitating the interactions would occur between the State health system and the facility. You could run it – and it doesn't necessarily mean it just has to be one model used. You could use both. There could be people who might be geriatricians who do several facilities as medical directors as their role.

MR KNOWLES: Yes. But you do see a place for somebody with suitable medical qualifications to take on some involvement in coordinating the care that goes to the residents in a facility.

PROF FLICKER: Yes. Absolutely.

MR KNOWLES: Can I go back to some more - - -

COMMISSIONER PAGONE: Do you have a sense of how many people they could service? A ratio? How many people per such director? What's happening in America, for example?

PROF GRAY: I wish I knew the answer to that. It's something that needs some investigation, I think. I'm sorry to say I don't actually know the answer.

PROF FLICKER: And often if – in America often the larger facilities they're full time but they also – under the Medicare system in the US, the rehabilitation – what we would consider subacute care is often provided in residential care facilities as skilled nursing facilities. It's a more complicated question so that, you know, for example, you might just say that this medical director role might be the equivalent of, say, half to one day a week for a facility of 60 beds. It might be something of that order.

PROF GRAY: That's what I was imagining, something like that.

PROF FLICKER: So you know, but depending on the role and how much hands-on care is involved and so on.

COMMISSIONER PAGONE: Would it in your view work if the functional activity of the role were given to somebody who had other functional activities, or should the

governance and effectiveness require that there be a wholly identified person exercising that function and nothing else?

PROF FLICKER: Personally, my opinion is that they'd be better to be shared with other functions in local hospital networks. So, for example, if you had a geriatrician who was responsible for acute geriatric medicine take at a local hospital and was also responsible for the care of several facilities in the – as a medical director role, you could see then that there would be some advantages in that the residents, if they required specialist care in hospital, they would be – it would be facilitated, it wouldn't necessarily require an emergency department attendance. There may be an ability to provide laboratory and radiological services through other mechanisms. So there – there are some advantages in smoothing the interface between the facility and the local hospital.

COMMISSIONER PAGONE: I was thinking really of Professor Gray's observation about economies of scale and if the facility was small, then the only way that you might get something like this being done is if you said to the nurse or a nurse, one of our activities is also that of care coordination, whether it be called medical director or executive assistant or whatever.

PROF FLICKER: Well, no, that would be a separate resource. So I think Len was trying to distinguish between the two roles. So the medical director role is a higher level order sort of clinical governance position - - -

COMMISSIONER PAGONE: Yes.

PROF FLICKER: - - - to make sure that there's some coordination between general practitioners and outside resources and so on. But there is also a need, no matter how small the facility, there are – there are requirements for a nurse coordinator role to deal with the specialist service and general practitioners. One of the things that general practitioners complain about all the time is trying to find somebody who actually knows the residents and can explain what's happening, and is able to facilitate their medical care.

So there is a requirement. And many – and many residential care facilities already have such a person who they delegate to be the coordinator for the health care in that facility between the general practitioners. So it's a slightly different role and, as Len was saying, the telehealth role might be that person as well, that nurse coordinating sort of role of trying to facilitate the interactions at the individual resident level.

MR KNOWLES: Just in relation to that role of medical director, do you see that being capable of being undertaken by, in a smaller rural or regional setting, the local general practitioner, for instance?

PROF GRAY: I don't know what Leon is going to say; I think the right person, yes, I think it probably of necessity would have to be, but certainly in my experience in dealing with rural GPs and the way they operate, I think one of them could take on

that role, as long as the responsibilities were clearly delineated and the accountability sits with the operators of the facility so they are acting on behalf of the facility, not on their own practice behalf.

MR KNOWLES: Yes.

PROF GRAY: And, you know, thoughtful intelligent people should be able to manage two roles like that without too much conflict of interest. I think it would be reasonable to – so I guess Leon and I are saying there's a variety of ways of doing this. The important thing is that the role exists, that its responsibilities are clearly delineated, the accountability is to the facility and the residents as a whole, and, you know, you probably have to do it different ways in different jurisdictions to make it work and we probably need to give some thought about what the default and best arrangement might be, but it probably won't be one size fits all, I suspect.

PROF FLICKER: I totally agree. Almost certainly if you're in a small town and there is a facility there, almost certainly one of the GPs will either be assigned or step up to this task. I mean, they would – as a group of general practitioners they would work out who would do it and they would just – and – and if they don't have the skills they would try to learn the skills as quickly as possible.

MR KNOWLES: Can I briefly return to the topic of the outreach services that you gave some evidence about earlier. It might be argued that there would be no need for these services if there was access to comprehensive and effective primary care. What would each of you say in that regard? Would you agree with that argument?

PROF FLICKER: I totally disagree with it, and the reason being is that within residential care and high level community care services we have the sickest, frailest, most disabled and the most complicated Australians. And those Australians normally would get specialist care from all sorts of different specialists. And for saying that because they are now in a facility they don't require specialist care is totally foreign to me. I think that those – those people who are the sickest, the most complicated patients really do require specialist care, just like every other Australian.

PROF GRAY: I'd just add to that that a lot of what we do, and I think a lot of general physicians and others kind of have to work out the kind of very careful balance of treatments that people might need in the context of vulnerable people who can't really be subjected to the standard treatments for many conditions. For example, they're not fit enough to undertake surgery. They're not fit enough to tolerate certain drugs. This, in many people's minds means it's kind of palliative; we don't worry about it. But, in fact, it just amplifies the difficulty in providing the care. It actually means you need more sophisticated care, not less sophisticated care. And I think that's forgotten.

It's thought of, well, we don't do anything anymore because the person is in the last year of their life but, in fact, their symptoms are really difficult to deal with, they've got multiple problems that need balancing. It really is a difficult task to do it well

and I think it needs a very specialist kind of approach that's not well recognised by that idea that they're beyond it, which is, you know, an unfortunate way to think about people.

MR KNOWLES: And so I take it then these outreach services you see as extending far beyond mere hospital avoidance or acute crisis response?

PROF FLICKER: Currently, a lot of outreach services in Australia have been developed on that basis because hospital avoidance – and that's a good thing too, I might add, that nobody needs to go to a hospital unnecessarily. No Australian wants to go to a hospital unnecessarily. So that's a good thing. But that shouldn't be just the sole purpose of these resources. We should be trying to maximise the health care and the health benefits for older people in residential care and in the community, not just trying to avoid hospital. So you would take – and you take a different view of the service when you start saying that because right now, for example, we look at palliative care in residential care as something to say, well, people don't need to go to hospital, they can have their palliation in the facility before death.

But you would actually then start saying that the more important role is actually symptom control generally within a residential care facility and that's probably what you would do if you start thinking about what a palliative care specialist's role within a facility is. It's not just those final weeks before death; it's actually looking at symptom control more generally and trying to maximise the quality of life of people within the facility.

PROF GRAY: I would have thought that the kind of philosophical difference between an outreach prevent hospital-type model into a more general model where there's a sort of ongoing support; the difference is that it's not reactive. It's kind of proactive. We're providing a network of capabilities and an access to advice on a week-to-week basis that wouldn't otherwise be there. And that means, for example, when new residents come in and an evaluation is undertaken to figure out what their particular needs are, there may be a consultation at that point even though there's no acute crisis. It's – it looks complex, we're not quite sure whether these drugs are right, how do we get the advice to kind of make those adjustments. And so that's – there's a lot of that that needs to be done and it needs to be done well. As I was indicating it's complicated.

MR KNOWLES: Yes.

PROF GRAY: So it's not reactive, it's proactive.

MR KNOWLES: On that, Professor Flicker, I think you mentioned subacute rehabilitation earlier. Should the purpose of these services also extend to subacute rehabilitation?

PROF FLICKER: Sure. So one – the subacute rehabilitation system within the State health system is there to maximise the ability of older people and to maximise

their quality of life and, on the whole, the services are targeted for people who are in the community who have had a problem, a stroke or a fractured hip or general deconditioning and those people are rehabilitated so that they can go back home to their maximum quality of life. Those services in general are not available to people in residential care. And so they're services – those services are not targeted for people in residential care and often when people have an acute medical problem in residential care they go straight back to the facility without even a period of subacute care. So that's the usual thing.

Now, when you're targeting services that may be appropriate this time, but it's certainly not appropriate to deny the benefits of rehabilitation and reablement to people in residential care or people on higher level community services. Those frail, older people should have the access to targeted and coordinated rehabilitation. Now, how you would run that, there are a couple of ways. You could just admit them to inpatient subacute care somewhere, but mostly, if you talk to people in residential care, they would prefer to have that rehabilitation in their own facility which has now been their home. So you're looking at outreach rehabilitation within facilities as well to maximise the care for those – those people who would be thought to benefit from rehabilitation.

Not everybody benefits from rehabilitation, but for those people who are thought to benefit from targeted coordinated rehabilitation they should be able to access that in their facility.

MR KNOWLES: Yes. Professor Gray, do you agree?

PROF GRAY: Yes, I agree.

MR KNOWLES: Yes. One of the things considered in this hearing is whether or not there should be performance targets for States and Territories in relation to rehabilitation for patients over 65 years old, particularly those living in residential aged care. And do you have a view about that one way or another?

PROF FLICKER: I have the strongest view, but we actually – in 2004, as part of a national action plan, we actually proposed developing benchmarks and targets for subacute care within Australia, and we never actually got them developed. And one of the things about generally about the interface between acute care, subacute care, residential care, those interfaces are very important because people drift across those interfaces. So if you don't provide enough subacute care, for example, you send more people to nursing homes without receiving rehabilitation and often inappropriately. So you require all these services.

One of the problems that we identified in 2004 was that there is a highly variable provision of services of subacute care. There were a couple of national programs that were meant to bolster the provision of subacute care. They were the schedule C and schedule E funding systems that were deliberately developed as part of the national hospital – health care agreement. The – but we never actually went on to

develop the benchmarks or the targets for subacute care within the system, nor did we make them transparent. And it really – even if they were just transparent at a local hospital network level that would be helpful so that people could work out what they're missing out on.

MR KNOWLES: Professor Gray.

PROF GRAY: Yes, I agree entirely with Leon. I think the problem – well, there's a certain amount of subacute care offered now. It's largely determined by negotiations, at least in the public sector, with the health departments around how many acute admissions are going to be purchased and how many bed days in subacute are going to be purchased. How the – in various States and jurisdictions, the planning around that seems to be non-existent or quite good, you know, from State to State. But, clearly, we are of the view that there must be a minimal amount of subacute care offered in the appropriate format in every region and probably affiliated with every hospital. And so the idea of at least some kind of range or ratio of beds to the aged population, for example, would be a reasonable starting point for planning.

MR KNOWLES: Would it be appropriate to stipulate those targets or performance targets in the National Health Reform Agreement and tie those targets to funding?

PROF FLICKER: Yes, that would. And you wouldn't just do it on beds nowadays, you probably – you'd probably do it on activity, subacute activity and you would – I know that the Independent Hospital Pricing Authority would be well able to sort of manage to produce those transparent figures for that. It would be relatively straightforward. I agree.

MR KNOWLES: Can I just ask a couple of final questions in relation to this concept of outreach services. Are there, in each of your minds, potentially unintended consequences of the introduction of this model nationally, and if so, how might those unintended consequences be avoided?

PROF FLICKER: One of the things that might happen, which would worry me, is that if we started talking about beefing up the health care and residential care, or we started talking about rehabilitation in residential care facilities, people would say, well, we'll be able to save money in subacute care by taking money out of that part of the system and then just sending people into nursing homes so that they could have that rehabilitation there. That would be a concern and that's one of the reasons why it's really important to have these benchmarks.

Some of the other systems are – I mean, for example, there might be withdrawal of primary care, of general practitioners which would be a major issue, I think, that we're trying to bolster a service, we're not going to try – you know, we're not trying replacing primary care here. So I think it's important that we engage primary care and try to make sure that they feel involved in this partnership because it's a partnership.

Providers might see that this is – might think that this is the health care that's coming in and they don't have to worry about it anymore because it's all being sorted out by somebody else. And that would be really wrong because what we actually want is more interest from them in health care. We want them to look at this as an addition on – that is supported by them with appropriate nursing staff who are key to making sure that these systems work. So it's really important, in my mind anyway, that we make sure that people don't withdraw from the space. They really – this is an add on that we're adding to the area and we're going to try and make sure all the different components continue to work. And if anything, to actually say, well, maybe we need more subacute care generally as well as this system.

MR KNOWLES: How might one avoid what you say, people withdrawing from the space? Would it involve some clear definition of respective roles and responsibilities of the key players?

PROF GRAY: I actually think that it all gets down to, you know, the accountability arrangements, the governance, the specifications about the roles that the various organisations must play. It should be reflected probably in the accreditation standards. There's a responsibility for the facilities to make sure that this happens, that they – they can't just devolve it off to somebody else. There obviously needs to be a kind of collective governance arrangement to make sure that these various groups work in concert rather than separate from each other. So I think that's – that's the challenge, how you set up the governance and responsibilities.

MR KNOWLES: Can I ask each of you whether you're aware of previous recommendations being made to introduce outreach services of this kind into residential aged care facilities or otherwise into the community for people receiving higher level aged care services?

PROF FLICKER: It was part of the national action plan from hospital to home in 2004 to '08. So there was some fairly clear recommendations about doing this. It wasn't prescriptive. It was – the idea was that the recommendation was that the Commonwealth and the States and Territories should work together to develop these services. For some reason they never got developed. So the – there was a clear plan to do this but on the whole, on a national basis, with clear governance arrangements they just never – they never got enacted.

MR KNOWLES: Well, you say for some reason, do you have any views about what that reason might be?

PROF FLICKER: Yes, there's time – there was a specific committee, an AHMAC committee at the time, an Australian Health Ministers' Advisory Committee that was charged with doing this. Eventually, that committee finished its time period and stopped working. A lot of the people who were involved in all this work moved on to different areas. People – both the Commonwealth and State governments realised that it would require further inputs of resources which they saw as a problem. Why do things not get done; for all sorts of reasons.

MR KNOWLES: Professor Gray, do you have anything to add to that?

PROF GRAY: No, I think – I don't know of any other sort of national efforts or intentions to do that kind of thing in my time. There's various State initiatives that have not really been, you know, consolidated yet but you can see that happening around the hospital avoidance kind of aspect that we're talking about. That seems to be maturing as an idea, but beyond that I don't think there's anything else, yes.

MR KNOWLES: Just going back to that issue about clear delineation or definition of respective roles and responsibilities, do you see that as requiring agreement between, on the one hand, the Commonwealth and, on the other hand, State and Territory Governments in order for it to be established what the roles and responsibilities would be of an outreach or other hospital-led intervention and otherwise other primary care services, such as general practitioners and the residential aged care facility itself?

PROF GRAY: Yes, I think there needs to be a national framework for this, a set of, you know, understandings generally about how it would work. I think there also needs to be, however, at the local level a set of understandings about who's going to do what as well. It should be a reflection of the overarching responsibilities and because it's really important that the groups who are actually doing the work understand at the day-to-day level who's going to do what and that they do that, you know, collectively, not just blaming the federal or state government every time there's a kind of difficulty. It's got to be managed well at the local level as well.

PROF FLICKER: In general, one of the things I've noticed over the years that if you want something done you have to make it very clear at the national level – at the higher levels exactly who's responsible for what and where the money is coming from, otherwise people will retreat from the space. But at the local level you want to maximise the flexibility of the services so that people can move the local situations. Particularly when you get out of the urban centres you need to be able to maximise flexibility in rural and remote areas because otherwise you get service failure. So at the top levels you really need it to be very clear and consistent and clear governance arrangements and who's responsible for what. But once you get down to the local level, particularly smaller places, you want to maximise the flexibility so as to be able to provide those services.

MR KNOWLES: Just in terms of that top national level that you describe, would, again, the National Health Reform Agreement be the right mechanism to achieve that definition of roles or a good mechanism to do that?

PROF FLICKER: Probably it would be the best start. I don't know where else you could do it, actually.

PROF GRAY: I don't know the answer to that.

PROF FLICKER: There's lots of people in the room who might have some other suggestions but I don't know where else in the bureaucracy it would work.

MR KNOWLES: Now, outreach services are one way of improving what you've both described as poor access to specialists. What about access to specialists who've been referred by general practitioners, how would those services interact with outreach – provision of specialist services through outreach services?

PROF GRAY: Well, that kind of thing goes on all the time anyway. Decisions get made. You know, it's often to do with previous relationships, ability to pay, wishes of family members and the resident. I don't think we can kind of lock it in to the point where they've got no choice, given that the prevailing system offers choice. But – well, I think you probably – the default would be the mechanism that we've talked about but you wouldn't want to – I don't think in the Australian cultural environment you could lock people out of everything else, that the other citizens can access. I don't think that would work particularly well.

MR KNOWLES: Professor Flicker, you've referred in terms have that type of private, if I can call it that, access to specialists to a disappointing take-up of MBS items for geriatrician items. Do you have any ideas as to why that might have been the case?

PROF FLICKER: I think it's probably a lot of little reasons. It's finding geriatricians who are firstly interested in it without necessarily being supported in managerial terms. Some of the facilities weren't particularly welcoming. Some of the primary care practitioners may not have thought of the need and therefore wouldn't necessarily refer people. It's probably a lot of small reasons why that doesn't happen. In these sort of arrangements, particularly for geriatricians, it's very hard to work as a geriatrician when you're not supported by a multidisciplinary team as well. So you don't – a lot of what we do doesn't just require us. It requires nursing staff, but it also requires physios, occupational therapists. To replicate that in the private system is often very difficult. It's a system – it's a systemic approach which, unfortunately, government services are usually pretty expert at, but other places are more – find it more difficult.

MR KNOWLES: Can I ask this generally in terms of access to specialists outside of the outreach services that we've described. Do you see there being scope for other funding models to incentivise greater access to specialists in residential aged care facilities?

PROF GRAY: The problem is that there's usually one – let's say – let's say a – I'll give you an example. So somebody sees a – has Parkinson's disease and they're on a complex drug regimen and eventually become disabled and need to live in a residential aged care facility. My experience of that is that's the end of the consults with a neurologist, because they're often quite some distance away and getting that person to see the neurologist is really difficult.

What would be nice is if that neurologist could be consulted, say, by telehealth. They already know the person, and they could give advice, even if it was on the phone, you know, to somebody else about continuing to manage some of those complex drug regimes. So I get confronted by this quite often. So – but basically it stops.

Now, how would – you know, you could pay someone a lot of money to be transported. That's not particularly convenient or comfortable for the resident. I would hope that that neurologist practice in time develops its telehealth capability so that it actually becomes a matter of course to provide that follow-up when requested. I think it's going to happen. The question for us is: how can we accelerate the future? How can we bring that forward? And that's a big issue for telehealth in general in this country.

MR KNOWLES: Yes.

PROF GRAY: It's not just the residential aged care facilities.

PROF FLICKER: And one of the advantages of having the local hospital networks involved in provision of these services – there's a lot of specialist services in every hospital network. They largely do have most of the sub-specialties of medicine, and people can be consulted on informal bases as well as formal bases. So it's possible, then, to give higher-level advice, particular sub-specialties or, alternatively, arrange one-off consultation with somebody through telehealth or whatever, through the local hospital.

PROF GRAY: Yes.

MR KNOWLES: Yes.

PROF FLICKER: It can be done.

MR KNOWLES: Can I ask some questions in relation to access to general practitioners for those living in residential aged care. And this is directed to each of you. Do you think that the existing MBS fee for service model is well-suited to the provision of primary care in residential aged care facilities or otherwise? Perhaps I can start with you, Professor Flicker.

PROF FLICKER: It's hard to say. I mean, one of the problems is that there is so much variability in the provision of general practitioner care to residential care facilities. The places that work best are where there are a small number of general practitioners who often have a specific interest in geriatrics and older people, who spend quite a bit of time at facilities, are regular attenders at facilities and not only know their residents well but often provide on-call services; they have a relationship with that facility. So that works well, and that's supported by the current system.

And then there are other service facilities where there is a multitude of general practitioners who have minimal involvement, who come – as Len said, come, usually, out of hours, where the staff are either in the middle of mealtime or in that period where they're about to go to bed. So it's, you know, completely the wrong mechanism. And it's still the same MBS system. So we have both things happening at the same time. So I'm not sure it's the MBS system that's incentivising that or whether there's other structural arrangements that need to be made.

MR KNOWLES: Do you see there being scope for greater flexibility in funding for primary care beyond the straight fee-for-service model?

PROF FLICKER: Absolutely. There are things that – if you're going to provide quality care in a residential care facility, you're going to have to start thinking about, "Well, what about family conference time? When do I talk to the family? Do I do it over the phone? Do I do it in person? When do I do it? How do I organise it?" You have all these other things that are required. "When do I talk to the facility? When do I talk about some of the governance issues about the facility? When do I do that? Who do I see?" And those things should be reimbursed.

MR KNOWLES: Yes.

PROF GRAY: Yes. I agree. Yes, I think Leon's first statement – there's good and bad with the current funding model. So maybe it's not the money. It's really about the sort of things we talked about before, getting – having some kind of structural arrangement in place that incentivises appropriate allegiance to the facility, relatively few doctors servicing it. They work together; they figure out how they're going to manage on-call, they make sure that someone shows up every day and will cover problems for each other if there's a kind of thing, and then they'll also work out who's going to attend, when they're going to turn up regularly, so that the in-house staff know when Dr X is going to arrive and when he will see his residents. All that kind of organisational arrangement makes it work well. And that needs to be managed, and I think it's the difference between a really good and a bad facility from the health care point of view. So - - -

MR KNOWLES: Do you think those organisational arrangements – insofar as they involve the time and effort of a primary care practitioner, do you think that they're adequately provided for under the present MBS fee for service model?

PROF GRAY: Well, I guess maybe you could do some adjustments to, kind of, incentivise better arrangements. For example, regular attendees may secure a retainer from the facility, for example. I certainly did that a long time ago. We wanted the five GPs looking after the place; we, basically, offered them a small retainer to come to meetings and other things. We got that out of our residential care funds, not from the MBS. So, you know, maybe there should be a funding stream that's held by the facility that provides funding for the primary care docs to fulfil those functions, not the MBS, you know? That gets the right alignment of accountability, you know? The MBS, sort of, makes it somebody else somewhere

else is paying, not the actual facility. So maybe a mixed-payment arrangement might work better.

MR KNOWLES: Can I just pick up on that. Professor Gray, earlier in the week Dr Paresh Dawda gave evidence in which he recommended a blended funding model, employing a mix of the current fee-for-service model with capitation, where a fixed payment is made per person irrespective of the type and amount of services delivered and the possibility of building in payments to incentivise certain practices.

PROF GRAY: Yes.

MR KNOWLES: What would your views be about that kind of proposal that he's made?

PROF GRAY: Well, I don't think it differs too much from what I just suggested. I think the principles are the same. The only point I'd make is I kind of like the idea of the aged care facility holding the funds rather than the MBS, so there's a better accountability arrangement at least to some of the funds. I don't know what the primary care physicians would think about that, but I think it gets some good alignment with purpose.

MR KNOWLES: Professor Flicker?

PROF FLICKER: The governance issues are clearly important. So if you're going to give the money, what's the accountability for it? I don't have a strong opinion about where that governance should arise. It could equally go to the medical director role, but it – clearly, you want additional money for good general practitioners and good primary care. You want additional money for the systemic issue about just working in a facility. So you want that additional money available. How you build the governance around that is – I'm not sure.

MR KNOWLES: Yes. Professor Gray, at paragraph 64 of your statement, you've called for a radical overhaul of the information framework for aged care and you've said that it should be harmonised with information utilised within the hospital and primary care systems.

PROF GRAY: Yes.

MR KNOWLES: Professor Flicker, would you agree with that?

PROF FLICKER: Yes. We - - -

MR KNOWLES: It was a Dorothy Dixer but - - -

PROF FLICKER: We want the ability to be able to share patient information throughout the system, so that we're not constantly trying to get out the same material from family members who are sick of telling us the same things. I have no

idea how many times I have to apologise to family members to say that "I'm going to ask you exactly the same questions somebody else has." And it's just - - -

MR KNOWLES: What are the key components of that radical overhaul that you've referred to, Professor Gray?

PROF GRAY: Well, I think there's two components to this. One is what Leon has just referred to. Having a common set of information about a person that can be shared amongst the various people that are supporting them. So that repetition of questioning and information seeking is minimised. There will always be some; you're going to have to talk to people and – but you can't eliminate it completely. But there are a lot of facts about people and observations that can be shared, and that needs to be sorted out. So then, of course, the other matter I refer to is the use of information at an administrative level.

And by "administration" I mean understanding who lives in our facilities, what their needs are from a service planning and design point of view. We, obviously – one thing the government does know about is is case mix intensity. Because they've got to pay, so they do collect standard information about parameters that drive cost. That's not – that's very limited to a number of issues that drive cost. And then, of course, for quality improvement, if you don't know much about the residents – for example, how many people in aged care facilities have severe uncontrolled pain at the moment? We will be interested in that. How many are taking opioids for pain and how well are they working?

I don't think anybody's got a clue. And I know it's a huge issue, so how do we get a handle on that? So these all depend on robust information. And if you design a system well, the information that's used by clinicians to support their interactions can be doubled up, to be used by administrators for the various functions I just talked about. In other words, we've got coherent, robust information that serves a number of purposes, that advances both clinical care and also administration of the system. So that's my vision of the information strategy.

PROF FLICKER: And moving on from clinical care, certainly – I'm just looking at the overall system and the information available. We're actually going backwards at that moment. We can't get the aged care assessment; data isn't available for analysis at present. We can't link that with the hospital morbidity. We don't have – the current residential care systems aren't accessed. So one of the things that we talked about 15 years ago was the importance of trying to link the data systems, so we knew how the system was performing. And we – it was and still is possible to link the hospital admission – the hospital admissions and the MBS items and the residential care facilities, the Aged Care Assessment Team information. But that's actually becoming harder in some parts of – some elements are actually impossible now to link. So it's really important that, as a system, we try to look at the data as carefully as possible, because that's one of the ways we monitor, to make sure that the system is working.

COMMISSIONER BRIGGS: Might I ask why are those elements becoming more difficult to link at this very time?

PROF FLICKER: I think at present it's because of just software mismatch.

COMMISSIONER BRIGGS: Okay. Right.

PROF FLICKER: I think that's the answer – the short answer.

MR KNOWLES: Professor Flicker, in your statement, at paragraph 41.2, you say:

> *Planning guidelines and benchmarks need to be established for health services across the interfaces.*

Does that connect with this particular topic of information collection and management as well?

PROF FLICKER: It connects a little bit.

MR KNOWLES: Yes.

PROF FLICKER: I mean, one of the things that happens is that we would like to know how the system is performing and, therefore, benchmarks for particular parts of the service are useful, to make sure that we're not missing out on individual components or services in different areas. So that's really important, from that point of view. But the ability to link the data actually gives us a higher level of information that we can use. We can see – and sometimes the variability in Australia isn't necessarily all bad. Some parts of it may be running better because they have this type of service and maybe – but we wouldn't know that at this moment because we can't compare it. So - - -

MR KNOWLES: Yes.

PROF FLICKER: - - - that sort of thing is useful, just – not only at the local level, to make sure that everything is being done and that we have some sort of comprehensive service, but also for overall quality control of the system, having good data and being able to link it together is really important.

MR KNOWLES: And I take it that you are saying that without that good information management, having these planning guidelines and benchmarks, their establishment is compromised?

PROF FLICKER: Exactly. Yes.

MR KNOWLES: Professor Gray, can I ask you about interRAI? What does it do and what's your role in it?

PROF GRAY: Well, as you said at the beginning, I'm a board member and I've been a research contributor to the interRAI network internationally for some 18, 19 years now. So it's quite an important part of my research and development program. In the context of the point I made earlier about the use of information for clinical care and for administration, that's precisely what the interRAI systems are designed to do. Useful toolsets for clinicians that are sufficiently robust to be used for administrative purposes. And so the systems that interRAI has built are built according to a set of design principles with those things in mind. Primarily, supporting clinical decision-making and sharing of information.

And so the – the systems for long-term care, as they're called, have been implemented across the US, Canada, New Zealand and various jurisdictions in Europe. So they're the most widely-used systems to support long-term care, home care. And I'm personally responsible for managing hospital systems that support older people and nursing care in general hospitals.

So what we have is a very standardised approach to recording clinical information that's common to every setting in which individuals can find themselves and I say children, disability services, palliative care, mental health, everything. So it's a massive undertaking we've been involved in over the last 20 years to produce these systems and harmonise them. One of the benefits is that one set of data can be used for – to support clinical decision-making but also for service planning, case mix development, payment arrangements and quality measures.

And so the only publicly available reported quality measures in the world at the moment are produced by interRAI systems and that's, namely, in Canada, the US, and recently New Zealand has started publishing performance measures for its systems. And so things like how many people are in pain, how many people lost weight, how many people lost function in the last three months are all available on public websites in those countries. We are so far away from that here. So interRAI is one way of achieving those kind of goals. It's not the only way, but that's the piece that I work on.

MR KNOWLES: Yes. And I take it from what you've is just said, another advantage is that if there are other countries that are using this system there's scope at least for comparison from one jurisdiction to the next.

PROF GRAY: Yes, I'm involved in work where you can look at who lives in facilities in different countries. It's a very important planning thing but what's the quality of care look like in each jurisdiction. We also do work on quality of life, what do people think about the care they get, how do they experience living in an aged care facility, can they get out of bed when they feel like it. Do they get food that they like to eat. All of these things we measure. We've now got systems where we can compare that between countries and facilities. It's very disturbing when you see these kind of results. So we don't have a clue in Australia about these things, unfortunately.

MR KNOWLES: Professor Flicker, can I finish by asking you a question. At paragraph 43 of your statement you say:

> *The coordination of the levels of government to work together to manage health conditions of older people traversing the interfaces has stalled.*

What's required to ensure that that coordination is resumed in a way that leads to improvement for people receiving aged care?

PROF FLICKER: I think we need government will, or political will and we need to basically re-establish the idea that this is an important area, that governments should work together for the betterment of older people generally, that we should try and define who does what, and that we try and make the system work for older people. Currently, at both – at a Commonwealth, and at a jurisdictional State and Territory level there is – decisions are being made to remove themselves from this area because it's somebody else's responsibility. And that's completely wrong.

These – this is me in a few more years. This is you. This is all of us and we should be trying our best to make sure that the standards of health care we have is as good as it can be and the quality of life of older people who are disabled, who have complex medical problems, that should be maximised at all times. And that's all we need to be trying.

MR KNOWLES: Professor Gray?

PROF GRAY: Yes. I agree. I can't add to that really.

MR KNOWLES: No, you don't have anything further on say on that?

PROF GRAY: No, only, you know, to cheer for any efforts that would really attend to, you know, a group of people. I don't want to only think about people in residential aged care but also vulnerable people living with family often in communities who are really struggling with the same set of issues we've talked about this morning. You know, it's going to need a huge effort. We know there are cost constraints so imagination is needed to get the most out of the resources that we have. It's not just a matter of yelling for more, but making the best of what we have. I think we've got to work on both fronts. I think that needs a lot of imagination as well so good to be able to talk to you. Thank you.

MR KNOWLES: Thank you both very much. I have no further questions for Professors Gray and Flicker.

COMMISSIONER BRIGGS: I do. I read your witness statement about the interRAI services.

PROF GRAY: Yes.

COMMISSIONER BRIGGS: And I was left with the question; to implement that approach in Australia, what would be required in terms of commitment and timeframe?

PROF GRAY: That – this has been done in many jurisdictions so I know quite well. This is a five to 10 year commitment. This is a serious investment that has to be made and it starts with working with providers to understand that recording their information in a standardised way will help them run their business better both from a care provision point of view and also understanding what goes on in their facility.

We're starting to work with some providers here in Australia now at the moment. Some of them like this idea. Others see it as just another government burden responsibility. This approach works well when it's the software and the training is well customised to the needs of the care providers. Not just the government saying that you will now collect 300 data points and we will tell you something about it in three years from now. It has to provide amenity to the people that are delivering the care.

But there are collections of organisations now around the world that share the same datasets and they work together to understand, you know, I referred to pain before as being an initiative in the US amongst interRAI users to kind of examine the problems with pain and opioids, a really big problem, and they start with a common language, you know, a common set of measures to think about what they can do to improve that. But it is a serious lifetime commitment to do this kind of thing. Even if we didn't use interRAI and said we were going to use structured information so that we understood who lives in facilities and we could measure what happens, it's still a five to 10 year investment.

There's all sorts of adjustments for the way you record things clinically, software issues, who's going to do the analysis, you know, all that. Representation of data on website. So New Zealand is about 10 years into this and this year they started representing their quality measures aggregate a few weeks ago and that's – that's been a well-organised process as far as I can see, so it's a serious long-term investment one has to make.

COMMISSIONER BRIGGS: Thank you.

PROF GRAY: Thank you.

COMMISSIONER PAGONE: Well, just before we let you go home, what would you like us to do?

PROF FLICKER: Well, if the Commission – if the Commissioners were willing at the end of their deliberations, at the end of next year to come with some firm recommendations for the governments of Australia to work together to increase the health services for older people in residential care and in higher level community services and that those government services should work together to produce services

that are fit for purpose to look after older people, and that the interface of the health system, residential care and higher level community systems should be actively managed from now on, and that we don't go through these cycles where we – we go to crises and then we look at how to fix the crisis. But rather than that, we try to actively manage it through government at the Commonwealth and State level, that would be very helpful, Commissioner.

COMMISSIONER PAGONE: Thank you, Professor Flicker.

PROF GRAY: I'd like to add to that. Perhaps the frontispiece, you know, a clear statement of what we're really aspiring to in Australia in terms of frail older people. What do we believe these people deserve, what sort of system should we expect them to have. And that then sits on top of what Leon has just said, you know, what's the machinery that then delivers that. But I think we've got to, as a community, think about what life should look like for vulnerable people and make that very explicit and try to get a community – a collective appreciation of how valuable and important that might be.

COMMISSIONER PAGONE: Good. Professors, thank you both very much for coming. Your experience and knowledge has been very, very valuable and thank you for giving up your time. Thank you.

<THE WITNESSES WITHDREW [11.24 am]

MR KNOWLES: Commissioners, I understand there is a short adjournment scheduled at this point. Perhaps a five minute adjournment for the purposes of witnesses to leave and enter the witness box.

COMMISSIONER PAGONE: All right. Well, shall we say 11.40.

MR KNOWLES: If the Commissioners please.

ADJOURNED [11.24 am]

RESUMED [11.42 am]

MR GRAY: Commissioners, the next panel of witnesses builds on the evidence that you've heard this morning, and indeed builds on evidence that you've heard in the preceding days of the week. We're now going to hear from health officials from four of the geographical jurisdictions of Australia: New South Wales, Queensland, Western Australia and South Australia. And I call Dr Nigel Lyons, Dr John

Wakefield, Dr Andrew Robertson and Mr Christopher McGowan and those witnesses are already in the witness box and will now be sworn or affirmed.

<CHRISTOPHER HENRY McGOWAN, SWORN [11.43 am]

<ANDREW ROBERTSON, SWORN [11.43 am]

<JOHN GREGORY WAKEFIELD, SWORN [11.43 am]

<NIGEL JOSEPH LYONS, SWORN [11.44 am]

MR GRAY: Thank you. I will start with you, Dr Lyons. What's your full name?

DR LYONS: Nigel Joseph Lyons.

MR GRAY: You're the deputy secretary, health system strategy and planning in the New South Wales Ministry of Health.

DR LYONS: I am.

MR GRAY: You've held that position since October 2016.

DR LYONS: I have.

MR GRAY: You've made a witness statement for the Royal Commission, WIT.0568.0001.0001 dated 8 November 2019; is that so?

DR LYONS: That is correct.

MR GRAY: To the best of your knowledge and belief, are its contents true and correct?

DR LYONS: They are.

MR GRAY: Dr Wakefield, I will ask you to identify your witness statement next. What is your full name?

DR WAKEFIELD: John Gregory Wakefield.

MR GRAY: You're the Director-General, Queensland Health.

DR WAKEFIELD: Yes.

MR GRAY: Your statement is WIT.0571.0001.0001 dated 7 November 2019.

DR WAKEFIELD: That's correct.

MR GRAY: Do you wish to make any amendments?

DR WAKEFIELD: No.

MR GRAY: Are its contents to the best of your knowledge true and correct?

DR WAKEFIELD: Yes.

MR GRAY: Perhaps I should tender these - - -

COMMISSIONER PAGONE: Yes, I was just going to ask whether you wanted to tender them.

MR GRAY: Thank you, Commissioner.

COMMISSIONER PAGONE: So the statement of Dr Lyons will be exhibit 14-27.

EXHIBIT #14-27 STATEMENT OF DR LYONS DATED 08/11/2019 (WIT.0568.0001.0001)

MR GRAY: Thank you.

COMMISSIONER PAGONE: And the statement of Dr Wakefield will be exhibit 14-28.

EXHIBIT #14-28 STATEMENT OF DR WAKEFIELD DATED 07/11/2019 (WIT.0571.0001.0001)

MR GRAY: Thank you. Dr Robertson, you're the assistant director-general, public and Aboriginal health and the chief health officer of the WA Department of Health.

DR ROBERTSON: That's correct.

MR GRAY: You haven't made a statement but Western Australia has provided a response to questions from the Royal Commission at WIT.0570.002.002.

DR ROBERTSON: That's correct.

MR GRAY: Have you recently familiarised yourself with that response?

DR ROBERTSON: I have.

MR GRAY: To the best of your knowledge and belief are its contents true and correct?

DR ROBERTSON: Certainly within my knowledge, the – either the information in the statement is either within my own knowledge or has been obtained through the examinations of the records held by the Department of Health or from advice of the officers therein – there within.

MR GRAY: Thank you. Subject to that qualification, to the best of your knowledge and belief are its contents true and correct?

DR ROBERTSON: They are.

MR GRAY: Commissioners, I tender that response.

COMMISSIONER PAGONE: All right. Well, that response from the Western Australian Department of Health will be exhibit 14-29.

EXHIBIT #14-29 RESPONSE FROM THE WESTERN AUSTRALIAN DEPARTMENT OF HEALTH (WIT.0570.002.002)

MR GRAY: Mr McGowan, what's your full name.

DR McGOWAN: Christopher Henry McGowan.

MR GRAY: Are you the chief executive, Department for Health and Wellbeing at SA Health?

DR McGOWAN: I am.

MR GRAY: You've made a witness statement for the Royal Commission, WIT.0566.0001.0001, dated 7 November 2019.

DR McGOWAN: That's correct.

MR GRAY: Do you wish to make an amendments?

DR McGOWAN: No.

MR GRAY: To the best of your knowledge and belief, are its contents true and correct?

DR McGOWAN: They are.

MR GRAY: I tender that statement.

COMMISSIONER PAGONE: The statement of Dr McGowan will be exhibit 14-30.

EXHIBIT #14-30 STATEMENT OF DR McGOWAN DATED 07/11/2019 (WIT.0566.0001.0001)

MR GRAY: Thank you. Commissioners, there are legal representatives for the various jurisdictions present who wish to make their appearance.

COMMISSIONER PAGONE: Yes. Thank you.

MR I. FRASER: Yes, may it please the Commission, my name is Fraser, and I appear on behalf of New South Wales.

COMMISSIONER PAGONE: Yes, Mr Fraser.

MS L. WARBEY: May it please the Commission. My name is Warbey, and I appear on behalf of Western Australia.

COMMISSIONER PAGONE: Yes, Ms Warbey.

MS WARBEY: Thank you.

MR GOLDING: May it please the Commission. My name is Golding, and I appear on behalf of Dr McGowan and South Australia.

COMMISSIONER PAGONE: Yes, Mr Golding.

MR GRAY: Members of the panel, the main purpose for your evidence today is to obtain from you each State's position on a series of propositions that we, the counsel assisting team, have been testing through the week. There are many such propositions to cover and for that reason I do ask you to endeavour to be brief in stating your relevant jurisdiction's position on each of the points that will be raised. Perhaps if you would limit yourself to even two or three minutes by way of response, that would be most be appreciated. I want to begin with the topic of the clarification of responsibilities for obtaining health care, and that involves also a proposition about the designation of care coordinators. And I will make a brief statement about the context in which we, the counsel assisting team, are raising these propositions.

It's clear from the evidence that the States bear a cost for ambulance callouts and public hospitalisations. Public hospital funding is on a shared basis under the National Health Reform Agreement which roughly approximates to a 45 per cent or so share borne by the Commonwealth and a 55 per cent or so share borne by the

relevant State or Territory over time. The evidence this week suggests that some aged facilities are calling out ambulances for hospital transfers on occasions when they're not warranted, and in circumstances where the transfer might not be in the best interests of the resident and that those callouts might be because of uncertainty about health issues or even the fear of risk of liability if care needs are misjudged by the aged care facility.

The States therefore have a clear material interest in better access on the part of those facilities to clinical knowledge and health care for the residents of those facilities as well as having a humanitarian interest in quality care being given to them. At the interface between aged care and health care, the relevant subordinate legislation imposes obligations on residential aged care providers to provide assistance in obtaining services from health practitioners. The content of that assistance is described in terms of making arrangements for visits.

Counsel are proposing two things. One is an amendment to clarify the roles and responsibilities of the providers of residential aged care and other aged care providers to secure health care, and another is an amendment requiring that there must be a designated care coordinator for each and every person in aged care who has high needs. That person could be a medical practitioner or a registered nurse within the facility or a person from an external oversight body. I will start with you, Dr Lyons. And in light of that context, in New South Wales' opinion are the relevant responsibilities of aged care providers clear, should they be clarified further?

DR LYONS: I think that this comes to our position, the foundational piece is actually defining the respective roles and responsibilities in relation to health care provision, the role of the residential aged care provider, the role of primary care, and the role of the public state health system as well as the role of other private providers and non-government providers in delivering health care to residents, and I think having clarity around their respective roles and responsibilities is absolutely key, and it's critical then to designing a system that can best support the care needs of the residents. So I would say it probably needs to go further than what you've proposed. I think there's a need to define up what we would want each of those components to be actually providing and how we best configure the services to support that.

MR GRAY: How does that need to be done?

DR LYONS: So I think our position would be that primary carers, foundational residents should have access to primary care. So what we should be designing is a system that actually allows people to get access to the care that they need, promoting health and wellbeing, preventing illness and disease, treating that as quickly as possible through primary care and then access to the specialist services that anyone living in the community should be able to access. Those are the foundational pieces. How we do that around particular groups who are frail and vulnerable and living in residential aged care needs some further thought. But coming back to the design principles and agreeing on who does what will then drive how that's actually delivered and the way we need to do that needs to be flexible and as we've talked

about, it's not the same configuration of services in every town, city and suburb and we need to think about how we, within those principles allow some flexibility and who does what and how it's organised.

MR GRAY: Does that need to be an intergovernmental agreement between all jurisdictions that clarifies the roles in these ways?

DR LYONS: That could be one mechanism. I mean, what we're saying within the National Health Reform Agreement in the discussion at the moment around the criticality of being very clear around the interface issues between a number of different service sectors, the aged care sector, the disability sector, primary care because primary care is so critical in impacting on the services that the States and Territories provide. So those are the sorts of examples – we're also saying mental health is a major issue, but those things do need to be defined more, I think, acutely between the States and Territories and the Commonwealth about what the respective roles are particularly for the specific cohorts like people living in residential aged care.

MR GRAY: Dr Wakefield, should the obligations in question that are to be imposed on aged care providers extend to taking proactive steps to seek out appointments with medical practitioners? How far should the obligation of arranging go in Queensland's opinion? Should there be an obligation, for example, to arrange transport if necessary to access a specialist or a GP after hours?

DR WAKEFIELD: If I could take a quick step back, I think in relation to the accountability question, I think the accountability by and large is pretty clear currently, in terms of the Commonwealth's responsibility for aged care and primary care, and the State's responsibility for hospital care. I think that – that the issue confronting us is that it's the execution and the levers that have failed in respect of that. So in respect of your specific question, should residential aged care be responsible for engaging with effective care coordinators of residents, I think the answer is absolutely yes. The challenge I think we're facing is the system is perfectly designed to deliver the results that we get. The system is a provider-driven market which fails significantly in my own State.

Its dependence on primary care through a provider model of a basic fee for service means that unless you're enthusiastic, it's highly unlikely that a general practitioner will choose to provide the sort of services to residential aged care that's necessary, and there are many places in Queensland where GPs are not present. So I think – I think if we – if we start off with determining what does a reliable, safe, high quality service look like to residents of residential aged care, then I think it looks very different to what we have now, which is essentially a provider-driven market fee for service model.

I think our view would be that it starts with a definition of care and care needs, and – but that is the responsibility of residential aged care providers to source that care and that that care be available and defined with specific indicators such as assessment

and admission type assessments. A sort of – the sort of planning that's necessary, medication reviews, arrangements for 24/7 response for the sorts of problems that occur that don't require transportation to hospital, and a really solid engagement with a hospital provider.

MR GRAY: So are you proposing a realignment of who is the care coordinator? Traditionally it's been coordination through the GP/patient relationship. Are you saying the time has come to realign that responsibility and locate it clearly in the realm of the aged care provider?

DR WAKEFIELD: Yes, I am. I think we've got – what's happening now, I think, is you've got a collision of ideology. The ideology which is I think founded basically on the situation 20 to 30 years ago and the types of residents of residential aged care. Now, residents that have a reasonable degree of function are actually in the community. Residents in residential aged care, certainly the ones that I'm responsible for and that I visit have the highest complex needs, and I think a model which relies upon individual choice and a myriad of GPs attending or not attending is not a model that delivers reliability, quality, access and the sort of standard of services that I think residents both expect – or certainly their families and loved ones do, and that they deserve.

MR GRAY: Dr Robertson, should the subordinate legislation under the Aged Care Act impose a requirement on aged care providers to coordinate health care? Should this at least be an option if the relevant person's GP doesn't occupy that position or if the relevant person doesn't choose to have the GP occupy that position. I note that in WAs response, at question 38, there's reference to having an effective residential care line to support residential aged care facilities, including a care coordination role.

DR ROBERTSON: Sorry. I will just move to that.

MR GRAY: Suggestions for improving, the last bullet point just above the examples.

DR ROBERTSON: So the – so the last examples from transition care or from care – sorry, a care coordination role. Look, I think we, from the care coordination role, we do look to support some of those concepts that are outlined there. The – look, we do note that – that there is – there are already functions that sit within the Commonwealth and the State to try and do some of this coordination already, and certainly we also note that the Commonwealth propose – some of the proposed reforms of aged care assessment look to streamline that. I would say we would be a little concerned with some of that because it moves – we already have some well-established assessment roles, so care coordination roles to a degree with our ACATs and some of the reforms of the Commonwealth in this area, you know, threaten to, if they're not handled appropriately, threaten to actually compromise the current arrangements going forward. So I think the – while we do support that, it obviously has to be done carefully as we go – move forward.

MR GRAY: Mr McGowan, what's South Australia's view? Should the subordinate legislation under the Aged Care Act require the specific designation of a particular person as a care coordinator for each and every high needs person in aged care?

DR McGOWAN: I believe that would be a useful advance. I think it needs to be managed within a broader context. I believe at the moment the way the incentives are structured, residential aged care services can shift both clinical and financial risk to the safety net system being the public hospital. I think that happens too much. I think if there was a – if every resident of the residential aged care had a designated coordinator and recalling the evidence from the prior witnesses, having somebody who – who was totally across every patient could coordinate the systems of care. In my 30 years as a senior manager I believe strongly that if care is going to be connected and joined up and systematic and bulletproof then the systems and processes are what underpins that, and that means they need to be germane to a facility so they're consistent.

And that – and therefore I think somebody in that facility who has overall clinical governance and I think that means coordinating care for the residence they're in would be a great advance.

MR GRAY: Should it be a model which in effect is a one size fits all whereby the facility must provide the care coordinator or should there be the option for the designated person, to be, say the GP if there is one, or even a person from an external oversight organisation?

DR McGOWAN: I would hold the view that the – by whatever of those mechanisms it should be the residential aged care facility who should be accountable for the coordination of the resident's care. In the event that they were transported to hospital, then the hospital would take over clinical governance for the duration of the acute visit. I'm more ambiguous about the rehabilitation side of it, should that be in a subacute service that's run by the State, it should be the State's responsibility, but I also strongly believe in rehabilitation in situ back in the home in which case it would also move to the residential aged care facility. So yes.

MR GRAY: Would it be important to have the aged care system at all times indicating who it is and the contact details for that person, and for that information to be available across the interfaces into the health care system?

DR McGOWAN: I believe that would be a great advance.

MR GRAY: And with respect to home care, would it be possible to implement this care coordination, designated care coordinator concept in the context of home care for people with high level needs, say level 3 and 4 under the current system?

DR McGOWAN: Yes, I believe so. It runs into a few, as John was saying, ideological intersects. In the home care packages very strongly orientated at the moment to the resident or the client, whatever, making the choices and you need a –

you need to join together the big issue with health across the system at the moment is the – as you call it, the points of intersect between the systems. But a specialist – a role that was a specialist clinical care coordinator that was a designated part of an aged care package that provided the person with a service that essentially coordinated their health care services, whether that – you know, at home, that could reside and, you know, be situated in the local general practice if you like, but being aware of what the client's issues are, knowing when to call the GP or schedule an appointment with the GP, can make sure they get there, I could see something like that working well.

MR GRAY: Thank you. I want to now take the discussion to a different topic. All of these topics are interrelated. This is a topic which involves consideration of movement up the ladder of needs into the more acute deterioration territory. I want to ask the panel some questions about the proposition that counsel assisting have been developing through the week relating to hospital network-led multidisciplinary outreach teams. The evidence establishes that access via Medicare fee for service to specialists, that is, access to specialists outside inpatient hospital settings for people in residential aged care is very, very poor. Almost 70 per cent of residents don't see a specialist in a given year. And 38 per cent of specialists in the areas that are relevant to aged care don't deliver any services to residents at facilities at all in a given year.

The natural consequence that can be inferred is hospitalisations. Hospitalisations to access the specialist attention that the residents aren't getting in facilities and this, of course, directly engages the State's material interests as well, of course, as your humanitarian interests. The evidence suggests that hospitalisation will place a strain on the wellbeing and health of people in the aged care system. So we're exploring a proposition that there should be an Australia-wide, system-wide implementation of multidisciplinary teams of the kinds that exist in some local hospital networks already, through which residents can receive specialist care in their own facility with a program of dedicated funding to be administered through local hospital networks. And, of course, local hospital networks go by different names in different jurisdictions. Dr Wakefield, the hospital – hospital – HSSs, I beg your pardon, hospital services in Queensland.

I have the same questions for each of you in turn about this important proposition. Each of your jurisdictions operate some version of a hospital outreach program or pilot in some or other area in the State. Are they achieving improvements in care for people in residential aged care and reductions in hospitalisations to the extent that that's a relevant metric. And can they be implemented across the system provided the way in which they're implemented is sufficiently flexible, and provided they're supported by dedicated funding. Starting with you, Dr Wakefield, you've referred in your statement to the RaSS programs that are quite prevalent in a number of HSS areas. I beg your pardon, have I got the right terminology there, or is it hospital and health service, HHS.

DR WAKEFIELD: Correct. Hospital and health service, HHS.

MR GRAY: HHS. Thank you. In addition, the Royal Commissioners have already heard a good deal of evidence about a program CARE-PACT that is running and has been running since 2014 in the Metro South HHS. I will ask that the operator – I will come back to that, sorry. With respect to CARE-PACT, Dr Wakefield, is it the case that CARE-PACT is to be trialled in a further seven HHS areas; is that right?

DR WAKEFIELD: That's correct.

MR GRAY: Why is Queensland not trialling CARE-PACT in all of the HHS areas; what are the barriers?

DR WAKEFIELD: So would it help initially if I just perhaps give a very quick overview of what CARE-PACT is.

MR GRAY: Well, the Royal Commissioners have heard a good deal of evidence about it already.

DR WAKEFIELD: Okay. So this – this service was co-developed with Metro South and as a partnership with the Department of Health and as a proof of concept, and it relies upon a multidisciplinary relationship model providing a one stop shop for support services and outreach and in-reach and tele – video conferencing and upskilling for residential aged care across that – the footprint of that health service. It was done largely as you have mentioned, hospital and health services being the port of last call in many respects. It was done, really, because we have significant skin in the game to make sure that residents get great care, but also don't find themselves in emergency departments inappropriately.

We have the – there is a significant and very rigorous evaluation undertaken of that model and that's currently for peer review publication but I can say that it demonstrated a six to one return on investment, but perhaps more importantly and material to this conversation, there was evidence of about a 30 per cent reduction, absolute reduction in residential aged care residents from the sector landing in emergency departments, and a similar reduction in admissions to hospital. I think – so this doesn't just feel like a good thing to do. We've got really rigorous evidence that it is. Part of my – my own experience in respect of developing this service and then industrialising successful proof of concepts across the system is it doesn't just happen because we want it to, nor does it happen by sending a memo out saying okay, here's a great model, we would like you to implement it.

It's very much – it very much requires a very careful culture and stewardship and leadership on the ground to be able to effect it. So to do that we've established a step-wise approach, not just with CARE-PACT; we've got a couple of other models as well that have been similarly evaluated, that initially we take it to the next step, which is establish a collaborative of willing health services and a funding stream with a specific goal of helping them work together to learn from the experience of the CARE-PACT originators and to develop and implement their own system.

Again, following that phase, we will likely then take it through the next phase and have another wave. So I think part of what we're talking about here is the science of spread and industrialising successful models. So that's where we are at the moment. But it's very clear – we're very clear that this delivers better care and it makes better economic sense.

MR GRAY: Thank you. Can I just ask the operator to now display tab 70, RCD.9999.0289.0001, although Commissioners, this is already a tab of the general tender bundle; this was not in the original tender. This is a two-page summary of CARE-PACT including its evaluation. Dr Wakefield, you've been involved in the preparation of this document, I understand?

DR WAKEFIELD: Yes.

MR GRAY: Are its contents – although they're not as detailed as the underlying Deloitte report, are its contents nevertheless at a summary level true and correct?

DR WAKEFIELD: Absolutely.

MR GRAY: I tender that document as tab 70 of the general tender bundle.

COMMISSIONER PAGONE: I see.

MR GRAY: There's no need for an extra exhibit number.

COMMISSIONER PAGONE: All right.

MR GRAY: Thank you, Dr Wakefield.

DR WAKEFIELD: Counsel, may I just add one more comment to that. So I think it's important to realise two things. One is that this is not a – this does not provide the sort of GP primary-care level support that's necessary care coordination off the – from the ground. This, in a sense, is a workaround, but it's a successful workaround, particularly at the more acute end. I think it's important to recognise that.

MR GRAY: Dr Wakefield, just on that point, were you present in the hearing room for Professor Flicker's evidence in the earlier sessions?

DR WAKEFIELD: Yes. I was.

MR GRAY: And this point was raised with him, the point concerning whether multidisciplinary teams with access to specialist expertise are, in effect, only an alternative to improvement of primary care for people in the aged care system. And he said not at all; they're needed now because of the increasing acuity of that cohort. Do you agree with Professor Flicker's views on that point?

DR WAKEFIELD: I think I'd have a view – which is that we need to be very clear that to base a system on a specialist model is probably neither realistic nor appropriate. So I think that the evidence would suggest – the broad evidence would suggest that primary care – and, by that, I don't just mean general practice. In fact, in the CARE-PACT model, I think it's fair to say that, in today's world, that nurse practitioner is well supported, perhaps more peripherally with general practitioners and/or specialists has – has been a very successful model. So I think we need to be – I just want to be clear that I think our view would be that any system has to be grounded in a very strong primary care model, but it does have to be – have specific additional expertise in the older person.

MR GRAY: I will come back to you, Dr Wakefield, especially when it comes to how something like this should be funded and whether the Commonwealth/state split under - - -

DR WAKEFIELD: Yes.

MR GRAY: - - - the National Health Reform Act is appropriate. But, Dr Robertson, can I just ask you about WAs trial at the Osborne Park Hospital? Has that trial been evaluated?

DR ROBERTSON: There has been some initial evaluation – this is the Geriatric Residential Outreach service. And so there has been some initial evaluation. And the initial results suggested a reduction in avoidable hospitalisations, so – but it is probably still too early to fully qualify that.

MR GRAY: Mr McGowan, perhaps with a different emphasis and more of a primary emphasis, as I understand things, the GRACE model in South Australia has worked well, although within a relatively small geographic area, within a single – both a single hospital network and a single primary health network.

DR McGOWAN: That's correct.

MR GRAY: How does SA Health expect that the GRACE model might be adapted to be successful in South Australia more broadly, and are there any other thoughts being given by SA Health to a broader model picking up more of that specialist expertise?

DR McGOWAN: Thanks. I would agree with a lot of the comments made by my colleagues here. And I think we don't put enough emphasis on imitation as well as innovation, as John was saying, and industrialising some of the successes. The GRACE model is very new, I think we've seen. I've got updated evidence just – updated advice just before coming over. I think we've seen 85 occasions of service of that now. I think we've saved about 35 admissions to hospital. It only started, I think – in 2 December, I've got here. Sorry, 28 October. So that's been going a relatively short period of time and showing good results. I think older people

unnecessarily coming to hospital is a pretty negative event, not – not only from a cost point of view, but it's very disorientating for them.

It was one of a number of trials we're doing, all aimed at trying to provide better care in situ, home or in the residential aged care service. There are parts going on in the northern area, around people who frequently – not necessarily aged but often are. Same in the south. A fourth project we have is a project called Integrum, which tries to provide a very comprehensive wraparound, integration of aged – you know, home based aged care, general practice physio, into a model that just continues to optimise around what the patient sees their end-of-life journey as being.

So there are several of these. I think they all work quite well. I think the real test is, as my colleague, John, was saying, is as you industrialise these, what are the right mechanisms, what are the change incentives, what are the unintended consequences? I think the idea of outreach from a hospital to provide either a short-term acute response to an escalation in acuity is – I think, works. It just is the right system to scale it up. I think increasing the intensity – going back to your earlier question about the role of the specialist versus the general practitioner.

I didn't hear the evidence; I don't think the same way as you might have. I thought the two professors were saying you can't just have a general practice – a general practitioner looking after the need for the specialist gerontologist or palliative care. Working with the general practices are now necessary, but the general practitioners in Australia are some of the best trained in the world and rely on the expertise of their specialist colleagues. But I think they remain a very important part of the service mix on the ground.

MR GRAY: So the answer is more integration?

DR McGOWAN: I believe so.

MR GRAY: Is that a fair summary?

DR McGOWAN: I always believe so. Yes. And I think – when it comes to the very old and frail, I think it's very important to take the care to them, because moving them is a lot harder than moving the clinicians to them.

MR GRAY: Just picking up the connection, then, with the first topic that I raised for all the panellists around primary care, there were some remarks made about whether fee for service was really, in the primary care context, fit for the purpose of encouraging and incentivising that integrated, more teams-based approach. Do you have any views?

DR McGOWAN: I have quite well-formed views, actually. And I don't believe fee for service is a good mechanism. I think it's a good mechanism for the general population, who can navigate the health system well, have, you know, short-term health needs and health literacy's quite high. Once complexity sets in, I believe fee

for service is quite detrimental to integrating services. Short-term fee for service, I can imagine some models where a general practitioner who's taking on a governance role of a number of residents in an aged care service, depending on the number of residents, might have an MBS item number 4, a four-hour session of care, and that is tied to a set of outcomes for that nursing home – you know, preventative management, patient confidence and their health reduced, carriage to hospital, etcetera. So it's not totally not fee for service, but it's a different way of packaging up the GPs time into more comprehensive areas.

MR GRAY: And can you see a funding framework that has those incentives for primary practitioners working well with this more specialist outreach?

DR McGOWAN: Yes, I believe so. I don't think they're mutually exclusive. I think the concept of good clinical governance and resident coordination of a GP or a nurse practitioner in a residential aged care facility, dovetailing in with, you know, short-term incentive multidisciplinary outreach services can work quite well. I agree with your point that the funding for that needs to be further developed.

MR GRAY: Dr Lyons, New South Wales, New South Wales Health provides a range of geriatric outreach services, supports a coordinated approach to care, with well-established referral pathways, you say in your statement. Has the set of outreach programs that you detail in your statement been evaluated? And what's the general verdict of such evaluations? Are these services that the state is going to continue to get behind?

DR LYONS: So there are a range of those services in place. And they've been established, as others have said, primarily because the system as it is currently configured is not delivering effectively for residents in aged care. And we were concerned that there were many residents being transferred to emergency departments and being unnecessarily admitted to those environments. So it's a reflection of the service system as it currently is configured, not working well. So as a solution, I think we need to think about what do we want the system to do and, then, how would we provide the appropriate services to reflect what we want it to do, and who does what. And I will go back to my previous answer. So the role of primary care, the role of the residential aged care provider and then what role these outreach teams might play.

I think it's important to think about that in the context of a redesign of the whole system, rather than imposing a solution that currently exists as being established for a different purpose. And I think that's the concern I've got about jumping to this as being the solution for everything. I think they are effective models; I've heard that. They have been evaluated as being effective, but they've been set up primarily to give residents access to care that they don't currently have and to avoid transfer to an emergency department and hospital admission. So that's been their primary focus. So I think we would want to see what they might look like in the context of that total redesign that we talked about before, the role of the provider, primary care and then what role these outreach services might play.

MR GRAY: Thank you. Dr Wakefield, I said I would come back to you and give you an opportunity to speak further about – this is what I would like you to focus on – what might be an appropriate way of systematising a program of this kind. Not to diminish the importance of Dr Lyons' point, but either having regard to the world in which we currently live or having regard to a redesigned system where there might still be a role for programs of this kind, if one were to systematise them across the country, is the best way to do that to have a National Health Reform Agreement level funding stream that is on the Commonwealth/state split? What's your view?

DR WAKEFIELD: So I would agree with Dr Lyons' comments. So if I can just put that as a matter of context, so that we're clear that, yes, this is – you need to be careful – the focus on industrialising one solution, it is not the fix. However, we know that, as part of a solution, it has shown benefits. I think that there's two – there's two bits, really, I think, which is do we have the will to do it and do we have the skill to do it. If we start with the will, right now, I think Dr Lyons is right, we – this has been done against the tide of funding incentives. And it's been done because, as we've heard, because the states are the – are the point of last resort.

MR GRAY: So when you say against the tide of funding incentives, it's come out of hospital budgets?

DR WAKEFIELD: So if I can articulate that, because it's really important, that in doing – in creating CARE-PACT, we get hit twice. We, first of all, have to pay for a service which, technically, is the – it's certainly in the current arrangements – is the responsibility of the Commonwealth, ie, providing primary-type care in residential aged care facilities. And, secondly, because it's successful in reducing work in the hospital, hospitals forego revenue because that's how hospitals get funded – by doing stuff in hospitals. So in terms of the will to do this, I think that the funding lever is critically important; as I said, it's necessary but not sufficient.

So to your question about does this have to be dealt with in the National Health Reform space, I think the answer is yes, there has to be an ability to fund a different model for a different outcome, without getting into the specifics of how that would look. But, clearly, at the moment, the funding – this costs twice. The second question, "But do we have the skill to do it?" again, I think we need to be very careful, to go back to Dr Lyons' point, about the fact that this may not be the solution – might be the solution in Metro South, but this may not be exactly the same solution in other areas. And it certainly is not the solution in rural areas, which is, I think – again, we've got to be very careful about context. It's all about context. But it is – I think it does have a broader application, as evidenced by the fact that we are expanding.

MR GRAY: Dr Robertson, WAs position on how one would go about systematising it, is the National Health Reform Agreement funding stream the way to go?

DR ROBERTSON: Look, I think the National Health Reform Agreement is certainly, you know, one of the more logical ways to go, but it may not be the only

one. And I think we need to consider whether there are other alternative processes that could be utilised to do that, given that there's, sort of – you know, the comments that have been made previously.

MR GRAY: Do you have any in mind?

DR ROBERTSON: Sorry?

MR GRAY: Do you have any specifically in mind?

DR ROBERTSON: No. Look, I think – we jump immediately to the NHRA because it's, obviously, across – you know, cross-country, but I don't think we should necessarily exclude – not look at other options. And that may be a de novo option as well. Look, I think we also need to look back, before we go there to the funding – is to look at the service delivery models and what are we producing.

I mean, if we look at the WA example, the GRO is only a pilot option with little – little – and while it appears to be effective, there's little option for us to expand at this stage and we need to be seriously having those discussions about what service delivery models will work going forward, how we fund them, and then how we address some of the issues about flexibility. Because one of our real concerns is around regional and remote areas and how we deliver this kind of care into those areas going forward.

MR GRAY: It should be possible, should it not, to design a program with sufficiently flexible criteria to adapt to regional variation and to cater for those services that are already up and running and to integrate them or bring them into a coordinated network through a program like this?

DR ROBERTSON: It should, but, you know, it is – they are – they are very key issues at the moment. There's been a number of attempts to address them through MPS programs and the like. We have very thin markets in a number of our areas where there are no providers and so we become the last resort provider. So it's addressing all of those kind of issues in an industry which is very – goes from the very well catered for to the very not.

MR GRAY: The rural health outreach fund doesn't appear to have any programs specifically directed to aged care but it has the capacity, does it not, to channel funding toward ramping up the provision of specialist services in rural areas. Has WA considered making a case for greater funding through that fund?

DR ROBERTSON: So we are already involved with the rural health outreach fund and it's currently delivered in WA by Rural Health West but it is limited and I think, you know, we would certainly support again, looking at how we increase the funding and how we expand and the – the RHOF priorities to include particularly that delivery into the aged care services.

MR GRAY: Does Rural Health West have a program directed to aged care services in WA?

DR ROBERTSON: Look, I would have to check on that but I think it is more the general - - -

MR GRAY: Population.

DR ROBERTSON: - - - population, yes.

MR GRAY: Mr McGowan, the funding model issue, the stream of dedicated funding for a program of this kind if it were to be systematised, what's South Australia's position?

DR McGOWAN: I think Nigel is right, that it's – it feels a bit like a workaround and it sits within a much broader very complex system with the nuances about how it would work in rural and remote areas versus the metropolitan city. With those sort of caveats and acknowledging all this stuff gets hard and has unintended consequences I think the short answer to your question is yes, I think that is where it belongs, and the health care agreement as it's currently being negotiated has schedules that create the space for development in these areas in the long term reform areas, attachments to it. It's yet to be agreed as you know. But I think there is a – there is a provision for it there. If your question more specifically, if you're flowing it into ABF-based funding, there would need to be quite a bit of work to get to that point.

While the concept is simple about packaging up some costs and popping them into a funding stream, there's issues about caps and variation between those and complexities of patients and where patients localities are and those sorts of things. But with all those caveats the short answer is yes, I think it would.

MR GRAY: Thank you. I want to go to a different topic which is closely related to the one you've just been addressing but it's really an important subcategory of its own and that's palliative care services with access to specialist palliative care clinical nurses and other practitioners. There's been quite a lot of movement on the national action plan front. I understand there are negotiations currently in play in relation to a national action plan with the Commonwealth. Is that right?

DR McGOWAN: That's correct.

MR GRAY: Starting with you.

DR McGOWAN: I think that's correct, I'm not full book on it but I believe there is. There's a lot of action going on generally in the palliative care space. Again, it was recognised as an area that needs a spotlight on it and there is negotiations going on across the jurisdictions, yes.

MR GRAY: Just by way of context, it appears that each of the jurisdictions represented on this panel has in some form or various forms publicly funded, that is, State funded outreach palliative care services. I want to ask each of you whether there is sufficient clarity around the point at which the State regards it as appropriate for those services to be utilised for the benefit of people in residential aged care, given that the subordinate legislation under the Aged Care Act does mention an obligation to provide, that is, to establish and supervise at least, palliative care for people in residential aged care.

So starting with you, Dr Lyons, are the interfaces sufficiently clear here? Does New South Wales regard a person in residential aged care as having exactly the same right to access publicly funded specialist palliative care services in New South Wales? Should that be made more explicit? What are your views?

DR LYONS: So I think palliative care like any service has a range of different levels of care that are required from people who need fairly basic support that can be provided by a range of practitioners, and we have models where in our system nurse practitioners, clinical nurse consultants, general practitioners provide those services from a community setting to support people who are at the end of life and palliative care, to our highly specialised services where you've got specialist palliative care physicians and multidisciplinary teams who provide outreach. So it's again around the assessment of the need of the individual and then the appropriate provision of the service from wherever that should be provided.

So there's a role around what the residential aged care facility might be required to provide, what a primary care service might provide and then what the specialist services provide in backup. It's a gradation and arranged depending on the individual needs of the patient, because each patient going through palliative care or an end of life might have a different need and then we need to make sure that they can get access to that appropriate service, no matter where they're residing.

MR GRAY: And is the point of gradation at which it's appropriate for the State specialist services to be called upon sufficiently clear, in your view?

DR LYONS: So that's a clinical assessment and I think the issue at the moment is that we're not just – because of system failure it's often not around the clinical assessment, it might be because it's the only service available that that referral is made. So I think again it comes back to the design of the system and having clear accountabilities for the roles in each part and ensuring that the system is designed to ensure that those services are linked up and provided appropriately.

MR GRAY: Dr Wakefield do you have any different views on the delineation point that I raised with Dr Lyons?

DR WAKEFIELD: No, I agree. I think that, again, it's very important to ground palliative care as it is older persons' care, etcetera, with – in primary care, first of all. And then to layer on top of that the support for increasing complexity. I think there's

a lot more work for us to do in palliative care but I do think that's an area – another area where I think that CARE-PACT model, that model which provides for, first of all, a relationship and then a sort of point of contact, you know, effectively 24/7 or certainly extended hours seven days, and then a layered response, including telehealth, including on-site response, with both specialised practitioners, like, for example, nurse practitioners with a specialty in that area can do an enormous amount; they can prescribe, they can basically do a lot of the looking after, with good backup from general practitioners with a special interest often, although it's again, I think it's a requirement for general practice to deliver good palliative care.

And then the palliative care specialist doctor is right at the outer ring creating a – creating the – supporting the team, coaching the team, building some of the quality management around that. So that's in CARE-PACT, that's a lot of what's happened, developing resources and training and so on for base level staff so they can do some of those more basic things. And I do want to add that I think an issue that's perhaps less clear in terms of the evaluation and the economics and so on of this in-reach model is something that I think is really important not to be missed which is the coaching and upskilling and developing of staff on the ground, be they care workers or, you know, enrolled nurses on the ground.

We have found – because there's very little for them in a production model, the current residential aged care production model so I think that's a tremendous benefit and again the previous witnesses spoke to that, I think very well, about that need to diffuse knowledge and upskill which comes with that.

MR GRAY: And Dr Nash and Ms Beecroft, who are employees of Queensland Health, spoke to that issue and the focus groups and the ..... align with CARE-PACT. Having regard to that aspect of what CARE-PACT does and the similarities that you see between the provision of a multidisciplinary specialist palliative care services that can ramp up the degree of care and intervention that's needed, tailored to the person's needs, do you see a similar argument for a dedicated funding stream agreed to at an intergovernmental level along the lines of the model I proposed in relation to multidisciplinary specialist teams more generally?

DR WAKEFIELD: I don't see how we cannot – we can redesign and improve the system without the two funders essentially coming together and in good faith really being prepared to shift the funding model. Because funding drives behaviour. It drives the way a system or the services get set up, and it drives all the perverse things that happen as well. And as I said at the beginning, right now, everything that's been described by the Commissioners in the interim report, and everything you've heard, I think represents that, you know, that this system we have now is perfectly designed to deliver those results we're getting. We must change some of the levers. It won't be enough. We will have to do other things as well, but if we don't start with lining up the money towards better – towards the outcomes that we want, we will just have some enthusiasts, but the average person will not get the benefit, in my opinion.

MR GRAY: Thank you. Dr Robertson, WA has seen benefits, according to the response from that upskilling point.

DR ROBERTSON: Yes.

MR GRAY: The model seems to be a reasonably prevalent one in WA whereby the outreach involves a significant element of upskilling the nursing staff of the residential aged care facility. Has – have there been benefits discernible from that in terms of better care outcomes by any measurable metric that you know of? What about reduced hospitalisations?

DR ROBERTSON: It's obviously a challenging area in palliative care so, look, there have been a number of benefits. I mean, I think you're referring primarily to the metropolitan palliative care consultancy service, so that as a service is very much about – I suppose it's unique in some ways but it's more focused on, as you say, not delivering care or assessment or treatment, but upskilling the – you know, the staff to be able to deliver that palliative care within those – within that forum. There have been a number of measures. They – they've certainly looked as part of the review against our end of life palliative care strategy. They have looked at how – and they've used a number of measures. Some of those are around capacity and capability building. So how much they are around access and choice, whether there is greater access to services as a result of the upskilling of the staff, greater choice of things that can be done within the – within the facility.

Some of the better coordination of care and, obviously, you know, at the end of the day, you know, are there improved outcomes. Some of those are hard to measure, I would have to say, but certainly, you know, we've found that it certainly has improved our ability to – to manage, you know, palliative care across the aged care system.

MR GRAY: Thank you. Mr McGowan, what's South Australia's position on whether this sort of a program should be funded?

DR McGOWAN: It's very strong in that it should be funded. The state government has just committed $60 million over four years to extend the outreach services to people both at home and in residential aged care services. May I just make a couple of comments about palliative care.

MR GRAY: Yes.

DR McGOWAN: I totally agree with John's comments that building capacity in the residential aged care service is very important. Those aged care workers are there 24/7 essentially, and the palliative process is a 24/7 process, and being cared for by people you know and are familiar with is a very important part of that process but palliative – in the literature we talk about trajectories to dying, there's four but the three that we're concerned with here is frailty, where all your organ systems are

depleting roughly in sync and you become more and more frail. When you're actually going to die is a bit hard to predict.

There is people with, you know, cancers of what sort, a very well-understood trajectory to death and you can be in quite good control of that, but the one that's emerging and is one that's difficult to understand, is organ failures, where one of your organs, your heart or your lungs or your liver or whatever is depleting in advance of the rest and it's usually characterised by acute on chronic episodes of care, and you're never quite sure until the person has died when – when they were in a palliative phase and when they weren't. So it's a much harder and a much more complex clinical decision to make. But also they are aware that they're towards the end of their life and they need the support. Their families need the support and their carers need the support that comes with a palliative care process. So it is quite a complex area.

MR GRAY: Should it nevertheless be possible to design a program with sufficiently flexible criteria that it can attract that joint Commonwealth/State agreement to split the funding, dedicate the funding, have the funding recurrent and stable so that these sorts of services can blossom?

DR McGOWAN: I know that the Independent Hospital Pricing Authority has canvassed this already. It was on their work plan. I think they decided to try the first large bundle around pregnancy, which is very well understood. The issue with end of life care or palliative care, a bundle might be for the last three months of life, for example, is predicting how close you are to the end. That becomes essentially an actuarial question which is resolved with data. If we can get that right, yes, I think there will be great benefits in it and it's all about the variation in the cohorts, of course.

MR GRAY: Dr Wakefield, there's a demarcation or a delineation issue that has occasionally arisen, as I raised with Mr McGowan at the start; sometimes there's been uncertainty about whether a State service is available. Would Queensland consider it appropriate that a statement in effect, a declaration of the rights of people in the aged care system to access State palliative care services on an equal eligibility basis with people in the community would be appropriate?

DR WAKEFIELD: I – I couldn't argue that it wouldn't be appropriate and I think I would – going back to further comments from other panel members and colleagues. I would say that it should be part of a broader set of principles about – about what services, what people in residential aged care homes or in the aged care system should expect. I don't – I don't think we should restrict it to palliative care and I think that then provides a measure against which any tactical policy and funding and so on decisions can be made as to how well they deliver on that.

MR GRAY: And Dr Lyons, returning to the point that you made right at the outset, would I be correct in assuming that would be your answer, too, that it really has to be

subsumed within the overall discussion about the whole spectrum of care and a precise systematic allocation of responsibility for each of those - - -

DR LYONS: Absolutely. Absolutely.

MR GRAY: Dr Robertson.

DR ROBERTSON: Yes, we would agree.

MR GRAY: The same position.

DR McGOWAN: Agree.

MR GRAY: I think you had already virtually covered it. Thank you, Mr McGowan. Could I now, in the time available before lunch, address hospital transfers. That's going to leave interoperability of information systems and data collection until after lunch. We're running a little late but is that going to present any problems for the panel?

DR LYONS: No.

MR GRAY: So hospital transfers, I made those contextual remarks at the outset of the panel being called and it's really in that context that the question of inappropriate or unnecessary hospital transfers arises. I now want to shift the focus on hospital transfers to the information that's provided when a hospital transfer occurs, particularly when an ambulance is used. There are a series of propositions that counsel assisting have been developing around the need for uniform standardised requirements about the information that needs to be transferred with the patient when there's a transfer between the aged care system and the hospital environment.

Starting with you, Mr McGowan, is South Australia's position that – what's South Australia's position on the need for standardised requirements for clinical care information to be transferred at the time of both the transfer from aged care to hospital and hospital to aged care?

DR McGOWAN: This could be a short answer. We're highly supportive of it.

MR GRAY: Dr Robertson?

DR ROBERTSON: Yes, we certainly would also support that.

MR GRAY: WA has, in amongst the discharge summary policies, adopted by WA Health, documents requiring a discharge summary to be faxed, emailed or posted to the relevant GP within 24 hours of discharge.

DR ROBERTSON: Yes.

MR GRAY: Shouldn't a discharge summary be contemporaneous, particularly if the person is coming from a high needs context in aged care?

DR ROBERTSON: Traditionally, discharge summaries have always been problematic. So I mean, ideally it should be going with the patient and generally our intention is that it will go with the patient or carer, that it will go with the – obviously, but it needs to also go to the primary carer and to any specialist as well, and to the aged care facility. All of those are failure points – or potential failure points. Going back historically we, you know, we were very – we weren't very effective at getting discharge summaries out within a week, let alone within a day and this has been about how we move forward to make sure it's as timely as it can be.

MR GRAY: Dr Wakefield, Queensland sets a 48-hour period of grace. The same questions: firstly, is there a need for standardisation of the information that has to be provided and if we're talking about the time in which it should be provided, should it be contemporaneous with transfer?

DR WAKEFIELD: So is there a need; absolutely. I think – again, our thinking about discharge summaries generally has moved on in the last few years to one of clinical handover. A discharge summary is an artefact and I think clinical handover is a verb not a noun, and so I think one needs to be careful to make sure that – that I think the focus needs to be on the information that needs to be provided between that interface and both ends of that interface such that care can be maintained and safety can be maintained. So I think that – so there's obviously the question of the artefact and how contemporaneous that is. I think more importantly is the process around which it happens, so again I would expect that that sort of interface, a telephone call, message sent, message received is a much better way of doing it and an artefact can follow.

Generally speaking, across that interface of a hospital and a residential aged care facility – and we have these sort of templates and so on, that's a more active process where there's a comprehensive artefact produced and goes with the patient and I think that certainly happens most of the time. The other way of looking at this – and I think we've done a lot of work in this space, is that you, rather than seeing artefacts move between one place and another, one has a portal that all providers can look into, and so with The Viewer that we have across Queensland which provides a summary of all hospital information, and including discharge summaries, medications, results and so on, that is available to all general practitioners and will soon be available – or a legislative change is afoot to make that available to paramedics and to nurses in residential aged care, for example, so that again they – they have a window into the same information without having to request it.

So I think that's – it's not either or, it's having both of those. Now, hopefully My Health Record will fill that gap. It hasn't yet. The other important artefact in there, particularly in a residential aged care setting, of course, is advance health directives and advance care planning documents, and I'm pleased to say from The Viewer

perspective we've got about 25,000 curated patients, curated advance care planning documents, again visible to any GP and hospitals across the sector to residential aged care. My understanding is about 5000 for the whole of Australia within the My Health Record at this point in time. So I think we're pretty proud of what we've done there, but a lot more work to do because that's a critical point of even at the point of knowing what that patient's wishes are around decisions such as end of life care, palliative care, transfers and so on.

MR GRAY: Thank you, Doctor. I will probably return, although I think we may not need to go over too much more detail on the interoperability of the IT systems in Queensland, thank you, I will return to that topic after lunch. I will just finish, though, with New South Wales on the need for standardised clinical handover at the point of transition between aged care and the hospital setting, and also when should that be occurring. Should it be contemporaneous? Ideally, if something like The Viewer was available across the country, it would be a real-time window into hospital records, but that doesn't sound like the approach that is going to be available in residential aged care facilities through HealtheNet by the sounds of your evidence, Dr Lyons, but what are your views on those points?

DR LYONS: So I think, you know, clinical handover and having information to provide appropriate care for a resident is absolutely critical and the need for that transfer of information at the time that the care is transferred is really important. So it's both ways in terms of what is provided as someone is transferred into a hospital system through an emergency department or an admission, and then back both ways is critically important. We have policies that support that, and require that handover to occur and then get backed up by discharge summaries which are available electronically. They are available in My Health Record.

I think the challenge for all of us at the moment is that GPs have access to My Health Record but the aged care provider may not, and so how do we address that issue about either a link with My Health Record to the aged care portal or some other mechanisms to ensure that the aged care provider have systems where they can access that information as well as the GP.

MR GRAY: And that – meeting that need for the standardisation of the information that should be handed over, what's the mechanism by which that clarity should be achieved? Does that have to be in a governmental agreement or can it be - - -

DR LYONS: I think from the point of view of – if you want systems to be able to talk to each other and you want a national approach to that, you've got to get some agreement about what data will be transferred and how that's defined. Within our State we've done work on the information that we provide in the discharge summaries and that's through consultation with teams about what's going to help them, you know, we've had a lot of consultation with GPs about the information that they find beneficial. But in My Health Record now there is prescribing information, there's diagnostic information, there's also the discharge summaries, there's

information about outpatient clinics; those are all from our HealtheNet system into My Health Record.

MR GRAY: So on a voluntary basis there's the capacity to use My Health Record. You don't need to use the State hospital/GP interface HealtheNet because My Health Record could do the job.

DR LYONS: That same information goes into My Health Record as is in HealtheNet.

MR GRAY: My point is why isn't there already an obligation binding on the aged care side and binding on the hospital side requiring this information to be shared upon clinical handover? Have the governments just never got together and agreed upon it?

DR LYONS: Well, I think electronic means is one mechanism but good care prescribes that handover will occur and we certainly see evidence where that doesn't occur. From our end we continue to have policies and practices and review, you know, whether or not that is being delivered effectively. I know at the local level some of our services even do a 24-hour phone call and follow-up to a discharge to ensure that, you know, there is appropriate transfer and that if there are any questions that they can be followed up. So I think it varies but we do need probably a baseline agreement about what is appropriate between and it comes back to my point earlier about if we're going to design the system, we design the components of the system to ensure it delivers effectively for everybody.

MR GRAY: My last question – we're now up against lunchtime, but the last question, it makes perfect sense with respect that there should be that dialogue about exactly what the responsibilities are and it makes perfect sense that there should be agreement reached, for example, on this detail of the information that has to be handed over during the transition from aged care to hospital or vice versa. Why haven't we had those discussions and agreements till now; why has it taken till now for there to be a conversation about it?

DR LYONS: The system has evolved over time and the aged care system as it is now is not the aged care system that was in place 10, 20 years ago. The residents who are in care are very different. What has been invested in by various governments whether its Commonwealth or States is also very different. So I think what we tend to see happen over time is that the evolution of the system and the policies that surround that and the funding levers that are used over time are not fit for purpose anymore. So there's a need to go back and say – and I think we're at one of those critical points now where we're clear that the system is not working well, and we need to go back and design what we believe from the health point of view in particular, needs to be in place for best care for residents in aged care facilities who are in the aged care system in the community and the role of the various providers and funders in supporting that.

MR GRAY: Is that a convenient time, Commissioners?

COMMISSIONER BRIGGS: Dr Lyons and perhaps Dr Wakefield as well, I want to pick up this question of redesign of the system and, ideally, we would work through the roles and responsibilities and allocate them accordingly. But I don't think any country in the world has managed to do that successfully, and there's always got to be a bit of shared responsibility in many different areas. Would you agree with that?

DR LYONS: Absolutely.

COMMISSIONER BRIGGS: Good. Thank you.

MR GRAY: Commissioner.

COMMISSIONER PAGONE: 2.15.

ADJOURNED **[1.03 pm]**

RESUMED **[2.16 pm]**

MR GRAY: Thank you, Commissioners. Members of the panel, before lunch I was asking you questions about arrangements for transfers between hospital and aged care settings. And I was going to finish up that topic and then move to data and interoperability of record-keeping systems. I just have a few remaining questions on hospital transfers. Dr Wakefield, I will direct this question to you.

The fully formed proposition that the counsel assisting team have in mind is as follows, the National Health Reform Agreement should include a requirement for hospital discharge protocols to be developed and implemented to ensure that discharge to residential aged care should only occur once a discharge summary, including medications list, has been provided to and acknowledged by the residential aged care service.

Now, just pausing there, noting what you said before lunch about the availability of telephone, there's been deliberate attention given to the need for a written record in the form of a discharge summary for reasons of certainty, clarity and reliability. What do you say that Queensland's response would be to that proposition?

DR WAKEFIELD: I'm fully supportive. I can't imagine a situation where – where it would be okay to discharge a – a patient back to a residential aged care facility without that residential aged care facility accepting that person, and in order to do that they would have to know – they would have to have the information necessary to be able to – to do that. So I think that's – I have no problem with that, in full support

of that, and that again works both ways, in my view. It's critical to patient care, so yes, full support.

MR GRAY: Dr Lyons, what do you say New South Wales' position would be to the proposition fully formed in these terms?

DR LYONS: I completely support it because in terms of appropriate care for people who are moving between the systems it's really critical that there's appropriate communication of the care requirements and what's changed in the circumstance where they've been in either part of the system.

MR GRAY: Of course, there's deliberate attention given there to contemporaneity, that documentation has to be prepared before the – before the transfer occurs and then it has to be acknowledged by the facility. Do you also agree that that's an obvious precaution for safety reasons and even legal liability reasons, is it not?

DR LYONS: Absolutely. So ensuring, you know, appropriate safety for patients or residents as they move between, it's really critical that clinical handover occurs and we've got policy directives that support the requirement of that to occur. It's most important that it occurs between the clinicians actually providing the care at the time and then backed up by a documentation that may be either a written or in electronic form.

MR GRAY: Dr Robertson?

DR ROBERTSON: We would support it. Look, I think the – that makes – it's obviously I think the best practice in this area. One of the areas that we do have a little bit of concern around is around the medications. One of the weaknesses we think probably in this is the reviews of the residents' medications and actually ensuring that not only the residential aged care facility is aware but so are the primary care provider, the specialist geriatricians and the pharmacies, and how we do that is, I think, also critical as well as ensuring the discharge summaries are provided contemporaneously.

MR GRAY: All right. But you're not – it doesn't sound like you're disagreeing with the inclusion of the medical - - -

DR ROBERTSON: No, I agree with the thing but I think what I'm saying is that it's – we have to – it's not all finished when we make sure that they have a discharge summary. We need to continue working because there may have been some significant changes to the patient's medications going forward, and it's not just here are the new medications because if there is a disconnect at the other end in either the residential care facility, with the primary care physician or even the geriatrician, then we've less than optimal outcomes for the patient so it's just something that needs to be considered in any – I think in any proposition going forward.

MR GRAY: All right. So you'd, in fact, add a sort of a review requirement to the proposition?

DR ROBERTSON: Yes.

MR GRAY: Mr McGowan, South Australia's position.

DR McGOWAN: I absolutely agree in principle. I think it would want to be coupled with some obligations on the residential aged care facility, the person is returning to the residential facility to respond in a punctual way. You can quite easily add half a day or a day to the length of stay which isn't good for the patient and it can be a quite significant cost, but you know, with that caveat, absolutely, I think, for all the reasons mentioned.

MR GRAY: Following hospitalisations there's often a period of transition care and each of the jurisdictions is an approved transition care provider. There's another proposition that counsel assisting have been developing which is along the lines of tying funding to performance outcomes in respect of the State's provision of those transition care services post hospitalisation. Starting with you, Mr McGowan, what's South Australia's position on that proposition and you have it in written form? Do you want me to read - - -

DR McGOWAN: You might just remind me of the detail.

MR GRAY: I will read it out.

DR McGOWAN: Yes. Thanks.

MR GRAY:

> *The National Health Reform Agreement should include performance targets for states and territories to ensure patients over 65 years, particularly those who are living in residential aged care facilities, receive appropriate periods of subacute rehabilitation with funding tied to this requirement. Where appropriate and particularly where a patient has cognitive impairment, hospital should be funded through the National Health Reform Agreement to deliver subacute rehabilitation to the resident's residential aged care facility.*

DR McGOWAN: Subject to the financing that goes with it, absolutely; I have no problem with that.

MR GRAY: Dr Lyons.

DR LYONS: So I think this comes back to the clinical assessment of the patient and whether or not there's a view that there is a benefit in providing that subacute rehabilitation and I think we heard from previous witnesses today about that's not always necessarily something that is required but where it's clinically appropriate

and required I'd support that. The question is about whether or not that's funded through the current National Health Reform Agreement. I think that would be something we would like to have some negotiation around.

MR GRAY: Thank you. Dr Wakefield.

DR WAKEFIELD: I don't think I would have anything to add. I support what's been said already. I concur with that.

MR GRAY: Thank you. Dr Robertson.

DR ROBERTSON: And similarly we would support that.

MR GRAY: Finally, and perhaps somewhat more controversially, the evidence has been uneven to date on how the detail of this proposition could be formulated and implemented, but the proposition is that pending the development of a full suite of performance indicators for aged care providers, the rate of ambulance callouts should be monitored at a facility level. These data may be considered by the Aged Care Quality and Safety Commission in the assessment of clinical care. Dr Lyons?

DR LYONS: So I think before we came to a performance indicator we would need to agree on what is that actually telling us about what we want the system to do in support of a resident. So you know, it may very well be appropriate to call an ambulance out. So I think before we come to a performance indicator we need to go back to say what do we want the system to be doing that it's currently not. And as we've talked about earlier on in this panel, a whole range of things about how we can provide better access care for residents in situ without needing to transfer them to an emergency department where that is appropriate would be desirable, and we all need to move in that direction.

So the performance indicator needs to reflect once we've got those changes in place, when it's an – when it's – when it's being done, when there's potentially another way to provide the care. So if it's done because there is no after-hours access to a clinician to make an assessment, and there should be, and we've defined that as a requirement of the system to do that, then yes, I would agree those sorts of indicators would reflect where the performance is not as it should be. So it's defining the accountabilities of what we want the system to do and who's responsible for what and then developing a performance indicator to reflect that.

MR GRAY: Dr Wakefield?

DR WAKEFIELD: I think I agree with what my colleague has said. I would add to that, though, and I think extreme caution has to be put in place about throwing in key performance indicators and the potential for unintended consequences. I can – I can sense and feel the unintended consequences of this already and again, I think what we need to be very careful of is that we don't – you know, residents also have a right to access and get benefit from the acute hospital sector when they need it. What

we're talking about here is what's appropriate. So I think – I think that – I would – I would have significant concerns about – about saying yes, or support an isolated indicator. Bearing in mind also an indicator is just an indicator; is there a target, is there some sort of threshold.

I would – I would – so there's two things I think I would put to the Commission to consider. One is that indicators need to be part of a suite of indicators of process and outcome, lead and lag, and they need to have pairing so that, you know, unintended consequences that might arise are paired with other indicators that actually allow you to monitor that. That's the first point. And again, I think Dr Lyons has outlined that they need to be part of a very coordinated and carefully thought-through set of indicators around the system that is agreed. The second thing that I would say in respect of the indicator is that I think that indicators generally – there's a tendency for indicators in any agreement to have a goal or a target put on them, and I would caution against that.

And I think that it's moving to the step of having transparency of indicators without thresholds or performance targets, and then very clear sharing between providers, across the sector, the transparency of that so that people get a – have a sense of how they're going compared to others, and that creates a sort of learning and improvement system, something that I think – an innovation which is something that I know the Commission commented on in its interim report, rather than some sort of arbitrary compliance which is where I think we get into trouble.

MR GRAY: Thank you. Dr Robertson, do you have any fresh points or any differences of opinion?

DR ROBERTSON: The only – the only thing I'd probably add to the conversation is that, you know, when we've reviewed this, we would have some serious concerns about the – the data, the veracity of that data and actually collecting that data in a meaningful way and we know that when we've tried to collect this data in the past that often the way that our ambulance collect the data is not actually particularly useful. And if that's then going to inform obviously a key performance indicator, we have to have that – the basic information sorted out first.

MR GRAY: And are you speaking there of a judgment that the call-out was unnecessary or avoidable?

DR ROBERTSON: Exactly. Well, that and also – and to a degree, even where they – you know, for example, you know, our – a lot of the data's based on pick-up address. And so we're not – it could be that somebody's picked up from that facility. It could be a staff member picked up from that facility. Obviously, we haven't got the – the, sort of, granularity of the detail at this stage. And we need that if we're going to have meaningful performance indicators.

MR GRAY: I will come to data in just a minute, but, Mr McGowan, any additional points or differences?

DR McGOWAN: I can't add any additional points to my colleagues, no.

MR GRAY: Well, Dr Robertson, I'll start on data with yourself. We've already heard from New South Wales and Queensland about interoperability of systems and the use of My Health Record for the provision of individualised care information. I'm now wanting to shift the topic to a focus on big data, the collection - - -

DR ROBERTSON: Sure.

MR GRAY: - - - of data which tracks the provision of health services to people who are in the aged care system. And it's the understanding of the counsel-assisting team that there is no aged care identifier in the admitted patient data, and it sounds like there is no aged care identifier in the ambulance call-out data either – maintained by the jurisdictions. Is that the case for each of the jurisdictions here, Dr Robertson?

DR ROBERTSON: I believe that's the case for WA, yes.

MR GRAY: South Australia - - -

DR McGOWAN: It's similar.

MR GRAY: - - - Mr McGowan? Dr Wakefield?

DR WAKEFIELD: There's no indicator for residential aged care at present.

DR LYONS: To there's no indicator in New South Wales.

MR GRAY: Yes. There's a proposition that we've been developing that is to the effect that the states should apply such an identifier. Would there be any – and, indeed, the information should be, then, published – about admitted hospital data, which is tracked by reference to that identifier. Are there any objections to that proposition from any of the jurisdictions present? Dr Lyons?

DR LYONS: It relies on us being provided that information, to enable us to establish the identifier. So that's – if it were provided to us and it was accurate, then we could establish that identifier.

MR GRAY: And that must come from the Commonwealth Department of Health; is that right?

DR LYONS: Correct.

MR GRAY: And are there discussions in place to obtain that information, the linkages of datasets which would enable that to be done?

DR LYONS: We've had a number of conversations with the Commonwealth about the need for linked data around not just residential aged care residents but all

citizens, to be able to establish patterns of care, service delivery, monitor how we're providing services across the service systems that we're responsible for.

MR GRAY: So what's the current status of the discussion around the aged care element of that, if we can try to single out the aged care element from the general population matters that you've raised?

DR LYONS: I think it needs to be progressed along with the others. At this stage, it's not progressed any further than any other data linkage and we need it to be.

MR GRAY: Is there any obstacle to the Royal Commissioners making a recommendation that will provide some impetus for focused attention on the aged care element? Is there anything wrong with singling out the aged care element in that discussion?

DR LYONS: Not at all.

MR GRAY: Dr Wakefield?

DR WAKEFIELD: I have a couple of comments about this. And I'd agree with Dr Lyons, but I'd go a bit further. I think – the information I have is that right now all of the – so if we can just go back to should we have a flag in the admitted data collection for residential – for persons in residential aged care facilities, I think you could argue that, but that is – that is a long way from solving our problem, and unleashing the benefit which, actually, we have now, if we only chose to use it. And I think that's the states and the Commonwealth coming together.

There is a project underway now. I'm advised it's too slow. It's called the – it's under the National Health Care Standards, NSA – NS – NHSIH or something. So there's an acronym for it. Anyway, the point is that if we – the information that we – we don't know, as a state, which – for which residents – so which citizens are on aged care packages of any sort, whether they be residential, whether they be care or whether they be support. That information sits with the Commonwealth. And the Commonwealth don't know about, I guess, what happens in our patch, but all that data goes to the AIHW.

So right now it's my understanding that all the data that is there, that would link not only residential aged care but anybody who's on aged care support, that that would link, then, with our admitted patient data collections, our emergency department systems. So we wouldn't need to go and have another identifier. It's already there, if we just put the data together. And in addition to that, PBS and MBS for general practice and specialist care. So I think that we have the information we need. We just need the collective will to - - -

MR GRAY: Dr Wakefield - - -

DR WAKEFIELD: - - - to put it together.

MR GRAY: - - - that sounds like, with respect, a useful end goal. But short of an elaborate data-linking project, I suggest it would be a simpler matter to have a flag and to simply ask the Commonwealth for that information or, indeed, ask the patient in question, or their representative, are they from a residential aged care facility, so that that data could be captured in a – in effect, a useful way, so that data analytics could be performed upon it; isn't that right?

DR WAKEFIELD: So if I would have thought it was quite simple to be able to identify a resident of a residential aged care facility coming to our hospital system. I was actually quite shocked that we could not. I thought that, "Well, it's perfectly simple. Why can't we?" Then I discovered the complexity of the system and the fact that, basically, our identifiers are all based upon, essentially, addresses for e-texts. And residential aged care facilities can have many different front doors and also have low-care and retirement-type components.

So I would like to think it was simple and I indicated to my team, "Surely this is simple." I don't think it's quite as simple as you're making out. We are moving already – we're doing a project now to make sure that we can better identify, through more sophisticated means, working with our ambulance service but also our hospital admitted data collections, to get better clarity have that. Well, actually, as I said, that requires a significant change to the way people do work and record information. My argument is why would we need to do that when we already know, the system already knows? It's just that the two parts of the system don't talk to each other.

MR GRAY: Mr McGowan, South Australia's leading the project known as the Health and Aged Care Interface Data Project, which may or may not be the project that Dr Wakefield was referring to a minute ago. What's the progress? When can we expect some scope – parameters to be clear and when can we expect some outcomes?

DR McGOWAN: I will have to come back to you with exactly where that progress is at. There are – might I mention two other issues that are going on? I think the utility of My Health Record is probably understated in the discussions so far. I think some small tweaks to some of the privacy provisions, to allow data to flow across, provides a lot of the access to the clinical decision-making data that's necessary.

MR GRAY: Just stopping you there, that - - -

DR McGOWAN: Yes.

MR GRAY: That's at the individual care level?

DR McGOWAN: That's at the individual care level.

MR GRAY: And I take it South Australia would have no objection to the Australian Government imposing on aged care facilities a requirement to have access to My Health Record? There's some evidence that the rate of take-up of access of My

Health Record is quite low. Do you see benefit in imposition of an obligation on facilities to have that access?

DR McGOWAN: I think they do have access, subject to the privacy provisions now. They could access it now. Anybody can.

MR GRAY: They have the right?

DR McGOWAN: Yes.

MR GRAY: They perhaps have the right to, but the question is are they taking it up.

DR McGOWAN: No. Well – and I agree with that.

MR GRAY: So an obligation that they need - - -

DR McGOWAN: Yes ..... take it up. I think that would be useful. The other issue is the Australian Health Ministers' Advisory Council, the Director-General, secretaries from across the country, including the Commonwealth, have just agreed, in principle, to a high-level direction of interoperability of health-related data. Now, this is a very high – there's quite large financial implications to implement integrated interoperability of data across the system.

And, certainly, that vision is about getting one set of – one railway gauge is for the whole country. That decision was taken just some weeks ago at ANMAC and is at the beginning of its process. Apropos the Commonwealth/state aged care interface project – my understanding is it's quite in the early stages of development, but I'd appreciate the opportunity to come back to you with a bit of detail on that, if that's possible.

MR GRAY: All right. Thank you. Dr Robertson, finally, are there any additional comments or differences you wish to express on those matters?

DR ROBERTSON: Certainly no differences. We – you know, the existing deficits in the health service datasets in both the residential and, obviously, home aged care makes it very difficult for us in this space. We'd certainly support any initiatives that would address that. But the flow-on on that is because we don't have the data we can't really understand – have a clear understanding of our health service usage by the recipients of aged care. So our planning for any growth or any issues in that area is, obviously, compromised by not having that data. So having the data, yes, we would support strongly.

MR GRAY: Commissioners, I have no further questions.

COMMISSIONER PAGONE: Gentlemen, thank you very much for your attendance. It's been very informative and very helpful. Thank you very much indeed.

<THE WITNESSES WITHDREW [2.41 pm]

MR GRAY: Commissioners, our next panel, once the current panel has been able to vacate the witness box, is the Commonwealth panel led by the Secretary of the Department of Health, Ms Glenys Beauchamp PSM. She will be appearing – well, I should say giving evidence – with Ms Penny Shakespeare, Deputy Secretary, relevantly responsible for Medicare benefits and the Pharmaceutical Benefits Scheme, and also with Professor Brendan Murphy, the Chief Medical Officer.

COMMISSIONER PAGONE: Yes. Thank you.

MR GRAY: So I formally call Ms Beauchamp and the other witnesses. And they're now in the witness box - - -

COMMISSIONER PAGONE: Yes.

MR GRAY: - - - if the oaths and affirmations could be administered.

<PENNY SHAKESPEARE, AFFIRMED [2.42 pm]

<BRENDAN MURPHY, AFFIRMED [2.43 pm]

<GLENYS ANN BEAUCHAMP, AFFIRMED [2.43 pm]

MR GRAY: Commissioners, the approach I wish to take with this panel is that I'll be directing every question to you, Ms Beauchamp. And, as I understand it, Ms Shakespeare and Professor Murphy are here to respond to questions only insofar as the question raises an issue outside your knowledge.

MS G.A. BEAUCHAMP PSM: That's correct.

MR GRAY: So that's the way we will proceed. And Ms Beauchamp you've given evidence a number of times before to the Royal Commission but I will ask again, what's your full name.

MS BEAUCHAMP: Glenys Anne Beauchamp.

MR GRAY: Thank you. You've made another witness statement for the Royal Commission, WIT.0573.0002.0001 which should now be displayed on the screen before you, bears the date 15 November 2019, although this particular version is an iteration of a document that originally bore that date; that's correct, isn't it.

MS BEAUCHAMP: That's correct.

MR GRAY: And even in this iteration there's going to be a need I understand for you to supplement and clarify a paragraph. I've been told you wish to, in effect, make an amendment or narrow the scope or qualify paragraph 99 which is on page 0024. And, Ms Beauchamp, if you've got access, if you can see that on the screen, what's the nature of the qualification or clarification you're making about this paragraph?

MS BEAUCHAMP: And, Senior Counsel – my apologies for having to make a qualification – it won't affect materially the comments made in this paragraph but I understand that there were some additional MBS items included in these figures, and do not solely relate to GPs. So I would like, and have asked staff to have a close look at this and make sure it just focuses on GP attendances to people living in residential aged care, rather than looking at a range of primary care services going into residential aged care.

MR GRAY: Thank you. Would those assisting you please provide that information separately after the hearing?

MS BEAUCHAMP: Yes.

MR GRAY: Thank you. With that qualification to paragraph 99, do you wish to make any other changes to the statement?

MS BEAUCHAMP: No, I don't.

MR GRAY: To the best of your knowledge and belief, are the contents of the statement true and correct.

MS BEAUCHAMP: Yes, they are.

MR GRAY: I tender the statement.

COMMISSIONER PAGONE: Yes. The statement of Ms Beauchamp dated 15 November 2019 will be exhibit 14-31.

EXHIBIT #14-31 STATEMENT OF MS BEAUCHAMP DATED 15/11/2019 (WIT.0573.0002.0001)

MR GRAY: Thank you, Commissioner. Ms Beauchamp, your department is responsible for both aged care and health and so is ideally suited to regulate issues at the interface between the aged care system and the health system. Would you agree with that?

MS BEAUCHAMP: The interface between the health system and the aged care system does not just purely involve the Commonwealth. It does involve other levels of government and, indeed, other providers of services in – across – across Australia. So we're not the only regulators of health care services.

MR GRAY: When one considers the division of responsibility over the health system that you outline in your statement, one sees that responsibility for primary health care is vested in the Commonwealth and also, of course, system management and funding of aged care. So at least with respect to primary health care and aged care, would you agree that the Commonwealth Department of Health is, in effect, responsible for both sides of the interface between that aspect of the health system and the aged care system?

MS BEAUCHAMP: Generally speaking, yes.

MR GRAY: Generally speaking?

MS BEAUCHAMP: In terms of primary care, there are primary care services offered by and provided by other levels of government. So when you're talking about the Medicare principles and MBS and Pharmaceutical Benefits Scheme and in terms of looking at workforce arrangements for GPs in particular, yes, the Commonwealth does have a role.

MR GRAY: And also when it comes to the provision of specialist health care outside hospital settings, akin to the position the Commonwealth department is in with respect to system management responsibility and funding responsibility for that aspect of health care, again, the department is better placed than any other entity to manage issues at the interface between specialist health care and aged care, I suggest, what do you say to that?

MS BEAUCHAMP: Well, just to clarify, in terms of access to specialists and indeed primary care, primarily through the Pharmaceutical Benefits Scheme and Medicare, our role is to assist and subsidise the benefits that go to patients and clients. Yes, we do have a role in influencing the supply of specialists and GPs through workforce policies, and that's certainly done in concert with the States and Territories.

MR GRAY: Ms Shakespeare, you have particular responsibility for Medicare benefits policy?

MS SHAKESPEARE: That's correct.

MR GRAY: Do you have any other responsibilities which would shed light on the issues of the interface between the health care system and the aged care system, or is that the limit of your responsibilities?

MS SHAKESPEARE: I'm responsible for the Pharmaceutical Benefits Scheme. I'm also responsible for digital health policy and our relationship with the Digital Health Agency.

MR GRAY: I'm sorry. Could you speak up a little, after digital health policy.

MS SHAKESPEARE: And portfolio oversight of the Digital Health Agency.

MR GRAY: Thank you. And Ms Beauchamp, on Monday, Ms Rhonda McIntosh gave evidence about the difficulties she had experienced in getting the facility where her father resides to arrange primary care access for her father, and her father was complaining of having a heart attack at the time. And she ended up having to make many inquiries of her own over a weekend to obtain an appointment at a GP and then to arrange transport for her father to the clinic herself. It's just one instance of the difficulties that seem to arise in the evidence before the Royal Commission relating to the ability of people in the aged care system and those who are their informal carers, relatives and friends, to obtain access to health care, in this case, primary health care in the form of a GP, although it turns out it was for an acute episode.

MS BEAUCHAMP: Yes.

MR GRAY: Just that piece of evidence alone, but also a range of other pieces of evidence suggest that clearer delineations of responsibility between the health system on the one hand and the aged care system on the other would be desirable and are required, particularly, I suggest, with regard to who is it that has the responsibility to coordinate the person's care needs.

When a person enters the aged care system and they have high level care needs, say, virtually anybody entering residential care, and some people in receipt of a home care package, I suggest it can be difficult to know who bears the responsibility for making sure that that person obtains the health care that they need.

There are some suggestions that that role, as has traditionally and in the community been the case, is to be reposed in the general practitioner but you will have heard evidence today that there are different views. What is the department's position on, firstly, the need to – is there a need to clarify the delineation as to where aged care responsibilities with regard to obtaining health care really lie? And next, whether there should be at all times a designated care coordinator?

MS BEAUCHAMP: I found that evidence that I did hear and listened to earlier this week quite concerning, and obviously a failure within the health system. In terms of who should, and how should we identify and clarify who provides what to whom, I think when you suggested in the first instance clarifying the delineation between aged care responsibilities and the health care system more broadly, there's no doubt that I think that would benefit from further work. I think when a resident enters an aged care facility, I think it should be made very clear, both to the resident and their carers, guardians, and agreeing with their treating GP in the first instance and,

indeed, the provider what the arrangements are within a certain facility and what the expectations are of – and should be of residents, particularly to meet some of the Medicare principles that we go back to about providing choice of treating clinician.

And I think – I think absolutely that needs to be made clearer at that point of entry and I think we could all benefit also in a system sense looking at where the responsibilities of providers start and finish, and indeed, clarifying that with treating clinicians and broader access to the health system; no doubt about that. In terms of coordinated care, I would be concerned about having outside of current arrangements another designated care coordinator and I think they should be absolutely embedded within the residential aged care facility. Now, I think there's a – if you assign a particular person that implies necessarily, a single point of failure, potentially. So I think it does require a much better team-based approach to care coordination, depending on the needs of the resident and in terms of understanding clearly the expectations of the person having entered the aged care facility what they can provide internally and in terms of what they would need to engage and provide access to in terms of the broader health system.

So I think a much better team-based approach to care coordination. No doubt about the need for care coordination, I think that is absolutely a principle that we should be pursuing, but having a separate designated care coordinator outside of those relationships that have already been developed with GPs, geriatricians, nurses and, indeed, the residential aged care facility, I think would add another layer and take it away from the responsibilities of treating clinicians and others there. So I think - - -

MR GRAY: I will stop you there, but thank you for offering it, because that was going to be part of my follow-up questions who should it be, if there should be one.

MS BEAUCHAMP: Yes.

MR GRAY: Could I just suggest to you that neither the Quality of Care Principles 2014 nor any other aspect of the subordinate legislation under the Aged Care Act currently impose that requirement of designation of the care coordinator upon entry into residential aged care or, for that matter, higher level home care. Do you agree with that?

MS BEAUCHAMP: I agree with that.

MR GRAY: So would you agree that that subordinate legislation needs to be amended to provide for that?

MS BEAUCHAMP: I think it probably needs to be strengthened. It does talk about clinical governance and it does talk about the need to provide coordinated care. In terms of what I term "care management", I think that's something that we're looking at specifically across the aged care system more broadly. So not just in terms of residential aged care, but also people at home and I think that care management is very, very important to specifically identify.

MR GRAY: I will just ask the operator to bring up the Quality of Care Principles, RCD.9999.0285.0001, and Ms Beauchamp you've covered a number of provisions of the schedule – the schedules to this document in the course of making points about responsibility of aged care providers as you had it in the statement to facilitate access to health care. That was in response to a question being posed to you which used that language. Could we please go to page 0019. Here's one of the provisions that you cover in the statement at item 2.7:

Assisting in obtaining health practitioner services.

And you see there that there's following that description of the care or service, a column referred to as Content and that refers to arrangements for various types of health practitioners, and indeed that's just – that's not an exhaustive list. It's a reference to a series of them but it doesn't exclude other health practitioners – arrangements for them to visit care recipients, and then it describes who the arrangements might have been made by. It seems, therefore, that that item is limited to practitioners coming physically into the facility, visiting care recipients, and although there's an item referring to referral a little later on, there's no imposition of an obligation on a residential aged care provider to arrange for externally located consultations and there's no obligation about transport, making appointments, things of that kind with regard to externally located appointments. Is that your understanding of how these provisions work?

MS BEAUCHAMP: Within the legislation and those provisions that you've presented, on their own they don't explain clearly the roles and responsibilities. There is guidance attached to this in terms of what providers should provide and should arrange, both in-reach and outreach, and I think this has to be read with that guidance material, but I agree with you, I think this needs to be strengthened to make it clear what arrangements might mean, and what assistance means.

MR GRAY: Well, you've used that word "strengthened" a couple of times, but the fact is that if that is the intention, that the obligation extends beyond arranging visitation and extends to facilitating externally located consultations, there needs to be an amendment here, doesn't there, at the very least to change the content of the service that has to be provided.

MS BEAUCHAMP: I think this needs to be read in consultation with the guidance and certainly the standards as well that are provided under the Act.

MR GRAY: But the guidance can't change the subordinate instrument, can it?

MS BEAUCHAMP: The guidance can assist in the care provider understanding what this actually means.

MR GRAY: You mention "clinical governance". That's a reference to an aspect of new standard 8 in schedule 2; correct?

MS BEAUCHAMP: Yes.

MR GRAY: We just go to standard 3 in schedule 2 first, that's on page 23, we see that there's an organisational statement, standard 3, substandard, if that's the correct word, or subparagraph (2):

The organisation delivers safe and effective personal care.

Also clinical care or both. The difficulty here is, I suggest, there's a tension between delivering safe clinical care tailored in a person-centred manner to the needs of the person and a limitation on the content of what we just discussed under item 2.7 in what service actually has to be provided. In other words, the standard seems to be asking for something that reaches beyond the service that the facility or the provider is funded to provide. What do you say to that?

MS BEAUCHAMP: I think that's where we need to have clarity for residents and their carers and families, exactly what sort of clinical care the aged care facility can provide, and if – I think of wound management or catheter management or PEG feeding and the like, we certainly need to – in some respects they're regarded as clinical care but they're also regarded as personal care and assistance with daily living requirements. So it can be personal and it can be clinical or both, and I think prescribing every sort of service that an aged care facility or indeed a GP or other clinician should and can provide, I think would be very exhaustive. I think we need to provide guidance in terms of what's practical and realistic based on the needs of the actual – of the resident.

MR GRAY: Well, let's think about the needs of the actual resident a little more closely. We know that the cohort in residential aged care is of increasing acuity, very frail, very vulnerable. We're told by the AIHW that now about 52 per cent of people in residential aged care have some form of dementia, and cognitive impairment is therefore on the cards.

MS BEAUCHAMP: Yes.

MR GRAY: Now, when you're thinking about a cohort like that, it's imperative, isn't it, that the place where they are residing, which has 24/7 supervision of them should have the responsibility for identifying when it is needed for that person to obtain additional levels of care, be that primary or secondary or acute care. Do we – are we agreed on that?

MS BEAUCHAMP: In the first instance, yes, and I think you need to look at – when you're talking about clinical care that you do have a health professional providing that guidance.

MR GRAY: And going further than that, and this now picks up the point you made about clinical governance, should it not also be an obligation on the facility, the aged care provider, the approved provider who operates the facility, to, in fact, obtain that

care in a practical way? Not simply to make a referral or pass information, but to actually have more of a responsibility to ensure that the care is provided?

MS BEAUCHAMP: In situ?

MR GRAY: Yes, in situ, or if necessary if there's an acute episode, then if necessary by hospitalisation.

MS BEAUCHAMP: Yes, so within – within the facility there should be a level of care and support and oversight to determine in partnership with treating clinicians what's required when. And it's hard to generalise because listening to the evidence earlier this week about the gentleman with the chest pains, I think it needs to be very clear in understanding the history, for example, the facility understanding the history of that person, and looking at not just the symptoms at a particular point in time, but looking at the overall health care needs. So I think yes, there is an obligation on – and to have robust clinical governance to provide the care and support for each resident.

MR GRAY: It seems – this is my suggestion – that when you look at the somewhat unclear content of item 2.7, and compare that with what you've just said, that there's actually a gap in the regime that 2.7 seems to be suggesting that the service that has to be provided stops at a point where the facility has assisted in an arrangement for the health practitioner to visit, and that's all they really need to do, but what you're speaking about now seems to go several levels beyond that and to embrace a far more proactive care coordination role.

MS BEAUCHAMP: I think there should be more proactive care coordination and before I hand over to Professor Murphy I'm thinking in terms of something like wound management. So when does wound management become a basic service that should be provided within the facility to something that does require specialist treatment if the person might have sepsis, for example, and that can't be provided and facilitated within the aged care facility. So I think you can't generalise about what should be provided within the aged care setting and what should be arranged to make sure that person is getting the appropriate level of clinical support.

When I talk about being proactive, we've got to make sure that catheters, PEG feeding, wound management doesn't escalate or the person doesn't deteriorate to require that more tertiary intervention. So I think it's a – it's really something that's not only in the standards but the quality and capacity of the workforce within the aged care facility too, to take a very commonsense pragmatic view and ensure that they are providing the appropriate care for those care needs.

MR GRAY: Well, I'm suggesting that this is not so much a matter of generalising as precisely delineating who it is who has that responsibility. Did you hear the evidence of Dr Lyons in the previous session?

MS BEAUCHAMP: Yes, I did.

MR GRAY: In my summary of his evidence he was saying that there needs to be an agreement struck at an intergovernmental level precisely delineating the roles and responsibilities so it's clear what an aged care provider has to do, what the State health systems have to do, what those aspects of the health system for which the Commonwealth is responsible have to do. Do you agree with that?

MS BEAUCHAMP: So if I can just respond to that at two levels. Obviously, around the individual and every individual is going to be different, at a system level I think there's merit in what New South Wales and, certainly, looking at the evidence of Victoria, about in a system sense providing that clarity, because I think all residential aged care facilities are different and offer different services as well. And I think we need to look at where does the responsibility from the Commonwealth in terms of primary care and access to primary care ensure that there's continuity of service with the State-based system so I think there's merit in us clarifying those roles and responsibilities.

MR GRAY: I think you're agreeing with Dr Lyons' evidence and my suggestion as to what his evidence amounted to on that point. Are you agreeing?

MS BEAUCHAMP: In general, yes, they're very principled but it's how you do it.

MR GRAY: Right.

MS BEAUCHAMP: And I think I quite like the idea that Victoria has put forward in their evidence.

MR GRAY: There's – with specific focus on State specialist palliative care services, there was some evidence at a hearing in Melbourne on 10 October, and I will quote from the transcript. We had a debate – this is transcript page 5667:

> *We had a debate the other day with a public hospital provider because they told us that the person we were providing services to on a level 4 package in the home who was dying was ineligible for State-funded palliative care because they were on a home care package.*

Now, without trying to pass judgment on that scenario, but just taking what is said at face value, it suggests there is uncertainty, at least at the interface with regard to State-funded palliative care services, and the obligations that are imposed by the Quality of Care Principles on aged care providers to provide a level of palliative care services, and that that interface needs to be clarified and delineated. Do you agree with that?

MS BEAUCHAMP: I agree with that in principle. I don't think palliative care would require a one-size-fits-all model. Palliative care can be provided through the primary care system, through GPs. It can be provided through the State-based system, through access to specialists and, indeed, specific hospice and hospital

services that – similar to – along the evidence that was provided to the Commission this week.

So I think the rollout and the implementation we're looking at in terms of the national palliative care strategy is particularly important to clarify those roles and responsibilities. As we heard from the panel just prior to us appearing, it's a complex issue, palliative care, and it does require a team-based multidisciplinary approach, and I would absolutely support the implementation plan that we're working on with the States and Territories in terms of how we might give effect to much better coordination across both our systems.

MR GRAY: If you take just palliative care as an example of a specialisation where you wish, as you've said, to be able to tailor the care to the particular individual's needs and it might be care that goes all the way from, in effect, analgesics - - -

MS BEAUCHAMP: Yes.

MR GRAY: - - - for which a general practitioner even without a great deal of experience in palliative care is competent to prescribe and manage, all the way through to the most complex comorbidities and circumstances involving oncologists and the like. When one considers that, one can see that it doesn't make sense for those aspects for which the Commonwealth is responsible and those more hospital-based aspects for which the States have system responsibility to be sharply demarcated, and there's going to be a need to share resources - - -

MS BEAUCHAMP: Yes.

MR GRAY: - - - and reach agreement. Do you agree with that?

MS BEAUCHAMP: I agree with that. And that's indeed what's happening through the development of the strategy.

MR GRAY: But there needs to be clear agreement about the programs that will result from that and how they're to be funded; do you agree with that?

MS BEAUCHAMP: I think there needs to be clarity about the continuity of care for a particular person, whether they're in residential care or not about escalation of procedures, who's best placed to provide what sort of palliative care.

MR GRAY: Yes, but I think we got past that. My question is about agreement being struck about the programs through which service is tailored to those objectives are to be delivered, and how those programs are to be funded. Don't you agree there needs to be agreement on those?

MS BEAUCHAMP: I agree. And we have been trialling and piloting a number of programs and if they can be rolled out nationally based on better practice, evaluation and evidence, that would be a good thing.

MR GRAY: Yes. So is it the department's position that there should be agreement at a National Health Reform Agreement level or as a part of amendment to the new National Health Reform Agreement which is currently under discussion, I understand - - -

MS BEAUCHAMP: Yes.

MR GRAY: - - - to the effect that there should be a – in effect a national model or group of models that can be supported by shared funding on a recurrent basis for the provision of palliative care around the country?

MS BEAUCHAMP: If I could just reiterate what I said earlier, I don't necessarily think one size fits all and I think we need to look at a range of interventions, depending on the needs of the older person and indeed their families.

MR GRAY: But if the program is sufficiently flexible - - -

MS BEAUCHAMP: Yes.

MR GRAY: - - - then it isn't one-size-fits-all. It might involve a team with a range of competencies and it might be able to tailor the care provided to the needs of the person accordingly. What would be a one size fits all would be the funding stream.

MS BEAUCHAMP: Well, there's funding that's already provided through primary care in terms of GPs providing palliative care and funding already provided to the States and Territories in their hospitals for palliative care – state-based palliative care services. I would see we need to make sure that the current funding is applied jointly. There is an opportunity under the health care agreement to do joint planning and joint funding of a range of services and palliative care I think is one of those areas that we should be looking at under that joint planning and funding of health care agreement.

MR GRAY: And what's the state of progress of the discussions on an action plan under the national palliative care framework?

MS BEAUCHAMP: Under the national palliative care framework we're required to deliver and finalise an implementation plan at the end of this calendar year to present to all Ministers, State and Territory and the Commonwealth, early next year.

MR GRAY: Has that yet been done with two weeks or so to go?

MS BEAUCHAMP: We're in the process of finalising it, yes.

MR GRAY: All right. Would there be any obstacle to the Department of Health providing a copy of that document which is going to the Ministers to the Royal Commission at the same time as it goes to the Ministers?

MS BEAUCHAMP: I don't see any impediments supplying it to the Royal Commission and, of course, it's something that's got to be agreed between health ministers and until they sign it off I would consider it a draft.

MR GRAY: I understand that. But as a draft, no obstacle to that being provided to the Royal Commission.

MS BEAUCHAMP: No obstacles that I can see.

MR GRAY: All right. Well, I formally do ask for that and I hope those assisting you are taking note. Care coordinators – thank you for your clarification of your view that it is appropriate that there be a designated care coordinator within the aged care system - - -

MS BEAUCHAMP: Yes.

MR GRAY: - - - if it be a person – if we're talking about a person in care who's moving to a residential aged care facility I think you said there should be somebody at the residential aged care facility who's the care coordinator. I think you then said that might not be a specific individual, it might be the occupant of a position, is that what you meant or did you mean it should be a specific individual?

MS BEAUCHAMP: I would be concerned if it's a specific individual outside the relationships already with that particular person. I also worry about a designated person that provides a single point of failure if that person's not there. So if that person works part time and the like. So I think there should be a care coordination model within the aged care facility, definitely.

MR GRAY: Yes.

MS BEAUCHAMP: And I think probably what's important – and I was going to say previously, what's important around that is documentation and communication, and clarity about who's going to be providing what, because I think it really is a partnership between the provider, the treating clinician and the family in terms of what they should expect around care coordination. And the reason I'm raising that is listening to the evidence this week about – particularly families, they don't know what they don't know, and you don't know if a certain residential aged care facility, for example, has got visiting geriatricians which is what I heard in evidence today. Some people don't know what palliative care means and the like. So I think there is a big communication role that a care coordinator, or a care coordination team can have in this regard.

MR GRAY: And it's the facility who's best placed, on your evidence, to supply or to supply the personnel who fulfil that function, whether it's in the form of a team or in the form of a designated role within the provider organisation that's occupied by a group of people so that they can be accessible at any time. Is that the gist of your evidence?

MS BEAUCHAMP: Absolutely. They are there 24/7.

MR GRAY: Now, earlier in the week there was an opinion expressed by, initially, I think Ms Beecroft around the possibility of using memorandums of understanding of a tripartite nature, assuming that a GP is involved, whereby there's clarification of roles and who's responsible for coordination, amongst other things, once a person enters aged care and in particular an aged care residential facility. When I say "tripartite" I mean the resident and his or her family and loved ones, representatives on the one hand, the GP if there is one; presumably there is one because there's meant to be a comprehensive health assessment done, and one expects that to be done promptly upon admission, and there may be continuity of a relationship with a general practitioner, although the evidence suggests that that's becoming less the case than it has been in the past and, thirdly, the facility. What do you think are the merits of that idea of a memorandum of understanding?

MS BEAUCHAMP: I think – I think the merits are – well, are good. And I think the current arrangements around having agreed care plans, care management plans and behaviour plans agreed with those three parties and, indeed, other health professionals who might be visiting is probably important. So I would support – I don't know whether it's called an MOU but certainly a care plan agreed – agreed with the resident and those parties.

MR GRAY: Should there be any obligation in any circumstances on approved providers of residential aged care services to themselves engage the primary health care practitioner? That would be moving from a tripartite arrangement to an arrangement where the facility retains the primary health practitioner for the purposes of delivering the care. The merits of that would be absolute certainty about where responsibilities lie for the entire suite of care including health care for the resident concerned, but there may be demerits. What are your views?

MS BEAUCHAMP: If I can just go back to the Medicare principles that I mentioned earlier where in Australia we provide choice around who the GP should be or a treating clinician. I would not like to take away that choice from the resident and/or their families. When you talk about engaging, do you mean employing a salaried GP?

MR GRAY: It could take that form and it has taken that form in the case of the business models of at least one approved provider that I've read some evidence about. Or it could take the form of retaining – putting on a retainer or a less formal arrangement, a particular GP practice to service the entire population of a particular facility. The benefits of that being continuity of the relationship between the facility and the GP.

MS BEAUCHAMP: Yes.

MR GRAY: That may sacrifice to some extent the idea of maintaining continuity between patient and the GP upon the transition from the community into the facility.

MS BEAUCHAMP: I think there are a number of different models and I think the principle is right. I still think we need to ensure that there's choice for the resident but also choice for the provider as a GP. And as you mention, there are different models. I've observed a model where a GP practice is co-located with a residential aged care facility. It is a separate business but that GP practice bulk bills all people within the residential aged care facility and their families, and staff of the residential aged care facility. So it's quite innovative and a model that absolutely meets the needs of people in residential care. So I wouldn't like to see a prescription around what we mean by "engage".

MR GRAY: So Ms Beauchamp, is it your evidence that without prescription, it's sufficient to allow these models to develop and the innovative models will win out if they're – if they're efficient and respond to patient choice in the end, and if they don't, they won't?

MS BEAUCHAMP: I don't think on their own and under the current arrangements we should be looking at if there are significant barriers to innovation that you've just mentioned, whether we need to look at different funding arrangements, and I know, for example, the Productivity Commission, whilst it very much supports and most people do, the Medicare arrangements we do have, we're looking at other funding arrangements which is allowed for under the health care agreement where we can look at contracting particular services and providing more of a – a shared funding arrangement for GPs. So one model that we're trialling at the moment, if I can talk about?

MR GRAY: Well, I was going to ask in more detail about funding just after dealing with one final topic - - -

MS BEAUCHAMP: Sorry.

MR GRAY: - - - on delineation and coordination, but would you make a note please and we will come back to that.

MS BEAUCHAMP: Okay.

MR GRAY: I did just before leaving the concept of clearly defining the roles and responsibilities, I did want to come to a point that was made by the department in its response to – well, in its – in its submission in response to an invitation following Melbourne hearing 3 on the workforce. There had been a point raised in the workforce hearing about action 9 of the 2018 Aged Care Workforce Strategy which called for strengthening the interface between aged care and primary and acute care.

MS BEAUCHAMP: Yes.

MR GRAY: And the Commonwealth response, please, operator, is at RCD.0012.0033.0016. And this lists actions which are described as being taken by the Department of Health in relation to that action. Many of the actions – you have it

here. It's at page – native page 6. That should be page 0022, I believe, operator. Strategic action 9, strengthening the interface. Do you see it there, Ms Beauchamp?

MS BEAUCHAMP: Yes, I do.

MR GRAY: Now, many of the actions that are then referred to are, in fact, actions that commenced before 2018, before Professor Pollaers made that recommendation for action 9. And so although they might be loosely stated to be in relation to.

MS BEAUCHAMP: Pollaers.

MR GRAY: In relation to that recommendation, they're not necessarily in response to that recommendation; I assume you would accept that. For example, one of the matters that's said to be in relation to strategic action 9 is the establishment of 31 private – I beg your pardon, 31 primary health networks in 2015. That clearly isn't a response to Professor Pollaers, is it?

MS BEAUCHAMP: Well, I think this is highlighting that the PHNs which have key areas of focus now do include aged care. So even though the PHNs were set up earlier, there's clearly a focus area on aged care.

MR GRAY: Well, you've referred in your statement to the performance criteria for the PHNs with respect to aged care. Just bear with me for a moment. If we go to your statement at – pardon me. At page 0028, the foot of that page, paragraph 116, the performance and quality framework for the performance of primary health networks, when it comes to performance on aged care, there's really only these two indicators and outcomes.

They are that older people in the primary health network region are supported to access primary health care services that meet their needs, including self-care in the home. While that is a broad-reaching aspiration, the indicators are simply the rate of Medicare Benefits Schedule services provided by primary care providers in residential aged care facilities and the rate of people age 75 and over with a GP health assessment.

And I went to the document which describes the expected indicator, and it's simply that there be an increase in each of those. If there's an increase in the rate of MBS services provided by primary care providers in residential aged care facilities in gross terms, that indicator's met. I suggest that that is a very broad – withdraw that. I suggest that that in itself doesn't tell one anything about the underlying need in the primary health network for MBS services to be provided to people in residential aged care facilities. It's simply a gross measure of whether there's an increase in the services that are actually provided. Do you agree with - - -

MS BEAUCHAMP: I agree with that, in terms of the – relating back to the needs-based assessment, I think we need to do more work in the performance framework. There's no doubt about that. And those longer-term proposals are other things that

we're definitely looking at. But in terms of quality, particularly in residential aged care, I think one of the things that we are working on, which the Commission knows about, is the quality and care within residential aged care and, indeed, home care, and looking at providing performance criteria and monitoring and publishing those performance standards. So I think there's a performance standard framework that we're looking at. This is one for the role of PHNs, but, I agree with you, we need to do some more work around the indicators, particularly on quality for the PHNs.

MR GRAY: So, at present, the work of primary health networks in the aged care space is, really, at a very early stage. Is that a fair summary?

MS BEAUCHAMP: They've been in existence for a couple of years. The role of PHNs is absolutely being embedded within the National Health Reform Agreement. And one of their primary responsibilities is assessing needs of the population at the local level, providing - - -

MR GRAY: I understand that, but if these are the indicators of that, they're at a very, very high level and they're not well-directed to actually discovering the degree of underlying need for people in residential aged care facilities to have access to GPs, for example, are they?

MS BEAUCHAMP: No, I don't think that – it absolutely does not relate back to the needs assessment done by the PHNs. We need to make some improvements around improving the quality indicators. It's a very large document that we're requiring the PHNs to look at, in terms of the range of performance indicators at the local level.

MR GRAY: Well, it's a large document, but there's not – there's only one page on aged care.

MS BEAUCHAMP: On aged care, yes.

MR GRAY: Now, did you hear the evidence of Mr – or, rather Dr Troye Wallett of GenWise earlier in the week?

MS BEAUCHAMP: I didn't hear it all. I heard some of it, yes.

MR GRAY: Dr Wallett has involvement and was a co-founder in a practice which is a mobile GP practice specialising in provision of services to people who can't come to clinics, essentially.

MS BEAUCHAMP: Sure.

MR GRAY: Including people in aged care. And he did an exercise – or he caused an exercise to be done of market-testing, to understand the level of demand at residential aged care facilities for general practitioners, to care for the people in the residential aged care facilities and provide primary health care to them. And in March 2019, out of a ring-around of 96 facilities, he found that 92 of them had either

an urgent or immediate need; that is, a same-day need or a very urgent, as-soon-as-possible need for a general practitioner. Have the local health – beg your pardon – the primary health networks been conducting surveys of that kind?

MS BEAUCHAMP: I think they do do more broader-population surveys around needs-based assessment. In terms of the evidence that was provided, I wasn't sure what was meant by "urgent" and "immediate", because my understanding, I think – one of those was entry into residential aged care, and I don't know if that meant urgent or immediate, in terms of the assessment.

MR GRAY: At page 0617.002.001, paragraph 8, urgent need meant:

The facility needs a GP today.

Immediate need meant the RACF facility needs a GP as soon as possible.

MS BEAUCHAMP: And I – I don't understand the – and it's probably just me – I don't understand the evidence behind that. So I think residential aged care facilities and residents should have access, and appropriate access, to GPs. I think what is shown in the evidence that's provided in my statement – there's certainly been not only an increase in the number of GP services going into residential aged care, but there's also – we have about 50 per cent or 54 per cent of the 37,000 GPs that are providing services in residential aged care facilities. So on the basis of the evidence that I've presented in my witness statement, access to GPs in a global sense doesn't seem to be an issue. That doesn't mean there aren't urgent and hotspots that might emerge at particular points in time or, indeed, in particular areas.

MR GRAY: Well, I will ask you a little bit more about that – that position in your statement, which you've just confirmed in your oral evidence, Ms Beauchamp. You say 54 per cent of GPs do provide services in aged care facilities. That's on the basis of MBS data; you're given a financial year which shows whether a GP has provided at least one service in that year. That is, a facility-specific service; correct?

MS BEAUCHAMP: That's correct. And the evidence also shows that people in residential aged care are seeing a GP, on average - - -

MR GRAY: I'll just - - -

MS BEAUCHAMP: - - - once a fortnight.

MR GRAY: Just stop you there. It's also the case that the evidence shows that there's actually only something like 4500 GPs who provide enough services to trigger what's known as the practice incentive payment – the aged care incentive component of the practice incentive payment, which – the upper threshold of which is for 200 in a financial year – 200 consultations in an – RACF in a year. Now, just taking that point, 200 is not a particularly large number. It's about, say, four consultations a week, isn't it, over a year?

MS BEAUCHAMP: I haven't done the maths, but I will take your word for it.

MR GRAY: Well, it's a little less than that. And what I'm suggesting is that there's a huge disparity between the 54 per cent of GPs who are defined by having provided at least one service and those GPs who are actually regularly visiting. That's the first point. If I'm right about my figure of 4500 GPs, there are only 4500 GPs who provide more than 200 services a week – beg your pardon, more than 200 services annually, then you would accept that there are, really, very few GPs regularly visiting facilities? Do you agree with that?

MS BEAUCHAMP: I'll ask the – Professor Murphy and Penny Shakespeare to answer the technical numbers, but I would have thought that seeing a GP once a fortnight is a level of service that not many other people are experiencing, for that particular age group outside of a residential aged care facility.

MR GRAY: Well, just stopping you there, those people who are seeing a GP, on average – this is just an average, seeing them, say, once a fortnight – but there are nine per cent of people in facilities who never see a GP for the whole financial year.

MS BEAUCHAMP: If I could - - -

MR GRAY: That's the case, isn't it?

MS BEAUCHAMP: If I could clarify, the nine per cent I thought was those that are accessing MBS services. And, of course, even on the example you gave earlier and knowing that a residential aged care service has a salaried GP, a salaried GP may not be accessing MBS revenue. So there are a number of services provided by GPs and by other specialists that do not show up in the MBS system. And I might just ask Penny Shakespeare to clarify that, please.

MR GRAY: Well, that would assume (a) that that model of employment of GPs has continued, and (b) that those GPs don't claim under MBS. What would be the reason for them not claiming under MBS?

MS SHAKESPEARE: So if GPs are employed under a salary model where funding is provided by Commonwealth or state health programs, section 19(2) of The Health Insurance Act prevents them also being funded through a Medicare service. There were some other exceptions, I think, to the data included in that study, where the nine per cent figure came from, which are important. So if the services were provided to a resident through the Department of Veterans Affairs, that wasn't included. That's not billed to Medicare; that's a DVA-funded program. Also, any services that were provided to Medicare-ineligible people – so there are people in residential aged care who are not eligible for Medicare. So those services also would not be included. So there are some exceptions that we would need to look at, to explain why nine per cent of people were not receiving Medicare-funded GP services.

MR GRAY: Well, I will ask for you to address those matters in post-hearing submissions.

PROF MURPHY: Counsel, can I just say I think it's inconceivable that anyone of 12 months in a residential aged care facility would not be seeing a primary care practitioner. And the other group of people in state-run residential aged care, where often there are salaried junior medical staff who wouldn't be claiming Medicare as well – we will do that further work. It is inconceivable that people would not be seeing a doctor over a 12-month period. That has to be a data that we will explore with the AHW.

MR GRAY: Very well. I'll ask the operator to put up a document that's been supplied to you, Ms Beauchamp. It's tab 68. It's a document prepared by staff of the Royal Commission. What you see on the screen, in the top two curves – or the top two lines of that graph are the growth in the blue line, the dark blue line at the very top, people rated under the ACFI – Aged Care Classification Instrument, ACFI, as high in all three domains of ACFI. And in the yellow line beneath it, which shows a similar profile but is at a slightly lower level, are people in the clinical care domain, who are rated or classified as high. And you see that both of those lines from the year 2013/14 to the year 2015/16 have a steep rate of growth, steeper than the other lines that appear on the graph.

The other lines include amongst them the growth over the same period in MBS services to residents and also some other curves, that – that MBS for residents is the bottom line. And also some other curves described and given different colours, and there's a legend appearing at the bottom of the graph. So what's suggested by this graph is that while there's an increase in MBS services to residents over time, there's a steeper increase in the classification or the numbers of people classified to either high in all three domains or high in clinical care under ACFI.

What I'm suggesting to you is that it's unsafe to rely merely on the increase in the provision of MBS services to people in residential aged care as any sort of evidence that their primary health care needs are being met. What I'm suggesting to you is that that doesn't tell us anything about their underlying need for health care and, in fact, a steeper increase in needs measured by classification under ACFI suggests that maybe the increase in provision of MBS services hasn't kept track with the increasing acuity of the residential aged care cohort. Do you have any comments about that?

MS BEAUCHAMP: I've only been made aware of this information today, so I haven't looked at some of the underlying evidence to support it. But on previous occasions – and you talk about looking at MBS numbers on their own. We have also presented evidence to the Commission on a number of times about the validity and efficacy of the ACFI funding model. So in those areas that have gone up quite substantially, we thought that was absolutely, as we've said previously, an anomalous growth. And did it reflect needs of residents? And I agree with you about increasing acuity, increasing frailty.

We have looked at the evidence and, hence, the drop-off, that they were anomalous numbers. They were providers looking to maximise revenue, which is understandable, and they were not based on need. They were based on care tasks, which the ACFI funding model is – has a deficiency in. So what we have presented to the Commission is replacing this funding model with a new model which we're currently trialling. So I think presenting – without presenting the long term, I think presenting these figures can be very, very misleading, given the evidence that we've provided previously.

MR GRAY: What I suggest to you is you haven't collected – your department hasn't collected any data of underlying need and that – do you agree with that?

MS BEAUCHAMP: I think now we're putting in train - - -

MR GRAY: Yes, but you haven't, to date - - -

MS BEAUCHAMP: Yes. No.

MR GRAY: - - - collected any.

MS BEAUCHAMP: Yes.

MR GRAY: And that leaves us with ACFI or nothing. ACFI may well have the defects that you've identified. Nevertheless, there's cause for concern in the data that are depicted in this graph that the mere increase, quite slow and steady increase in MBS services, gives us no confidence that underlying need is being met. Do you at least agree with that?

MS BEAUCHAMP: No. I don't, on the face of it. Because I think when you're looking at people in residential aged care, it's not just access to MBS and GPs that are an indicator of quality and support. As people become frailer, access to activities of daily living, not necessarily provided to the – through the clinical system, is probably just as important in terms of quality outcomes as are clinical care.

MR GRAY: Is there anything else you can point to, apart from just a rise in MBS services, on this topic of whether underlying needs of people in aged care for primary health care are actually being met?

MS BEAUCHAMP: For primary health care, because this covers a range outside of primary care - - -

MR GRAY: I'm moving beyond this graph. And I'm just asking – your argument, with respect, seems circular. You're saying MBS items are increasing; that shows that underlying need is being met. I'm suggesting to you that that is an unsafe assumption because there's no endeavour to understand the underlying need and, therefore, the mere fact that services are rising gives us no comfort or confidence that the underlying need for primary health care is being met.

I also point to anecdotal evidence before the Royal Commission. Dr Wallett's market-testing survey which was renewed in September and came to the same conclusion. There seems to be a pattern of evidence here that primary health care needs in residential aged care facilities are not being adequately met and the mere reliance on the MBS – the rather modest increases in MBS rates within aged care facilities gives us no confidence that those needs are being met. Can you point to any other data source that gives us confidence?

MS BEAUCHAMP: I can't – well, firstly I can't draw the same conclusion based on this evidence. I think the work we're doing around care needs under the new funding model for people in residential aged care will go some way to better understanding those needs. I think we've got population data that we're looking at in terms of planning and I agree that's probably not enough in terms of granularity around assessing the needs of people in residential aged care. So I – I – I just don't think you can rely on this graph to draw the conclusions that you're drawing, senior counsel.

MR GRAY: Commissioners, notwithstanding that Ms Beauchamp doesn't accept that this graph can be used to question the premises behind the argument Ms Beauchamp makes about the MBS data, it has been traversed extensively. It should be included in the tender bundle so that the transcript can make sense to those who wish to make sense of this evidence. It's tab 68 and I will be seeking to simply add that to the general tender bundle with your leave.

COMMISSIONER PAGONE: Well, for that purpose, I mean, it obviously hasn't been accepted by Ms Beauchamp, but it is obviously appropriate to be there so that we can make sense of the transcript.

MR GRAY: Thank you.

MS BEAUCHAMP: Senior counsel, can I request something in response to this. Can I go away and do some work within my department in terms of a response that also could be tabled in the tender bundle?

COMMISSIONER PAGONE: In principle, yes.

MS BEAUCHAMP: Thank you.

COMMISSIONER PAGONE: It may depend upon what you come up with, but yes.

MR GRAY: Ms Beauchamp, there will be an opportunity for parties who have leave to appear to make submissions after the hearing, and I will be proposing a timetable to the Commissioners at the end of the hearing.

COMMISSIONER PAGONE: Yes, but in addition to that though, Mr Gray, I think it would be useful to have that kind of information, not necessarily as a submission, but as additional material upon which you might then want to make submissions.

MR GRAY: Thank you. Built into that if parties wish to advance fresh material of that kind they can address that in the submission and we will bring that before the Commissioners to see if leave will be granted for that material to be added to the tender bundle.

MS BEAUCHAMP: Thank you.

MR GRAY: Now, I wish to go to a point about continuity of care and you mentioned the key statistic. You mentioned that it was 54 per cent of GPs are providing services in facilities. You mentioned that in support of the position the department has that primary health care provision into aged care facilities is adequate. I wish to ask you some questions about the corollary of that figure. The corollary of that figure is that 46 per cent of GPs are not providing services in aged care facilities; correct. Now, when one considers that a GP, generally speaking, will be providing services to the entire demographic, putting to one side Dr Wallett's model, on the whole, general practitioners in order to be in an accredited general practice will be meeting the obligation under standard 2 of the fifth edition of the standards to provide services to the entire demographic of a particular community.

And the fact that 46 per cent of them are not providing services into aged care facilities suggests that in nearly half of cases, the GP is not following the resident into the aged care system. That suggests that the assumption of continuity of care on the part of GPs is somewhat unsafe and is probably being eroded. What do you say to that?

MS BEAUCHAMP: I go back to the Medicare principles around choice but also looking at the population of people in residential aged care we're talking about on average 250,000 population out of a population of 65 years and above of much larger than that. And I think we need to look at the provision of GP services to the population as a whole. And when you look at just the correlation between the number of GPs providing services into residential aged care facilities for 250,000 people, is that adequate or not? I can't judge that, but I would have thought on a population level, it does appear – it does appear reasonable.

MR GRAY: Well, let's think about it on an individual level. You've got a roughly 50/50 chance that your GP is not a GP who provides services to residential aged care, so when you move from the community into residential aged care, you're not going to have continuity of care from that same GP; agreed?

MS BEAUCHAMP: Well, no, you couldn't draw that conclusion. Really – you really need to look at each individual and whether they're accessing their ongoing GP that they access prior to entering an aged care facility.

MR GRAY: I suggest that you can at least draw that conclusion. In fact, it's probably worse because the GPs who provide services into residential aged care facilities, the 54 per cent, they will include a fair number who have new patients, who have newly formed relationships with their patients facilitated through the entry

of that person into that facility. Be that as it may, it sounds like we disagree on that basic proposition.

MS BEAUCHAMP: I just – no, I don't necessarily disagree. I just can't draw that basic conclusion just based on the population numbers. I think, as a principle, though, that continuity of care is very important, particularly as the evidence shows in periods of transition, whether it's hospital into residential aged care, whether it's from the community into residential aged care, and, of course, people may change doctors and the doctors may not be able to continue to provide services.

MR GRAY: Ms Beauchamp, I wasn't asking you about whether it's a good idea, and continuity of care is not something I'm trying to disagree with, I'm just asking you about what the likelihood is that you're – that a person moving from the community into aged care is going to have continuity of care. But let's move on. Are you aware of the 2017 AMA survey relating to medical practitioners who provide services in aged care and the indication in that document that roughly a third of the respondents – it's quite a large survey – had an intention to reduce or cease visiting residential aged care facilities in the near future?

MS BEAUCHAMP: I am aware of the survey.

MR GRAY: Now, these facts, the 46 per cent, the indications in the survey, I suggest indicate that you can't make a safe assumption that the traditional model of GP provision or primary health care practitioner provision of services supported by a remuneration model consisting of fee for service under MBS is going to be sufficient to ensure adequate primary health care and even more than that, high quality primary health care is going to be provided to residents in aged care facilities in the future. What do you say to that?

MS BEAUCHAMP: And I will ask Professor Murphy to talk about the methodology in that survey, but if I can just start by saying that survey was an advocacy document. We certainly consulted and spoke to the AMA about what that meant in terms of making sure there wasn't going to be a drop-off either in the number of GPs going into residential aged care or, indeed, the number of services accessed by residents. And the changes we did make to MBS, particularly around flag fall probably was a result of that particular document. The document, as a survey, does not reflect some of the evidence I spoke about in terms of the number of GPs going into residential aged care. But I might ask Professor Murphy who's looked at it in detail to provide more comments, if I can, on the actual survey and - - -

MR GRAY: I will come back to it but maybe we can short-circuit this point. Earlier in your evidence you referred to some evidence you wanted to give about a different approach to the way primary health care practitioners should be remunerated. That's as I understood it, the point you were wishing to go to and I said we will come to that – we will come to funding later.

MS BEAUCHAMP: Right.

MR GRAY: And you were making some remarks about whether the current funding model is sufficiently – is sufficient to foster innovation and whether it's going to be – perhaps these are my words – whether it's going to be fit for purpose. Can I just ask you what your views on whether the current pure MBS fee for service based model for primary health practitioners in the aged care setting, whether that is sufficient or whether it needs to change?

MS BEAUCHAMP: Can I just make the comment about the drivers for changing some of the care models for people accessing primary care is not primarily remuneration of GPs. It's really to provide a much better coordinated and quality of care service to older people, both in residential aged care and in the community. So we looked at not just the AMA survey but also looked at the Productivity Commission shifting the dial in terms of what sort of funding arrangements should we look at in order to supplement Medicare, a fee for service approach to provide what we call blended payments and more innovative care models. And the Productivity Commission said that, yes, we did need to keep Medicare, it was their – or their recommendation, sorry, not recommendation, their statement, but we needed to look at more flexible funding arrangements for primary care. And I was going to talk about some of those more flexible arrangements that we're putting in place at the moment, building on the Health Care Homes example. And - - -

MR GRAY: Are you talking about 70-plus voluntary enrolment.

MS BEAUCHAMP: Yes.

MR GRAY: And could you also speak about Health Care Homes.

MS BEAUCHAMP: So Health Care Homes was to look at – and it's still in trial because we've extended the trial, looking at much better coordination and wraparound services, a GP-led – a GP-led provision of primary care that would involve a range of other carers, health professionals, whether they were allied health or others so it did – and it continues to look at how do you provide those wraparound services through the GP that's going to provide better coordinated care rather than the patient having to shop around for different services. And so coming out of the health care model we're looking at a 70-plus enrolment model and, Ms Shakespeare, do you want to talk a bit more about where we're up to with that?

MS SHAKESPEARE: Certainly. So enrolment – patient enrolment model was also a recommendation from the MBS review taskforce which had looked at evidence before its general practice primary care clinical committee, a subcommittee. They also looked at the AMA survey around services into residential aged care, and recommended that rather than it extending the number of MBS items to fund particular, you know, coordination of care, there needed to be a supplementary type of payment which would allow GPs to better coordinate care for enrolled patients doing things like telephone calls, looking at test results when they weren't with the

patient. Those sorts of services which aren't funded directly under Medicare at the moment.

So that's now to be rolled out in the first instance to patients over 70 which, of course, will include people in residential aged care facilities from 1 July next year and we're – we have a group headed up by Professor Steve Hambleton but also including a lot of eminent GPs, consumer representatives, representatives of the AMA, the Royal Australian College of General Practitioners and the College of Rural and Remote Medicine working on what will be the service offering for patients who are enrolled and the final payment arrangements. So the level of payments and how frequently they will occur.

MR GRAY: Ms Beauchamp, taking the work that's been done on those more flexible funding arrangements – and I will just loosely refer to them as capitation based arrangements, they're based on enrolment of a particular number of people, the proposition that counsel assisting have been testing during the week is – you have it in documentary form, it was provided to your legal team. It is that the Australian Government should work with the aged care sector, professional and consumer groups to introduce a new funding model.

This would be to provide improved access to and higher quality primary health care for people living in residential aged care or who require higher levels of home care. And the funding model should have these goals: it should incentivise practitioners including through teams, to pick up what you've been saying, to deliver more proactive and preventative primary care. Just pausing there, there's a similarity with the Health Care Homes concept.

Although that didn't extend to aged care, it was looking at groups of people who share particular kinds of needs, in particular – in particular chronic – who suffer from particular chronic conditions, and with the 70-plus enrolment model we can see there's really an even closer affinity to being able to adapt something like that to residential aged care. So just pausing there, a model of this kind involving a capitation fee, an enrolment fee for a period would clearly help incentivise that proactive and preventative primary care, would it not?

MS BEAUCHAMP: I think we need to look at a range of models, so not just have one fixed new funding model but funding models and arrangements that reflect the needs of particular communities and the needs of particular residents, and if you look at primary care, for example, in – for aged care recipients in an indigenous community, it might be very different and it is in terms of some of the metro services. And indeed other rural and remote services. So the features here that - - -

MR GRAY: Well, not everybody has the document so I will just - - -

MS BEAUCHAMP: Sorry.

MR GRAY: No, not at all. I will just mention the other two guiding principles which are to promote a greater range of practitioners to be involved in the care, ensuring more flexibility and a more teams-based and integrated approach, and to promote innovation.

MS BEAUCHAMP: Yes.

MR GRAY: Now, we then proposed – as you can see in your document, we then proposed that the model might include a mix. It could be risk-adjusted base funding on the basis of enrolment per person, a capitation payment. It could be blended with a fee for service element for nonstandard attendances. It could also on the – involving either of those two or both of those two elements, it could also have a performance incentive element. What's the Commonwealth's position on a proposal that (a) the funding model needs to change, and (b) that this approach should be taken to how to change it?

MS BEAUCHAMP: I would suggest that the funding model needs to be supplemented, not necessarily changed. I agree with some of the proposals put forward here. I would like to see not primary care treated separately from access to other State-based services; so what is the funding model we want for that continuity of care you spoke about that's going to meet, I guess, the patient or resident journey through the health system and aged care system. So some of the things that the previous panel did speak about, and we're negotiating in the health reform agreement, is joint commissioning and joint funding of particular health care services, and then having the data to support it and in terms of performance, putting some performance expectations around that as well.

So I wouldn't like to see primary care as a separate funding model in terms of what we're doing at the local level around access to health care services. And just by way of example, and I think the evidence clearly shows we need to do more around access to geriatricians, palliative care, mental health services. Some of them are State based services and some of them are delivered by primary care clinicians. So how do we – how do we bundle those sorts of services together so we've got a good continuity of care?

MR GRAY: So is it fair to summarise your evidence as no, the fee for service model shouldn't be dispensed with, but it should be augmented and supplemented by a – by the addition of another element. Precisely what that element should be might depend on different practices in different facilities and different residents, but there should be consideration given to the capitation models in the form of a blended model along the lines I outlined. Is that a fair summary?

MS BEAUCHAMP: Basically, yes, I think there should be.

MR GRAY: And it's an additional element of this proposition that we've been testing that aged care residents should retain the ability to choose their general

practitioner if they wish, and to elect to take part in the new model or not as they wish and you would agree with that.

MS BEAUCHAMP: Yes.

MR GRAY: That's consistent with what you've been saying, that importance of choice.

MS BEAUCHAMP: Yes.

MR GRAY: Can I now move to some other topics – and I will try to move more quickly through those. The practice incentive payment, particularly the aged care incentive initiative, perhaps this might be a question for Ms Shakespeare, I don't know. This is payable to an accredited general practice that – to which a GP belongs and where the GP meets the various thresholds for provision of MBS services in residential aged care facilities. Now, there's a blockage to accreditation for mobile practices that don't have a bricks and mortar presence and that specialise in providing services just to one fraction of the demographic. What's the Australian Government's position or the Department of Health's position on whether those requirements of accreditation should be relaxed so as to permit the accreditation of practices that are mobile but otherwise meet all the quality and safety standards for accreditation?

MS BEAUCHAMP: Generally, to me, that seems sensible, but I will ask Professor Murphy to comment.

MR GRAY: Professor Murphy.

PROF MURPHY: So I think the accreditation standards are determined by the College at the moment, and there are good basis for them. I think their standards probably haven't evolved with these new models like – you have to be very careful not to accredit somebody who didn't have a range of proper quality and safety systems and record-keeping, but we certainly are of the view that we should encourage the College to be a bit more flexible and look at those models as long as they do meet the quality. Because you could get someone who might set up, perhaps I describe it as a Lincoln Lawyer-type practice that might not have the right quality and safety parameters around it. So we would encourage – Dr Wallett is on my aged care clinical advisory committee. He's a leader in this space and I think his practice probably provides very good service so we would encourage the College to have a look at that.

MR GRAY: Thank you. The next point is one that arises, again, partially out of the AMA aged care survey report but also it's been reflected more recently in a draft document produced by the Royal Australian College of General Practitioners raising for discussion, in effect, a wish list of various supports that GPs would wish to see in residential aged care facilities in order to support or incentivise or encourage them to continue to visit. One aspect of this raises the following proposition, that the Quality

of Care Principles or any subsequent instrument under any new regime, should include a requirement for approved providers of residential aged care to provide a room with sufficient lighting and privacy for consultations by primary health care practitioners which could be the resident's room if it's sufficiently secure and meets those requirements, and also providing access to necessary equipment and necessary lev

Now, the visiting health practitioners in question may not be restricted to primary health care practitioners. We may also be talking about specialists such as geriatricians. What's the Department of Health's position on that. Ms Beauchamp, are you able - - -

MS BEAUCHAMP: I might ask Professor Murphy to - - -

PROF MURPHY: I think – I think we would support that and I would be pretty surprised if most aged care facilities don't have sufficient lighting in the patient's room for an examination to take place. In many cases the doctors would like to see the patient in their room but many of the bigger facilities have treatment rooms and consulting rooms. GPs don't generally require much in the way of equipment, much of which they bring, so I think we would support that general contention.

To what extent you define everything in the Quality of Care Principles is a matter that we will continue to debate and – but I think it would be a reasonable expectation on an aged care facility to provide those services. And it's also a reasonable expectation that the nursing staff are engaged with the visiting doctors and, again, as the secretary was saying before, we strongly believe that that care coordination role should really sit in the facility nurses and they should have a much stronger leadership role and that would include interacting with the GP and a partnership in care coordination.

MR GRAY: With respect to the concept of moving to a more integrated teams-based approach, the provision of primary care for this group with subacute needs, perhaps I will direct this question to you, Professor Murphy, because of your workforce responsibilities as chief medical officer, there's a proposal or a proposition that counsel have been testing along the lines that there should be a greater role given to the training up of more nurse practitioners and the deployment of more nurse practitioners in aged care, particularly in aged care residential facilities. There's a specific proposal to incentivise this through scholarships with return of service obligations. What's the department's position?

PROF MURPHY: So the department's position is that aged care nurse practitioners are a very valuable addition to the aged care workforce. They're tiny in number at the moment, they're a tiny fraction of the nursing workforce. Some – one of – some of the barriers to their take-up have been actually employment models. Some very forward-thinking providers have employed them and to great – great value. We probably feel there is a stronger case to enhance the role of the registered nurse and

get more advanced practice registered nurses up to – with advanced skills in aged care.

To do a nurse practitioner qualification is quite a long and arduous process. The major advantage of being a nurse practitioner is that you can prescribe and order tests and refer, but if you're working in partnership with a GP that's not always necessary. So we've found in the past that scholarship programs tend to have a high drop-out rate. So you would have to make sure there was a good career path for the nurse practitioners. So we are certainly happy to look at ways to enhance advanced nursing in general in aged care, including nurse practitioners but not limited to nurse practitioners.

MR GRAY: Ms Beauchamp, I suggest that part of that solution to the career path problem and the prospects issue that Professor Murphy alluded to then is that, again, the funding model needs attention. Now, the nurse practitioner reference group, the MBS nurse practitioner reference group has made recommendations to the MBS review taskforce about more liberal access to rebateable items in MBS. There's also submissions about increasing the levels of remuneration through those rebateable items to which nurse practitioners have access. In addition, I will ask what your position on that is or perhaps what Ms Shakespeare's position on that is in a minute, but in addition to that is the answer also lying in the idea of reform of the funding model to provide more emphasis on incentives to teams-based integrated primary care through a capitation-based funding model?

MS BEAUCHAMP: I will hand over to Ms Shakespeare in a moment but just in terms of comments in relation to that, you're talking about the funding model just around primary care. I think when we're looking at practice nurses within residential aged care facilities, and the evidence we've given in the past, we want to free up nurses' time to focus on care and support. And the new funding model within the residential aged care to replace ACFI will allow nurses to actually focus on care and support. What I would like to see is – and building on what Professor Murphy was saying, is rather than nurse practitioners being treated separately, how do you get from the career pathway assistants in nursing, enrolled nurses, registered nurses and then nurse practitioners.

I think the focus on registered nurses with specialties around aged care, palliation and dementia is absolutely worthy and we discussed that in the last workforce hearings. In terms of responding to what's been put forward in the MBS, I think the MBS is reviewing arrangements around GP and primary care services and, indeed, specialist services and I think that's just one input into the process. But I might ask Ms Shakespeare to talk about that one.

MS SHAKESPEARE: That's right. So we wouldn't respond to the reference group recommendations. They were developed for consultation and those recommendations are not finalised yet. They need to go and be considered by the MBS taskforce itself before they would make final recommendations to the government, which we then will respond to.

MR GRAY: All right. So I take it, turning to another proposition we have, which is that the MBS items for comprehensive health assessments and team care arrangements so they're, for GPs 701 through 707, for medical practitioners more generally 224 to 227, you're not going to comment on those either. We've suggested that they be made available more frequently, six monthly - - -

MS SHAKESPEARE: So those items are also under consideration by the primary care committees of the MBS taskforce and we will respond to those recommendations once they're finalised.

MR GRAY: Ms Beauchamp, I want to now move into specialists – the area of specialists and outreach services. I spent a lot of time in the previous session, you would have noted propositions that I was putting there and the answers that were forthcoming from the jurisdictions represented in the previous panel. Each of those jurisdictions has a form at least in trial of team outreach based on access to hospital specialist expertise, if I could put it that way. The GRACE model might be the exception in that it's more an assessment as opposed to outreach and provision of specialist care. However, the proposition – you've been given it in writing, of course, and I don't have time to spend a lot of time on it, but what is the Department of Health, the Commonwealth Department of Health's position on the proposal that there be dedicated funding agreed at the National Health Reform Agreement level for a systematisation of outreach teams of this kind to meet those deteriorating acute conditions and potentially to save hospitalisations?

MS BEAUCHAMP: The principles that the Royal Commission has put forward are sound. I think people in residential aged care facilities should have access to multidisciplinary teams when they need it, and access to State-based health services. And I think the only – the only comment I would make about the model is it's a separate dedicated team rather than using a network of providers and specialists that might be in a particular region.

So one of the things that we've been looking at is for the primary health networks and the local health networks to look at a combined, if you like, arrangement where we can use specialists and GPs, including specialists in hospitals, including GPs, and GP primary care that we fund through Medicare and looking at can we have a much more integrated model around that. So our view is it definitely reflects what the previous panel says. The only thing I've got a concern about is, I guess, a whole bunch of specialists doing rounds in residential aged care facilities.

MR GRAY: That's not necessarily the proposal.

MS BEAUCHAMP: Okay.

MR GRAY: So the rounds or the more proactive element will be clinical nursing resources.

MS BEAUCHAMP: Right. Okay.

MR GRAY: There may be need for nurse practitioner, possibly even a geriatrician but it's not – it's not proposed that there be rounds of specialists - - -

MS BEAUCHAMP: Right.

MR GRAY: - - - taken out of the hospital to do that but rather that there be access to them through telehealth and access for advice purposes. Now - - -

MS BEAUCHAMP: Can I just say, in terms of the specialists, I think the core specialties that the Commission has highlighted, psychogeriatricians, geriatricians and palliative care specialists - - -

MR GRAY: Thank you.

MS BEAUCHAMP: - - - are certainly something that we do need to do more work on.

MR GRAY: What I need to get from you is your position on whether the basic proposition that this should be a dedicated funding stream agreed at the intergovernmental level, say on the 45/55 split that comes out of the National Health Reform Agreement.

MS BEAUCHAMP: I would like to look at the service model and then look at the funding that follows because we've heard from the previous panel the quite significant reduction in hospitalisations presenting to ED, so that must be a huge saving as well. So I think rather than looking at a dedicated stream we should be looking at the models under the current funding arrangements where we can pool funding rather than look at a separate dedicated stream.

MR GRAY: If the saving is to the hospital system then doesn't it follow that logically speaking the funding of the program should be on the same basis that the hospital system is funded?

MS BEAUCHAMP: Indeed. Indeed.

MR GRAY: Okay. Now, we're close to the end of our time. And I will just ask you about My Health Record. One of the propositions that we've been developing is that the Minister for Health through the subordinate legislation should impose a requirement on residential aged care facilities and also those home care providers who provide for people with high needs, but let's specifically focus on residential aged care providers, impose a requirement on them to avail themselves of access to My Health Record and to use it, at the choice, of course, of the resident and subject to any privacy concerns that they may have. What does the department say to that, Ms Beauchamp?

MS BEAUCHAMP: So My Health Record does actually belong to the person that's receiving care. I think in terms of sharing information across the health system and

aged care system My Health Record provides a great opportunity to do that and we've heard about discharge summaries, care plans and the like and there's a capacity for all the information around a particular client to be included on My Health Record. And like other health practitioners, I think there should be opportunities for health practitioners within residential aged care facilities to have access to My Health Record. You mentioned privacy and indeed security goes with that.

In a sense you wouldn't want open slather on, for example, the administrative staff being able to access My Health Record but for continuity of care, for clarity around interpreting discharge summaries and clinician requirements, My Health Record does offer a great opportunity and can I just say we're piloting – we're actually piloting between the digital - - -

MR GRAY: I need to just stop you there. We're very short on time.

MS BEAUCHAMP: Sorry.

MR GRAY: It doesn't sound like you're wholeheartedly endorsing the idea of an obligation that, if the resident chooses, then the facility must avail itself of My Health Record.

MS BEAUCHAMP: That was only my reservation was around consent.

MR GRAY: If that consent is provided - - -

MS BEAUCHAMP: Absolutely.

MR GRAY: Yes.

MS BEAUCHAMP: Absolutely.

MR GRAY: Very well.

MS BEAUCHAMP: Absolutely.

MR GRAY: Now, the take-up is very low.

MS BEAUCHAMP: Yes.

MR GRAY: It's 279 provider organisations out of some 1600 or so if you count – I'm not sure if one counts home care and residential care separately for this purpose, but either way it's only something around between 10 and 20 per cent of organisations that have taken it up. Don't they have to be compelled to take it up?

MS BEAUCHAMP: I would like to see, based on that consent, an opportunity for residential aged care facilities and home care providers take it up. And I was just

going to say in relation to that, we are, on the Digital Health Agency, and the Commission of Quality and Safety in Health Care looking at standards that should be applying to how we might roll that out digitally as well.

MR GRAY: Does it also require as a precondition, really, that all residential aged care facilities and it really should apply to home care providers who are caring for people with high needs as well, that they must have digital electronic care records, they must move to electronic care records. That should be mandated, shouldn't it?

MS BEAUCHAMP: Absolutely. And I think probably what's more important is clinician behaviour and people who are providing input into My Health Record and I think that's where we need to focus a lot of effort in terms of getting clinicians to use it and make it easy to use.

MR GRAY: Finally, on big data what's the hold-up with the aged care identifier being applied to State-admitted patient hospital data? That should have happened long ago, shouldn't it?

MS BEAUCHAMP: In hindsight I can say that sitting here, but just to echo Dr Wakefield's views, requiring system changes, and it sounds simple, in terms of a person's usual place of residence on a number of different systems which are very fragmented does require - - -

MR GRAY: But Ms Beauchamp, that's an implementation issue. The agreement should be made urgently between the governments that it must be done as a necessary first step in the other negotiations that are also taking place around the integration of data between health care and aged care.

MS BEAUCHAMP: And it's a key priority of the health care agreement, yes.

MR GRAY: I have no further questions.

COMMISSIONER BRIGGS: I have a very simple procedural question, and it's around the health care agreement for 2020 ..... we're very conscious that throughout this Royal Commission governments, normal government business procedures, and we might be making recommendations on changes to these areas ..... if our recommendations are to be considered within the context of the health agreement, when would they need to be made public?

MS BEAUCHAMP: Thanks, Commissioner, in terms of process, we're in the process of finalising through health ministers the Health Reform Agreement and we only met as officials last Friday. But I think some of the principles that have been raised already in the interim report, is certainly something that all the chief executives are cognisant of. For example, those interface issues where there are big risks, they absolutely will be picked up in the health care agreement. Specific reference to aged care will also be made. I think the improvement in the health

performance framework and data sharing is a commitment that's consistent with the Commission's findings.

In terms of the funding arrangements that the Commission may touch on and has started to touch on now, we need to look at what we need to do, particularly in terms of block funding arrangements because if we are looking at blended models of care and funding, there's much flexibility within the Health Reform Agreement to do that. And the onus is on us as CEOs to look at how do we actually measure that performance and how do we fund it. But there's certainly a commitment to do that. And we do focus on aged care at most of our senior officials' meetings.

COMMISSIONER BRIGGS: So when – finally my machine is working – so finally when do you expect decisions to be taken at senior Ministers' level?

MS BEAUCHAMP: In terms of – the Health Care Agreement is to apply from 1 July 2020, I think. Whilst it needs to go through our health Ministers and it will, it also needs to be agreed by all what we call Premiers and Prime Minister departments and treasurers to make sure, because it's quite significant, as you know, in terms of funding, so we expect to have an agreement in place early next year and that's me saying that, but, of course, it's got to get through all the jurisdictional approvals and certainly our approvals at the Commonwealth level as well.

COMMISSIONER BRIGGS: Thank you.

COMMISSIONER PAGONE: Thank you. Thank you for your attendance and evidence. It's been very helpful and very informative. Thank you very much indeed.

MS BEAUCHAMP: Thank you.

MR GRAY: May the witnesses be excused.

COMMISSIONER PAGONE: Yes, the witnesses are excused. Anything else today. 10 o'clock tomorrow morning.

<THE WITNESSES WITHDREW [4.34 pm]

MATTER ADJOURNED at 4.34 pm UNTIL FRIDAY, 13 DECEMBER 2019

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