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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

MUDGEE

10.03 AM, WEDNESDAY, 6 NOVEMBER 2019

Continued from 5.11.19

DAY 63

MR P.R.D. GRAY QC, counsel assisting, appears with MS Z. MAUD and MS E. HILL
MR M. FORDHAM SC appears with MR FRASER for the State of New South Wales
MR S. FREE SC appears with MR B. DIGHTON for the Commonwealth

COMMISSIONER PAGONE: Ms Maud.

MS MAUD: Thank you, Commissioners. The first witness this morning is Julian Krieg who is already here in the witness box.

<JULIAN KRIEG, SWORN [10.03 am]

<EXAMINATION BY MS MAUD

MS MAUD: Have a seat, Mr Krieg, make yourself comfortable. Can you state your full name, please.

MR KRIEG: Julian Krieg.

MS MAUD: And Mr Krieg, have you prepared a statement for the Royal Commission?

MR KRIEG: I have.

MS MAUD: Have you got a copy of that there in front of you?

MR KRIEG: Yes, I have.

MS MAUD: Does it have a code in the top right corner, WIT.0590.0001.0001.

MR KRIEG: Yes, it does.

MS MAUD: Yes. Have you had an opportunity to review it recently?

MR KRIEG: Yes.

MS MAUD: Are its contents true and correct?

MR KRIEG: Yes.

MS MAUD: I tender that statement, Commissioners.

COMMISSIONER PAGONE: Yes, the statement of Mr Krieg of 28 October will be exhibit 12-19.

EXHIBIT #12-19 STATEMENT OF MR KRIEG DATED 28/10/2019 (WIT.0590.0001.0001)

MS MAUD: Thank you. Now, Mr Krieg, you're a resident in York in Western Australia.

MR KRIEG: I am.

MS MAUD: And until 2002 you worked in various roles as a teacher; is that right?

MR KRIEG: That's correct.

MS MAUD: Yes. Are you retired now?

MR KRIEG: Yes, pretty much. I'm still on a couple of boards, and I still – I'm involved with the Rural Financial Counselling Service of WA plus the York Health Advisory Group.

MS MAUD: I see.

MR KRIEG: But predominantly retired.

MS MAUD: After you stopped working as a teacher were you employed for a while for the Wheatbelt Division of General Practice running programs in education of suicide prevention?

MR KRIEG: That's correct.

MS MAUD: Yes. And for the last six years you've been the chair of the York Health Advisory Group; is that right?

MR KRIEG: That's right.

MS MAUD: Can you tell the Commission what the role of that body is.

MR KRIEG: It's a community-based body that gives advice – or not really advice but we negotiate with the health department on how the health system is working and we sometimes advocate for individuals that have special needs or whatever, and we work with the community to actually try and get good outcomes for everybody in our community across the system.

MS MAUD: In effect, is it the role of a conduit between the York community and health service providers?

MR KRIEG: It was set up by the WA Country Health Service to actually provide that feedback or a conduit to the health service about things needed, what things that were going well or whatever.

MS MAUD: And since May this year, have you also been a member of the Western Wheatbelt District Health Advisory Committee?

MR KRIEG: Yes, I have.

MS MAUD: What's the role of that committee?

MR KRIEG: It's an overarching group and so the York Health Advisory Committee has representatives on the District Health Advisory Group so that that overarching group for bigger issues can take those issues forward to the health department as a collective. So it's an overarching group.

MS MAUD: And how many local advisory groups are members of the district committee?

MR KRIEG: I think about 12.

MS MAUD: Right. Now, I want to ask you some questions about the aged care services that are available in York. How are aged care services delivered in your area?

MR KRIEG: We have an MPS hospital which is a multipurpose provider service. So most of the aged care services are provided through the hospital in our district, and they provide a whole range of services from home nursing respite care, gardening, all those sort of things. So the whole range of things are delivered through the MPS.

MS MAUD: So the MPS has a hospital that has an accident and emergency department; is that right?

MR KRIEG: It does. A small accident and emergency department, mainly to stabilise people involved in an accident so they can be either shifted to our regional hospital which is in Northam, or airlifted or driven by ambulance to tertiary hospitals in Perth, and it's a pretty important centre for that sort of thing.

MS MAUD: Yes. And does the MPS also have residential aged care facilities?

MR KRIEG: It does. I wrote down some stats about what it does have if you don't mind?

MS MAUD: Sure.

MR KRIEG: We have one palliative care room in the hospital, in the MPS hospital. We have a high care unit which has got six beds in it. We've got a further six beds for acute care and care awaiting placement for people. And then off-site we have Pioneer Lodge which is for people who are not high care but need residential care, and then there's a private provider that provides the high care, and another 26 beds that's done by a private provider.

MS MAUD: So Pioneer Lodge that you mentioned, how many beds does that have for - - -

MR KRIEG: 15 beds. That was built by the community quite a number of years ago but since taken over by the WA Country Health Service and run as part of the overall collective of services that are run out of the MPS.

MS MAUD: And in your experience how does the MPS work with the private residential facility that's in the town?

MR KRIEG: Reasonably well. In that the private provider was given money from the Federal Government to establish in York. I'm not sure exactly how many years ago but not that long ago, five or six years, seven years ago, and they now take the dementia-type patients. They've got a secure facility and the Pioneer Lodge deals with those people who are not such high care patients and they can come and go a little bit as they please. There's quite a split there, but they work together where people go to one or go to the other, and for medical services, if one of the people in the dementia unit, the private place, falls or something, they are taken up to our hospital for triage and care as needed. So there's quite a good working relationship between that provider and us, but, yes.

MS MAUD: And you mentioned that the MPS provides home care services. Can you explain what those services are and how they work?

MR KRIEG: Well, we have three home care nurses. One looks after Pioneer Lodge. One delivers home care nursing and the third one is the coordinator of the home care system. So she's the lady everyone goes to when they need help or until the changes, which was last year, that was how services were delivered. She – people would ring her and she would coordinate, you need whatever. They've been assessed by the ACAT team that they need some in-care help, that may have been help with their cleaning, that may have been help to get to the shops or it may have been some gardening or whatever else. So that lady, a third nurse, looks after all of that.

We've got a lot of volunteers that work in the system as well. We've got cars that take people, that are supplied by WACHS, WA Country Health Service, that take people off for doctors' appointments in Perth or over at Northam which is our regional hospital; they're driven by volunteers. We have volunteers that deliver the Meals on Wheels. Meals on Wheels are also cooked in the hospital, in the kitchen of the hospital but volunteers deliver them. And all those ancillary volunteer staff are monitored by our nurse manager, if you like, who's under the direction of our overall manager of the MPS, and those volunteers are encouraged to report back how Mrs So-and-so is going or what's going on down there and so-and-so needs any more help, tell me, and someone went there yesterday and saw that so-and-so hadn't had a shower for a couple of days, can you see if that's happened since yesterday.

So the volunteers don't actually do the things that need to be done, but they report back to Sally who then organises for the nurse practitioner that deals with home nursing to actually go round and maybe check on how that particular client is going, and maybe arranges for some extra help or whatever they need. So that's pretty much how it works.

MS MAUD: And has that system worked well in York?

MR KRIEG: It works really well in York. We're a small community. There's only about 3800 people in total in the shire. Around about 1200 houses in York. The rest are on farms around about. The main industries are farming and tourism. Mostly English-speaking; very few people that are not able to speak and communicate well in English.

MS MAUD: And you mentioned in your earlier answer some changes to the system. What are those changes?

MR KRIEG: WA was one of two States, I believe, that resisted taking on the home care packages, or the client-directed packages about home care, but in June or July 2018 we were told that that was going to happen from then on. So the HACC services continued under the home care system and new clients were then expected to find an external provider who would come in and deliver the services. And WACHS, or our MPS was excluded from being one of the options that they could use, even though the Minister of the day said there was no reason why they couldn't do it, but the State government elected that we would see if we could make it work with private providers. There wasn't any consultation about that process, it just seemed to creep up on us. Although, there was some discussion in 2016, there wasn't any consultation.

MS MAUD: So, just to understand that, customers in the York area who were receiving home care through the local MPS prior to July 2018, are they continuing to receive those services through MPS?

MR KRIEG: They continue to receive that. and there must be some block funding. And it comes from the Federal Government to cover that.

MS MAUD: And if their needs change, what will happen now under the changes?

MR KRIEG: If their needs change – and if I could give you an example of what happened last week. One person who's been receiving those services through MPS, an old – older than me person, receiving his services through the MPS was re-assessed and eligible for then higher level care, which meant that he had to go to a private provider to get that, which meant that his care that he was getting through the MPS was cut off.

Now, this man is old and he is frail and he does receive in-home nursing care. His nursing care is now coming from Toodyay, which is around about 70 kilometres

from our town. Now, in a bad situation where he perhaps has a fall or something, he doesn't have access through the MPS to the care he was receiving. And just the stress of knowing that he can't do that is having a detrimental effect on his capacity to cope, really. He feels insecure now.

MS MAUD: Yes. In the past when the care was being provided through the MPS, if that customer or a customer generally was to have a fall, what would their options have been then?

MR KRIEG: Ring the hospital. The home care nursing person, if she was available, would be there within – the hospital wouldn't be more than 10 minutes from his house. The hospital's not more than about 10 minutes from anyone's house in York, but could get there pretty quickly and see what the assessment – what the need was or he could ring triple-0 and an ambulance would be there and get him to the MPS site quickly.

MS MAUD: And, now, using a private provider, if a person needs care quickly, unexpectedly, what would happen?

MR KRIEG: You would still have the option of ringing the ambulance, but if it was something that he was not so desperate, he could ring his care provider 70 kilometres away. And that's then an hour or so journey to come – not an hour, but 45 minutes at least to come from where that person is to where he is to assess the situation.

MS MAUD: So have many private providers made services available to the York area since these changes?

MR KRIEG: It is – there's cherry-picking going on. There's bits and pieces that are happening. One person has got a level four package. His carer that does his housework and those sort of things comes from Beverley, a town about 30 kilometres in the other direction. He's happy with the cleaning and so forth, but he's not happy when he has to go to a doctor's appointment in Perth. She – or that person also provides that service.

With our car system under the MPS a client will pay $20 and they will get taken to Perth, see their specialist, usually two or three people in a car, so they get dropped at various doctors or hospitals around the city, and then picked up in the afternoon and brought home. But this particular individual, on a Friday afternoon he was told there was no money in his package to take him to his specialist appointment. He's got liver cancer. No one to take him to his special appointment – no money left in his package to take him down to Perth on Monday morning. So that's how I got involved with him.

And he told the chemist that and he was very distressed about the situation, "How am I going to get there?" And the chemist rang me and said, "What can we do?" I rang the after-hours number for his service provider and by Sunday afternoon they decided they would take him to his doctor's appointment. But the cost of him going

to the doctor's appointment was $300 plus, about $345, because he gets charged an hourly rate for the person who derived the car, plus mileage for the car going to Perth. And he could have done that for $20 through the MPS system.

So it's sort of very scratchy about how the service is provided and not very efficient, and very distressful for the person involved. The man involved is struggling with his health anyway. And to then be told "We can't do this, because there's no money. You've spent all the money out of your package" just doesn't seem reasonable to me.

MS MAUD: And is – you mentioned the provider was coming from Beverley in that instance. Are there other providers that are closer to York?

MR KRIEG: No. No.

MS MAUD: And does that raise issues for the use of packages in the area?

MR KRIEG: Well, the whole MPS service is designed around being local. So people don't have big costs about travel from other towns to provide services. So our nearest bigger town, which is a town about the size of Mudgee, is Northam, which is where our regional hospital is. And that's the closest place where some providers could be there.

We have stories about people. You know, a lady had an operation in Perth, went to recuperate for a while with her daughter, was provided nursing care in her daughter's house while she was having her wounds dressed or whatever she needed. When she decided she was coming back to York, that particular service provider said, "Well, I don't go to York. Make some other arrangement." So that fell back on the MPS.

So I think WACHS – WA Country Health Service are doing their best to try and make this work and people are getting helped a lot by WACHS, but at the expense of the state health budget, rather than the Federal Government. You know, we had another fellow whose wife had MS and had a level four package, but could not obtain a service provider to deliver what his wife needed in town. So that was actually picked up by the MPS.

It started just before the changeover, so luckily she sort of had the option of going to the local WACHS service. And, to their credit, they helped her right through to the end of her life with all sorts of in-home care and respite and so forth, all of which is set up in the town anyway. So for someone to actually duplicate that, there's a huge expense of duplicating it, unnecessarily, because it's already there. But for her and her husband, I think there's a bit in my statement about that family, because he is so appreciative of the care that he got through the MPS right to the end of her life, right to the last day.

MS MAUD: And, just to clarify, did you say that she had been approved for - - -

MR KRIEG: A level four package.

MS MAUD: Yes.

MR KRIEG: And not $1 of that level four package was spent.

MS MAUD: And why was that?

MR KRIEG: Because WACHS doesn't have a mechanism for taking the money and no way of actually getting that money into the health budget. Now, it should go into the WA Health Department budget for redistribution, but it doesn't happen.

MS MAUD: Was there a private provider who could have provided those level four package services?

MR KRIEG: Not in York. Not in York. Not really outside of Midland, really.

MS MAUD: So, based on your experience prior to and since July 2018, have you formed views about how home care services should be provided for areas like York?

MR KRIEG: We would like to retain what we've got, which is block funding. Now, when I was working for the division of general practice, there was some research done on what nurses actually did in rural areas. And it – at the time – and I would suggest that it's about the same. It would definitely be the same in York. About 80 per cent of the nursing time is going into aged care in some way or another.

So, for me, block funding, where, if you could just say something like the Federal Government – all right – we should be trying things like the MPS model of delivery, where you can have block funding which actually pays 80 per cent of the operating costs of the hospital, if that's the ratio of nursing time that's going into aged care, and all the ancillary bits that go with that. If that's the case, just a block funding of 80 per cent and the 20 per cent which covers the ED component of what the hospital and so forth does can be paid out of the state's health budget.

Because I feel sorry for WACHS in many ways, because the cross-pollination, you know, who's paying for what. With that guy wife had MS, I would suggest a whole lot of that was paid for out of the overall health budget for York, which is, you know, sort of dodging the figures, not really doing it properly. And I think if we actually set up a couple of models like that where we actually trial and said let's pay for 80 per cent of the health services in York from the state – from the Federal Government's aged care budget, and let's monitor that properly and see how that actually works out. Can we make it work?

Because the notion that even though the principle of consumer-driven aged care and that sort of stuff sounds good in principle, the reality is people just want the service. And I'm not sure that it's cost effective the way we're doing it, when we're having to pay mileage and hours for people to drive one on one in a car to Perth. That fellow who went to Perth for his doctor's appointment could have gone by Uber for half the

price. Now, that's the sort of thing that's going on in our area and I would suggest other areas of WA.

I don't know about over here, but certainly where I am there's other places that would give you other stories, exactly the same sort of stories, where there's huge amounts of money going into what I would call unnecessary expense for these people that are trying to get service. Got to remember that about 90 plus per cent – and it varies a little bit, but at least 90 per cent of the population want the home care stuff, the aged – the residential care only affects about 10 per cent of the population. But we spend a lot of effort saying, "What are we going to do about that part of it?" And we need to do that better, too. But the home care stuff is where people want to be, where they want to live and where they want to die.

MS MAUD: So if there was to be a system whereby a preferred provider was selected to deliver home care packages to areas such as York and if it was open to the local MPS to be considered as that preferred provider, would that be a system that you think would address the needs in York?

MR KRIEG: If the MPS was to be considered, there seems to be an attitude that we don't want our hospitals to deliver aged care. Now, the greater risk is that if we take the aged care out of the MPS system and you're then providing a hospital for ED-type emergency stuff, and you've only got a 20 per cent workload, there's no way you can sustain that. You actually need an MPS model in these small country towns to actually make it work. They've got to have a broad range of activities to keep the nursing staff actively involved in the community.

And the reason MPSs, in WA at least, were set up was because of that very thing 20 years ago. So they looked at how do we actually make hospitals work in rural areas? And the MPS model was established at a place called Dalwallinu and quickly spread through the wheat belt of WA. And in our area we've got 17. In the wheat belt of WA there are 17 MPS sites, all of which would be struggling with the same problems we are.

MS MAUD: And has the York MPS had access to any capital grant for capital development in recent times?

MR KRIEG: We had a thing called Royalties for Regions under the previous government which was about putting some of the royalties from the mining industry in WA back into the areas where the money is generated and the Royalties for Regions did an upgrade on all the MPS hospitals across the wheat belt. It only finished at the end of last year, and our hospital had quite a significant amount of money. I'm not sure exactly how many dollars but it was in the millions spent on upgrading our ED section, and I've got to say that the ED section works really well because we do not have – we have a doctor's surgery in our town but they do not service the on-call stuff at the hospital but we have ETS which is video conferencing with tertiary hospitals in Perth which I believe works better than having a GP at your bedside in the case of an emergency.

I had an experience of having a heart problem about 18 months ago, I went up to the local hospital and talked to a cardiologist in Perth as clearly as if – he wasn't even as far away as you are from me here, and was able to make recommendations about what I should do. So in many ways that ETS system works really, really well because the nurses just dial in and get specialist input, no matter whether you need a bone doctor or you need a neurologist or whether you need a cardiologist, you can just talk to the specialist directly related to what you've got, who make decisions on whether you need to be helicoptered out or whether an ambulance would be good or go to your local hospital, or here's two Disprin, go home and get over it.

COMMISSIONER BRIGGS: Might I ask just a question following up something else you said earlier on. There's a real tension between the objectives of the Commonwealth and the States in the MPS service, isn't there? So we hear from the Commonwealth that the residential care beds that are in MPSs, that they seem a bit too hospital-like because they're part of a hospital infrastructure. We also hear that because packages are meant to be consumer-directed, they can't then – the funding controlled by the consumer, they can't put the money into a pooled arrangement because that would then undermine the customer-directed care. So can you respond to how you feel about those concerns at the Commonwealth level, and whether you think they're valid or not?

MR KRIEG: I think – I think – yes, I think I agree in some ways. I know that when that research was done when I was working for the Division of General Practice that the research about the nursing staff also indicated those sorts of things, that the aged care people were treated too much like a – an ED - - -

COMMISSIONER BRIGGS: A patient, yes.

MR KRIEG: - - - type patient care, of forcing older people to get out of bed and have a shower when they maybe didn't need to at 7 o'clock in the morning when you could sleep in till 10 o'clock or whatever. So there was some of that criticism. I think the advantage we have is that Pioneer Lodge is a little way away from where we are and built by the community and people come and go a little bit more as they please rather than a hospital environment. So I think some of that criticism is valid. The consumer-directed stuff, I ask myself whether a person is really that interested as long as they get the care. An older person is not that interested in getting value for money. I believe that responsibility rests with the Federal Government to make sure they're getting value for money.

Some of the things that have changed in recent times with all the extra compliance that's been put onto aged care is that that's money – that money to fulfil that compliance role has actually come out of the provision of service funding, and the provision of service used to be mandated at about 75 per cent of the budget had to go on the provision of care. I think it's now down to about 57 per cent because of all that compliance stuff. So there is really big tension, in my opinion, between State and federal, and I think that the decision around the MPSs having to give up what they had in WA was probably made at a government to government level rather than

– and based on – on the sort of political stance that each government took on those matters.

And I – I – I actually feel sorry for WA Country Health Service trying to accommodate this in a very sparsely populated State. It's very, very difficult and – I supplied with my – an attachment to my statement a copy of the letter we got from our State minister which was actually sent back to our local member, which actually said that the transition period is extended for another two years, with the hope of actually attracting private providers. It's economically not viable.

COMMISSIONER BRIGGS: Yes. I fully appreciate that. I think when policy is being made, people are forgetting a key issue here is geography and the size of this country and that we're not a little country like Germany or the UK. We're a whopping great country, and we need to find arrangements that work effectively. Anyway, I'm taking up your time, counsel, please proceed.

MS MAUD: Not at all, Commissioner. Mr Krieg just mentioned two letters that were attached to his statement and I omitted to mention at the outset that they are in the general tender bundle, they are tab 61 and 62.

Mr Krieg, just to finish, you were talking about the use of technology by the MPS in the provision of health; is technology used to provide aged care services in York in other ways?

MR KRIEG: It is. Particularly with palliative care and that's – I think it's becoming more general to use technology across health services, but with palliative care, people who wish to stay on their farm perhaps, through a difficult period towards the end of their life, our palliative care nurses who are based at our regional hospital, not at our hospital, visit those clients and they have FaceTime with an iPad and so they can get 24 hour contact anytime. And it's helped keep people supported where they are so that's another example of how that happens.

MS MAUD: And just to clarify, so the nurse is visiting the patient in their home and who are they contacting using the iPad?

MR KRIEG: The nurse – no, the patient. The nurse goes and makes contact. With aged care, it's really important to have personal contact. People like to see people. And so the nurses form a relationship with the person receiving the palliative care. They can't be there 24 hours a day.

MS MAUD: I see.

MR KRIEG: And for them it's quite often 150 kilometre drive to get to where that person is. So they set up the iPad with the person and that person has the direct link to the palliative care person – nurse who could be 150 kilometres away. But they can just talk – most of us know how FaceTime works – I've got grandkids and it's a great

thing – but you can actually talk. But it's based on your relationship that you set up in the first place. It's not just something out of the blue.

MS MAUD: Yes.

MR KRIEG: People need face-to-face contact. They need care from people. And compassionate care is more than the delivery the services. My experience is that a lot of the service providers are delivering services. So you can tick the box, they delivered the service. But is it compassionate care? There's a big difference and people in aged care need compassionate care.

MS MAUD: Thank you, Mr Krieg. I have no further questions, Commissioners.

COMMISSIONER PAGONE: Yes. Thank you. Mr Krieg, thank you for sharing your experiences with us. It's very important for the Commission to understand how aged care gets dealt with in country towns like yours and it's been very informative and helpful for our work. Thank you very much indeed for coming.

MR KRIEG: Can I make one closing comment?

COMMISSIONER PAGONE: Of course you can.

MR KRIEG: I believe that we should do a formal assessment of the financial viability of what we believe are MPSs, without just saying we're going to go to these self-directed packages. I know that in our town we could actually quantify the costs and the savings of what we're doing – or what the health system is doing, I'm not doing anything. But we could actually measure that really well and show it against what would happen if we just forgot about it and let it drift. So I think there's a real model there that we could exploit, if you like, or use as an alternative to the self-directed packages, client-directed packages.

COMMISSIONER PAGONE: Very useful. Thank you very much.

MS MAUD: Thank you Mr Krieg. If Mr Krieg could be excused.

COMMISSIONER PAGONE: Yes, Mr Krieg, you're excused from further attendance. Thank you.

MR KRIEG: Thank you.

<THE WITNESS WITHDREW [10.40 am]

COMMISSIONER PAGONE: Mr Gray, do we need time to reconfigure things?

MR GRAY: No, we're all right for the moment, thanks Commissioner. Our next witnesses are Dr Nigel Lyons and Ms Sharon McKay. They're being called to give evidence concurrently. Mr Fordham will announce his appearance while the witnesses are getting ready.

COMMISSIONER PAGONE: Yes. Thank you. Mr Fordham.

MR M. FORDHAM SC: Thank you, Commissioners. My name is Fordham. I appear with my friend, MR FRASER, in the interests of New South Wales.

COMMISSIONER PAGONE: Thank you, Mr Fordham.

<NIGEL JOSEPH LYONS, SWORN [10.42 am]

<SHARON-LEE McKAY, SWORN [10.42 am]

MR GRAY: Thank you, Commissioner. Dr Lyons, what's your full name?

DR LYONS: Nigel Joseph Lyons.

MR GRAY: You are the deputy secretary, Health System Strategy and Planning in the New South Wales Ministry of Health; is that right?

DR LYONS: That is correct.

MR GRAY: You've made a witness statement for the Royal Commission, WIT.0532.0001.0001 dated 21 October 2019; is that right?

DR LYONS: That is correct.

MR GRAY: Do you see the first page of the statement on the screen before you bearing that doc ID?

DR LYONS: I do.

MR GRAY: Thank you. Are there any amendments you wish to make to your statement?

DR LYONS: There are no amendments.

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

DR LYONS: They are.

MR GRAY: I tender the statement.

COMMISSIONER PAGONE: The statement of Dr Lyons of 21 October will be exhibit 12-20.

EXHIBIT #12-20 STATEMENT OF DR LYONS DATED 21/10/2019 (WIT.0532.0001.0001))

MR GRAY: Thank you, Commissioner. Ms McKay, what is your full name?

MS McKAY: Sharon-Lee McKay.

MR GRAY: I beg your pardon. I've been mispronouncing your name.

MS McKAY: That's okay.

MR GRAY: Ms McKay. Thank you. Ms McKay, you are the director of rural health services, Western New South Wales Local Health District; is that right?

MS McKAY: That's correct.

MR GRAY: Ms McKay, you've made two statements for the Royal Commission both dated 21 October 2019. I will read the doc IDs for the first – I will read the doc ID for one of them, WIT.0533.0001.0001. Do you see that document on the screen before you?

MS McKAY: Yes, I do.

MR GRAY: It's a little hard to tell but for the record I will just state that this is the statement in relation to Gulgong MPS.

MS McKAY: Gulgong.

MR GRAY: Gulgong MPS. Thank you. And do you wish to make any amendments to the - - -

MS McKAY: No, I don't.

MR GRAY: To the statement in relation to Gulgong?

MS McKAY: No. All good. Thank you.

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

MS McKAY: Yes, they are.

MR GRAY: I tender that statement.

COMMISSIONER PAGONE: Yes. Well, do you want us to tender the two together or as two separate exhibit?

MR GRAY: I think it's two separate exhibit, please, Commissioner.

COMMISSIONER PAGONE: All right. Well, the first statement by Ms McKay, dated 21 October 2019, bearing the reference number 0533.0001.0001, will be exhibit 21 – sorry – 12.21.

EXHIBIT #12-21 FIRST STATEMENT BY MS MCKAY DATED 21/10/2019 (WIT.0533.0001.0001)

MR GRAY: Thank you. And, Ms McKay, the other statement dated 21 October 2019 is WIT.0534.0001.0001. And that should now be appearing on the screen in front of you. And this is the statement in relation to the Nyngan MPS.

MS McKAY: Correct.

MR GRAY: Do you wish to make any amendments to that statement?

MS McKAY: No, I don't.

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

MS McKAY: Yes, they are.

MR GRAY: I tender that statement.

COMMISSIONER PAGONE: All right. Well, that statement will be exhibit 12-22.

EXHIBIT #12-22 SECOND STATEMENT OF MS MCKAY DATED 21/10/2019 (WIT.0534.0001.0001)

MR GRAY: Thank you, Commissioner. Dr Lyons, I want to address a question to you, but to the extent, Ms McKay, if you wish to say something in relation to it, please speak up after Dr Lyons. The MPS program was established in 1993. You've identified a number of its strengths in your statement, including its flexibility and the ability to share resources within the local health district, including in relation to training, education, electronic records and such like. There's a reference in your statement to obtaining support by local health district-wide clinical streams and

networks. What is the role of the local health district in coordinating access to LHD-wide clinical streams and networks?

DR LYONS: So it's a primary function of the local health districts in New South Wales. So we have 15 geographically based local health districts and they have a responsibility for the population within the boundaries of the district. And each of those communities will have services provided locally, but there will also be linkages to higher levels of care. And so if there's a need for more specialist care, then the connections can be made.

In addition to that, we've, I think over many years now, established mechanisms to support through having district-wide clinical networks and streams, a sense that people who work within a particular area of care can access advice and support from colleagues who might have knowledge or experience that is, you know, more specialised or unique. And that helps people, particularly in rural and regional areas who might have more generalist responsibilities to be able to access advice and support if they have a patient – a client who needs certain levels of care that they may not have, you know, the experience that they feel confident to be able to deliver it, they can get that backup and support. And those arrangements have been ongoing and having developed and having maturing now over 20 years.

MR GRAY: Thank you. Now, just taking that a little further and perhaps with reference to this local health network of western New South Wales – and, Ms McKay, if you want to speak from your operational knowledge of this particular local health network, please do. How does that work in practice? If an MPS decides that it has a deficit in relation to the care of a particular resident, for example, is there a central office to which the MPS then directs inquiries about assistance? And is that a service that is available only to MPSs or can general mainstream residential aged care facilities also do the same?

MS McKAY: I will take that one. Within western we have a centralised centre, formally known as our patient transport unit, which has undertook significant transformation, now called V Care. That service provides non-urgent specialist and emergency support and advice to every facility within our district, whether you're an MPS or a community hospital, district hospital or base hospital. So that's a service that's available. We also have a very robust telehealth system and virtual allied health system, where MPS sites can access telehealth service, consults for residents as required.

MR GRAY: Is there - - -

MS McKAY: It's really been quite a game changer for us in eliminating the need for lengthy transports, which is not ideal for some of our frailer residents.

MR GRAY: Yes. Indeed. Is telehealth more prevalent in MPSs than in residential aged care facilities or are you finding residential aged care facilities in the mainstream in this local health district also have telehealth generally?

MS McKAY: I probably can't speak for non-MPS aged care providers. However, our MPSs due to our rurality and remoteness, have quickly embraced telehealth in the absence of a physical resource, particularly around allied health. And probably for residential aged care that's very much around physio, dietetics and probably speech.

MR GRAY: So do the MPSs, putting to one side the question of telehealth, have an advantage in being able to access these clinical health streams over the mainstream facilities or is it, essentially, an even playing field as regards access to the clinical health streams?

MS McKAY: I would say that we probably have an advantage. We're part of a bigger machine, so to speak, as part of New South Wales health and the wider health district that provides acute services. And MPSs, we mustn't forget, also provide often ED services, acute, subacute. Some even provide surgical services in our district – or one, actually. So we're – by the nature of our organisation, we're very much connected and our nurses are working one minute with an AD hat, acute hat and then an aged care hat on.

DR LYONS: So if I could add a little to that, because I think this is one of the benefits of the multipurpose service model, which is why we've embraced it in New South Wales. It's evolved from the roles of small rural community hospitals where there were changes in how care was provided over time and as technology and advances and lack of medical support often, because GPs may not have been in the communities 24 hours a day occurred, the role of those facilities changed. And our ability to provide services in a sustainable way over time would have been compromised.

The other thing is many of these communities are small and were ageing in the community sense. The population was ageing. So we needed to tailor the services to support those local communities. Many of the hospitals had – and we've still got some small rural community hospitals, where because there are limited aged care services in the town, people will be admitted to the hospital for care. And so this was a whole move 25 years ago to say we need to start to reflect that for these communities we need to provide services that are appropriate and tailored to their particular needs. We need to recognise that there are shifts in how we provide care and what can be provided. And we need to tailor that to the specific needs of the communities. And that's why it evolved.

So the whole concept of having these services together is actually a huge advantage in having a sustainable service model for the town and enables us to provide services in a very cost effective way, but using staff across emergency care, across acute care and into the aged care environment. Now, that creates some challenges because there are different philosophies in care delivery which we're addressing, as well, but it's been very important in creating a sustainable model of health service delivery into small rural communities. And we're very proud of that achievement.

And it's actually – initially I think there were some concerns. They were back in the days where they were first proposed. Many communities were concerned that they were losing their hospital. I think things have moved so far now in most of our community in New South Wales, rural communities are actually asking for MPS models.

MR GRAY: Can I ask you, Dr Lyons, about - - -

DR LYONS: It's seen as a positive.

MR GRAY: Can I ask you, Dr Lyons, about the New South Wales rural health plan which you've referred to. You referred to three demonstrator models in three local health districts relating to the New South Wales integrated care strategy. In the document that you cited, which is in the general tender bundle, but I won't go to it – it's at tab 32, for the record – there isn't a specific reference to integrating aged care into the local health planning in relation to those demonstrated LHDs. I just wanted to give you the opportunity of addressing that.

DR LYONS: So that model of the integrated care was different in different – in the three different sites. And Sharon may be able to talk more about what happened in western New South Wales, because that was one of the sites. So the approaches that were taken were different. So in some of the districts it was around integrating community care around chronic conditions that were being managed better. Aged care may not have been a focus in some of those, but I think in others aged care would have been a component. And I would be interested in Sharon's comments about how that might have worked in western New South Wales.

MS McKAY: Whilst the aged care demographic wasn't particularly targeted in the demonstrator sites, in western, I think we could say that the nature of the population that we were engaging to try and maintain at home, keep healthier or optimise their health to the best that we could, and avoid hospital – or unnecessary hospital admissions, most of those clientele would have been the over 65 demographic.

MR GRAY: All right. Thanks.

MS McKAY: So I'm fairly confident that aged care would have been incorporated into those demonstrator sites.

MR GRAY: Can I ask you about one of the weaknesses that you identify and others identify in the MPS model for caring for older Australians who are needing residential aged care. And it's the home-like environment criterion of the new quality standards. Is it the case that the new quality standards don't per se apply under the statutory regime yet, but you are under agreement obliged to comply with those new quality standards, and there's a module being produced under the accreditation standards promulgated by the Australian Commission on Safety and Quality in Health Care, which is an exposure draft which is due to come into effect in

2021 which will cover home-like environment. Are you on track? Is that all correct? Is my understanding of those matters correct?

DR LYONS: That's correct. And we're very committed towards moving towards a more home-like environment .....

MR GRAY: So how – are you on track to be able to do that and will it require infrastructure investment?

DR LYONS: It may require further infrastructure investment, which we've made a commitment to. So in 2015, I think, we announced a capital program for refurbishment of some of our MPSs over time to reflect the fact that since many of them were built in the early 1990s to now, the standards have evolved, the approach in out we provide care has matured and there is a need to refresh and renew based on those new standards of care.

MR GRAY: So are you going to need capital contributions from the Commonwealth on that matter and how are those discussions going, if you do?

DR LYONS: So we've in New South Wales provided the vast bulk of the capital for the MPS program over time. And I think there have been a few examples where the Commonwealth have made a contribution under the Health and Hospital Fund program in early 2012, around that time. And that was a 50 per cent contribution for three or four sites around the state. But the vast bulk of the capital program has come out of state capital.

And that's because the MPSs that we've implemented in New South Wales have been rural community hospitals that have changed their role and we've, basically, initially refurbish some, but mostly rebuilt to reflect that new service model. And so the capital has been provided through the state. So that's one of the deficits at the moment in the model, is that we don't receive a capital of contribution from the Commonwealth for those services.

MR GRAY: Notwithstanding the absence of it, you don't see any difficulty in meeting the July 2021 timeframe for providing a home-like environment?

DR LYONS: Well, it's not just around the capital in that regard; it's around the practices. And we've actually introduced a whole range of supports for our staff in MPSs. There was a program of Living Well and MPS developed a toolkit from the agencies for clinical innovation in New South Wales, resources supports for staff, training, education, and a self-assessment, checklists,. There's a whole lot of resources that have been provided around how we can move our thinking and our approach and philosophy to be much more around a home-like environment for the residents.

MR GRAY: And those Living Better resources are tendered into evidence in the tender bundle in this hearing?

DR LYONS: They are.

MR GRAY: Ms McKay, in your statement – this is in relation to the Gulgong MPS at paragraph 17 to 18 – you address the absence of a requirement for a means-tested care contribution as both a strength and a weakness. I'm talking about the absence in the context of MPS, when one compares MPs to mainstream residential aged care.

MS McKAY: Yes.

MR GRAY: Could you explain what you mean by it being both a strength and a weakness.

MS McKAY: And I've just prefaced that; I've said that for Gulgong and not so much for Nyngan where we've got an MPS and a community where there is no other provider, it doesn't appear to be an issue. It can be an issue in a town such as Gulgong where there was a pre-existing provider with a significant residential aged care base. I think they have 25 which is two kilometres away, so that means testing, a lot of the population would probably prefer to come into an MPS where there's no income and asset testing, there's no bond or deposit and it's just the daily rate that's set by the State.

MR GRAY: So Ms McKay, the weakness is the very same thing as the strength, is it - - -

MS McKAY: It creates a tension.

MR GRAY: Well, that can be unfair on others, I assume.

MS McKAY: Yes, yes.

MR GRAY: So Dr Lyons, does New South Wales have any plans to iron out this potential inequity, that is, when you compare those requirements that apply to mainstream residential care with the absence of them in the context of MPSs?

DR LYONS: I think this is emerging as an issue through changes in policy and approaches to the payments models that – and that's varied over time from the Commonwealth's perspective. When we were initially introducing these models it was, as I said, because they were small rural community hospitals with many people admitted who were under residential aged care so - - -

MR GRAY: Pardon me, we're just so short on time.

DR LYONS: That's okay.

MR GRAY: Do you have any plans to iron it out?

DR LYONS: We are open to those concepts. I think at this stage our issue is that we actually tailor our approach to the introduction of MPSs to the local community. So the planning will be done by the local health district in a particular town involving the local community and the current providers. We are not in the business of wanting to be competitive. We're wanting to be collaborative. So where we are thinking about providing a different model, we will work with the local providers to assess whether or not that's an appropriate way to introduce additional resources for aged care into the town, and how we can do that in a complementary way with the existing providers. We're not at all interested in trying to be competitive. We're want to be collaborative.

MR GRAY: Have you seen a copy of the October UTS report on the MPS program?

MS McKAY: Only yesterday, I have. Yes.

MR GRAY: Just very recently.

MS McKAY: Yes.

DR LYONS: I was provided yesterday as well.

MR GRAY: All right. Well, perhaps it's unfair to ask you whether you've had a chance to reflect on the recommendations, including recommendations around achieving uniform approaches across the country, and ironing out inequities on matters of this kind in contribution disparities. It sounds from your answer that you're not going to be implementing a system-wide one-size-fits-all set of means-tested contributions for the MPS system but it's going to depend on location. Is that - - -

DR LYONS: We have no plans for a State-wide position on that at this point in time. The point I would make is I think we need to be thinking about providing aged care in a way which reflects the needs of communities, and we are a very large and diverse country and the particular needs of rural and regional communities can be different to those in metropolitan settings. So where market – a market might be available in a large community where there is opportunities for choice. When we move into many of these communities we've got major challenges in continuing to provide services due to workforce issues, geography, disparity in population dispersion. All of these factors need to be thought about in the context of how do we provide appropriate care for the people who live in those communities. And I think we need to tailor our approaches to the fact that it is different in different environments.

MR GRAY: Just taking that one step further and then I will move to another topic. By reference to those sorts of matters which, in a sense, all contribute to scarce or even a shortage in supply of aged care services in a particular location, is it your intention to approach this question of when to impose the means-tested contribution

requirements in line with mainstream residential aged care on the basis that if there's a workably competitive market in a particular place, then it will be appropriate for competitive neutrality reasons to impose those requirements but where there isn't a workably competitive market, there won't be such reasons.

DR LYONS: They would be considerations in relation to our move if they were to be movement in that direction; as I said, there are no plans at this point in time. And I do think we need to think about in the context of the points I made before which is that we want to work in collaboration with the providers in those existing towns. So as Sharon has highlighted, it can create some tensions. We don't want to create tensions where we can avoid those tensions. We want to provide the best possible care, person-centred, in the town, for those residents in the town so our approach will be focused around how we can achieve that.

MR GRAY: Thank you. I just want to ask about another aspect of collaboration, not local collaboration but collaboration with the Commonwealth. There's a reference in the material to the former mode for the allocation of flexible MPS places, and the gist of what's said is that there was a more collaborative consultative model for allocation of flexible MPS places in the past, but that's at some point become more of an application and allocation process which doesn't have nearly the degree of consultation and discussion that the previous mode of allocation had. Dr Lyons, do you wish to speak to this? Are you making a criticism of the current level of consultation you're getting with the Commonwealth around the allocation of flexible MPS places.

DR LYONS: Might I frame it in the positive and say there's an opportunity to improve and that, you know, in the past there were different approaches to how these agreements and arrangements were negotiated and agreed between the Commonwealth and the State. In the last five-plus years, we've tended to move away from arrangements where we work together in planning and agreed where the next priority might be and the process for establishing an MPS-type model and the places to support that into these rounds of funding where we're considered to be just another provider. And I think what that's created is a difficulty for us in working through some of our state-based process, particularly accessing capital money. That's a program that's four years – 10 years in advance in terms of thinking about where we need to be and the priorities for investment.

And so it's – I think there's an opportunity for us to work much more closely. And this whole concept of us being another provider, while I accept that in principle and the concept of it, I think it does create challenges for us as we work together to resolve these issues. I mean, we are so inextricably bound with the Commonwealth around responsibilities for health, aged care, disability, it's important that we work collaboratively in all of these interface areas and we find solutions, particularly when we get into smaller rural communities where it's critical that we find solutions that will work to support those local communities.

MR GRAY: So is one of the key points there the need to really engage with local issues and the only way you're going to do that is through a consultative process?

DR LYONS: Absolutely. You know, joint planning, high levels of consultation, discussion around the relative priorities across the geography. We're happy to have a conversation across national geography if we need to in terms of priorities but we need to think about the needs of those communities and work with the Commonwealth directly, rather than be at arm's length and just be considered another provider.

MR GRAY: How does New South Wales Health ascertain the level of access at that local level, and I'm talking about a much greater level of data than might appear in, say, the report on government services. Is there any data available to the Ministry which indicates where the gaps, disparities and inequities in levels of access to various modes, I think in particular home care, might be. How do you go about trying to identify those gaps?

DR LYONS: So the first point of assessment is the local health districts. They have the responsibility of making those assessments for their local communities and then that is – that information is conveyed through to the Ministry on a State-wide basis and then we look across the State at the relative needs based on the input in the planning processes from the districts, and that gives us a sense about where, across the State, we might need to focus, where the particular gaps are and where the priorities might need to be addressed.

MR GRAY: Would there be a case for establishing, in essence, a nation-wide mapping process of the level of access to aged care services particularly at that higher level in the home care space, that people are getting in rural and remote areas so we that can discover on a nation-wide basis where the variances are?

DR LYONS: The challenges in that, I think, and it would be useful – the concept of it I can see is very appealing. The challenge will be about the fact that across even New South Wales we have huge variation in what services are available to local communities, the needs of the communities can be different. We need to factor in a whole range of different things in that assessment process. So it will be difficult. And the first thing to say is it won't be static either, it will change. The movement in what happens in communities with – whether a GP is in the town or not, whether there are certain services available in the town or not, that can vary and can change quite quickly.

MR GRAY: I understand that. But would you see a use for it in trying to identify disparities based on degrees of remoteness from population centres?

DR LYONS: If we could agree on how that could be assessed and we could address issues I said which will be confounders then, yes, it would be useful.

MR GRAY: I want to raise some other propositions with you. Now, I haven't asked about what you say, Ms McKay, on workforce issues and there are a number of things in your statement that I haven't had time to ask further about, but perhaps before I go to the detailed propositions, I will just ask you about a couple of programs or mechanisms that you mention, Ms McKay, in your – in both your statements, in the Gulgong one in paragraphs 87 to 97 and in the Nyngan one at 89 to 99; you're addressing staffing issues there and that widespread and well-known issue about challenges in obtaining adequately numerous and adequately skilled staff in rural and residential – I beg your pardon, rural and regional areas for the purposes of providing aged care services.

And you identify an increasing trend toward what you call the use of premium labour such as agency nursing; do you mean premium in terms of the cost?

MS McKAY: Premium as in cost. So high-cost labour.

MR GRAY: Yes. And perhaps I will – either of you please answer this. Does the Ministry have a view on whether the current level of funding for basic daily care is keeping pace with whatever those cost-based differentials may be in rural and regional areas for your MPS program, or do you think it's not keeping pace and needs to be raised?

DR LYONS: Well, the first thing I would say is that we have a differential rate to other providers so we've always had a lower rate of funding from the Commonwealth. And one of the issues will be about whether if we move towards more standardised and consistent approaches that would need to be addressed. We've always provided resources to the MPSs based on our funding mechanisms at the State, and we recognise that we will be providing additional sources in to support the fact that residential aged care can be provided in those MPSs through the funding we provide at the State level. So I would say there will be, you know, a huge amount of additional resource that the State is providing in to support these MPSs and the care of the residents in those over and above, you know, the rates that we receive from the Commonwealth in terms of the revenue streams.

MR GRAY: Have you quantified what the extent of the gap in meeting the staffing cost base might be?

MS McKAY: Not specifically. However, from my experience and monitoring, you know, expense budgets, the more rural and remote you go, so in western New South Wales LHD, as you go north and west from here you will find the expense budget for labour is a lot higher, which is indicative of the challenge of trying to recruit into very small communities when you require a skillset of a registered nurse.

MR GRAY: You do also mention a source of assistance, the LAP program or Locum Assistance Program, but that's Commonwealth-funded, I understand. Is that right?

MS McKAY: Yes, the rural LAP program. That's available for leave relief, so that's planned. It's not always available when we need it, but we encourage our – our facility managers often will try that in the first instance before we go to agency-type staff.

MR GRAY: Are there any workforce – specifically rural workforce directed subsidies that represent a loading on – on what might be your base funding for basic daily care, which is intended to try to bridge this gap that you receive from the Commonwealth?

DR LYONS: So our staff are employed under industrial awards at the state level. And that's uniform across the state and there's no variation on those, depending on the geography or site in which they're working. The only variation of that that I'm aware of is for junior doctors who are seconded from metropolitan sites into rural. And they get an increment for the time they're actually out in the rural services. But the rest of the staff are employed under the consistent arrangements and the industrial awards, state level.

MR GRAY: Now, in terms of workforce, in particular attraction, retention and training, we've got a proposal – I've got a proposal that I would like to raise with you and test with you. And it's not intended to be at all limiting. If you wish to make any other suggestions and proposals, please do. But would it be workable and appropriate, do you think, to implement a widespread rural and regional scholarship program to entice, both at the VET level and at the nursing level, workers into the aged care sector in rural and regional regions? Possibly scholarships conditional upon them then taking up positions if they're offered to them in rural and regional areas.

MS McKAY: Being bonded.

MR GRAY: Well, bonded is a difficult word.

MS McKAY: Yes.

MR GRAY: There might be conditions about – who knows – about refunding of a portion of the scholarship if it doesn't eventuate or something of that kind.

MS McKAY: I think it would be valuable. Outside of the MPS, I have other responsibilities with other facilities. And even with our medical workforce, we're looking at how we can present something to the Commonwealth on some innovative ways of recruitment and retention, particularly around whether it be, "We will pay your HECS debt if you stay with us over time", particularly in rural and remote areas. I would value it if the Commonwealth was able to come to the party with some sort of incentive.

DR LYONS: Certainly at state level we are providing scholarships. And there have been a number of scholarships that we have provided to support service attraction

and retention in rural environments. I think scholarships are one component which might be seen as a positive. I know that in many of the rural – and it varies across – think the LHDs their approach is trying to ensure that they've got appropriately skilled staff.

But the sorts of models that have worked in health services that I've been responsible for in the past have been where you have a resident in the town who might take on a role where we actually provide support for them to gain skills. Initially they might come in at a lower level of skill and we will provide them support through a VET program initially and then maybe onto a degree program. Particularly in nursing those have worked very well.

And the benefit is you've actually – you've got somebody who's already committed and based in the town and has those connections with the town, who is then provided employment opportunity, but also gains skills whilst in employment. And that creates this sense of, you know, commitment to the organisation and sustainability of service delivery.

MR GRAY: Another limb of this proposition might be that there could be linkages encouraged between aged care providers and local RTOs, or possibly TAFEs, if they exist in rural and regional location. Does that have – does that have attraction in terms of its workability?

MS McKAY: Definitely. One of our challenges, however, in rural and remote is still needing to go to the larger regional centre. So I've got some communities where there's staff that are really interested in undertaking their assistant in nursing or cert III, IV for enrolled nursing, but due to family commitments or farm commitments – many of ours are married to farmers – find the travel to Dubbo and needing to stay in Dubbo for study a real challenge.

MR GRAY: So the idea of specific targeted subsidy programs to assist establishment or extension of RTOs, so that they have a presence nearby rural aged care providers, has attraction, does it, and seems workable?

MS McKAY: Absolutely, or even better use of telehealth, you know, video conferencing. We're doing it in health, so why can't we do it in that space?

DR LYONS: Yeah. I think that's right. I mean, within New South Wales we have the Health Education and Training Institute, which is an RTO. We've moved to much more extensive, because of this issue about staff not being able to move for educational opportunities, much more online courses and using technology to support educational opportunities in situ. And I think that's one of the things we need to make sure we address in this process, use the technology to support people being able to gain that experience and knowledge, do that in their site.

The other thing we do is we've got a mobile clinical simulation, a team who actually go out and provide teams-based clinical experience and exposure to training. Those

things are the sorts of things we need to move to, which is, rather than having the individual having to go to the educational opportunity and travel and move away from family and the challenges that creates, actually take the education to them. And we're doing much more of that in health in New South Wales. And I think we can extend those concepts.

MR GRAY: In the limited time remaining, I will just raise a few other propositions quickly and just test them. Firstly, with respect to the MPS program specifically, should there be a targeted program of expanding the MPS program into areas with thin markets?

DR LYONS: So, in my view, it is a solution that addresses this issue around the fact that in rural and more remote you get we don't have services, there is no market. And this is a way to address providing access to care and to service to communities that would otherwise not receive access to that care. I think it's really critical that we ensure that there's an assessment of the environments in which that's appropriate, though.

And I think that joint planning process is the really – the key thing, which I talked about earlier, that each community needs to be assessed. And they need to be assessed, because they're all very different and we need to assess whether or not there is an appropriate way to expand service through MPS models. If that's not the appropriate model, what's the right model for doing that? And it might be that it's – if there is a market there, then there's a potential to use other providers.

MR GRAY: Dr Lyons, you've expressed New South Wales support for the proposition of an extension of sufficient capital grants to refurbish MPSs to assist the Living Better principles and meet the home-like environment requirement by 2021, in any event. But presumably you would also have a view on the following proposition. The Australian Government, together with the State and Territory Governments, might agree upon and establish a capital grants program to rebuild and refurbish older MPSs to ensure that the infrastructure is suitable for residential aged care, including dementia care.

DR LYONS: Absolutely. I think this is a big challenge for dementia care and managing people who've got challenging behaviours is increasingly a challenge for our services. And so the physical environment in which that care is provided is really important. So I would definitely support that that is a need.

MR GRAY: In addition to those two particular propositions I floated a little earlier about workforce initiatives, what's your view on a proposition that the Australian Government, together with the State and Territory Governments, should agree upon and establish a program of initiatives of that kind and other related initiatives to improve workforce training, recruitment and retention in rural areas?

DR LYONS: I think the state's doing a lot in that regard. We're always very happy to work with the Commonwealth and other states and territories to look at what are

the issues we can work on together. There are lots of conversations around this at Australian Health Minister's Advisory Council, which I attend on a reasonably regular basis. There's an ongoing commitment to that at both state and national level. We're very happy to continue to work to look at ways that we can further support attraction, retention and workforce, particularly into rural and remote environments.

MR GRAY: And, finally, on the question of a level of funding that MPSs are receiving for basic care, what do you think of a proposition whereby an independent price setting mechanism might be established, perhaps along the model of the Independent Hospitals Pricing Authority?

DR LYONS: So I think there is a need to understand the costs. Given that we are providing services for emergency care, acute care, there are other services on those sites, as well, that create that, you know, the pooling and the benefits of the economies of scale and the critical mass, the component cost of each of those – you know, the fixed cost, the variable costs, the various components that come together I think we need to understand in greater detail.

We've done some work in New South Wales around a state model for funding those services based on some of those principles, but we're very open to having an independent assessment. Independent Hospital Pricing Authority is well known to us. We worked with them on hospital pricing and funding now. So their knowledge and expertise is, I think, acknowledged by us.

MR GRAY: Thank you. What's the New South Wales model called?

DR LYONS: I think – I will have to go to my notes - - -

MR GRAY: Yes.

DR LYONS: - - - but I think we call it the Small Rural Hospital Funding. It's got a mix of fixed costs and block funding, as well as activity, because we recognise that the small hospitals there isn't enough activity to ..... activity-based funding.

MR GRAY: You refer to it in your statement.

DR LYONS: I do.

MR GRAY: And you contrast it with activities.

DR LYONS: I do.

MR GRAY: I have no further questions, Commissioners.

COMMISSIONER BRIGGS: Thank you both for your evidence this morning. There are a lot of questions I could ask you, but I will focus on something that flows

out of Ms McKay's community nurses story. What we're interested in is how to ensure that people living in the community get good access to nursing services as and when they need them. Do you have suggestions for how that might be improved in the areas outside the cities, the big capital cities?

MS McKAY: I think, generally, we have scarce resources within our rural MPS settings. There may be only one community health nurse. A lot of their time is taken up with supporting older people in the community. Whilst we're not the deliverer of high care packages, we do have home care places allocated within some of our MPSs across the district. We were fortunate enough that we've got a fabulous manager who negotiated with the Commonwealth many years ago to pool those.

So, rather than being site by site, we've centralised those, so we can provide emergency home care places to those that most need it whilst they're waiting on the national queue, which in some of our communities is 12 to 18 months, which is unsatisfactory. We would value some more places that we could quite easily support from a community nursing side of things to keep people well in their home.

COMMISSIONER BRIGGS: Dr Lyons, do you think that would improve the efficiency? But say whatever else you were going to say, too. I don't want to interrupt.

DR LYONS: Well, I think it highlights one of the issues generally in aged care, is that increasingly our sense is that the state is stepping in to provide services, because there is the lack of service available for whatever reason. And so the concern for us is that what happens in residential aged care is if people can't access care when they need it, whether that's medical care or nursing care, then often what happens is that they're transported to an emergency department by ambulance. And that's not good care for the individual and it's not the best place to provide that care often.

And so what we have seen increasingly across our local health districts is they've increasingly looked at models where they provide inreach to the residential aged care facilities or provide services in the community that support people where they need access if they can't get access under the aged care arrangements. And so we are stepping in as a state to provide those services where they don't exist, because if we don't provide that care, these people will end up having their health deteriorate and they will end up in our emergency departments and our hospitals. And that's not the outcome we want for them.

COMMISSIONER BRIGGS: Yes. It really does seem that there's a clear need for an effective mechanism to manage the provision of nursing services. And at the moment state, Commonwealth, the system isn't working as well as it might.

DR LYONS: There's no doubt about that.

COMMISSIONER BRIGGS: Thank you.

COMMISSIONER PAGONE: Thank you, both. It's been very informative and very insightful. Thank you both for attending. You're both excused from further attendance.

<THE WITNESSES WITHDREW [10.29 am]

COMMISSIONER PAGONE: Mr Gray, we've got a little over time, but the issues are, obviously, very important and you need the time to pursue those that you need to pursue. So we had scheduled to break. Presumably if we have the 10 minute now - - -

MR GRAY: Yes, please.

COMMISSIONER PAGONE: - - - and then add that onto the bit immediately before lunch.

MR GRAY: Yes. Thank you, Commissioner. We're going to move to a witness by video link after this short .

COMMISSIONER PAGONE: I see.

MR GRAY: And then I'm going to begin another witness after that. And that witness is going to run over lunch, in any event. So I think things will even out.

COMMISSIONER PAGONE: Sure. Sure. Sure. Thank you.

UNIDENTIFIED MALE: Commissioners, may we be excused?

COMMISSIONER PAGONE: Yes. Of course. You're excused also. And we will resume at 11.40.

ADJOURNED [10.30 am]

RESUMED [11.43 am]

COMMISSIONER PAGONE: Mr Gray.

MR GRAY: Thank you, Commissioner. I call Margaret Denton who is currently on video link.

<MARGARET ANNE DENTON, AFFIRMED [11.43 am]

<EXAMINATION BY MR GRAY

MR GRAY: Ms Denton, my name is Gray.

MS DENTON: Good morning.

MR GRAY: Good morning. What is your full name?

MS DENTON: Margaret Anne Denton.

MR GRAY: You've made two witness statements for the Royal Commission, haven't you, one dated 18 October 2019 which is of a general nature in relation to your role and supervision of MPS services in the WA Country Health Service; is that right?

MS DENTON: Yes, that's correct.

MR GRAY: Let's deal with that one first. It's WIT.0535.0001.0001. Do you have access to that document bearing that document ID?

MS DENTON: Yes, I do. Thank you.

MR GRAY: Do you wish to make any amendments to that statement?

MS DENTON: No.

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

MS DENTON: Yes, they are, to the best of my knowledge.

MR GRAY: I tender the statement.

COMMISSIONER PAGONE: Yes. That statement of Margaret Denton dated 18 October will be exhibit 12-23.

EXHIBIT #12-23 STATEMENT OF MARGARET DENTON DATED 18/10/2019 (WIT.0535.0001.0001)

MR GRAY: Thank you, Commissioner.

Next, Ms Denton, your second statement is WIT.0587.0001.0001 dated 23 October 2019 in relation in particular to two MPS services in the Wheatbelt region supervised by WA Country Health, and those MPSs are York and Kellerberrin; is that right?

MS DENTON: Yes, that's correct.

MR GRAY: Do you have access to that statement?

MS DENTON: Yes, I do.

MR GRAY: Do you wish to make any amendments to it?

MS DENTON: No. Thank you.

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

MS DENTON: Yes, they are.

MR GRAY: I tender that second statement.

COMMISSIONER PAGONE: The second statement of Ms Denton dated 23 October 2019, exhibit 12-24.

EXHIBIT #12-24 SECOND STATEMENT OF MS DENTON DATED 23/10/2019 (WIT.0587.0001.0001)

MR GRAY: Thank you, Commissioner.

Ms Denton, you're the chief operating officer of WA Country Health Service; is that right?

MS DENTON: Yes, that's correct.

MR GRAY: I wish to ask you about your views on the strengths and the weaknesses of the MPS program as administered by you or under your supervision in, in particular in the Wheatbelt region, but just stepping back and considering the strengths and the weaknesses that you've identified in your statements, what's your view on which outweighs the other? Is it on the whole a useful program or do you think its weaknesses outweigh its strengths?

MS DENTON: I think the principles that underpin the MPS program, so in terms of a flexible arrangement, the cashing out of subsidies, I think the principles as a whole are a very strong point. And I think if we could – some of the weaknesses that we probably outlined in terms of the funding levels, particularly for rural and remote

locations and for country, the capital funding component, if we could address those, then I think the strengths of the MPS model would outweigh the weaknesses. The challenge is the sustainability and viability for country areas is difficult, so without that funding addressed I think it will continue to be a challenge. But I think the key principles around flexibility of service provision, integrated service care are really strong.

MR GRAY: So let's just look at those funding issues. Are you referring only to the capital funding element, or are you also raising issue about the level of the recurrent funding?

MS DENTON: Both. So I think in rural and remote WA we're challenged with increased costs, probably not unlike other remote localities as well where the cost of staffing, general overheads are significantly higher than delivering in a metropolitan area. So that challenges us in terms of service provision generally in rural and remote areas, and managing the financial impost that those geographic and other factors such as, I guess, poorer health status, etcetera, have on the funding mechanism. In terms of capital, I think also many of our MPSs are delivered from existing infrastructure that in some cases is very aged and wouldn't meet contemporary standards, and so without capital investment through the State, we are definitely challenged in that respect as well.

MR GRAY: I want to test a proposition with you on the question of addressing a level of the recurrent funding or subsidy in the future. Is there merit and would it be workable – is there merit in the idea and would it be workable to have an independent authority charged with conducting a costs study and updating that cost study annually, and for, in effect, subsidies to be loaded by reference to an index of remoteness from economic and population centres in the future?

MS DENTON: I think definitely the – having that level of analysis and adjustment on an annual basis would be beneficial. I think what we struggle with is certainly those additional costs but also, generally, community members who are subject to lower socio-economic standards, have less ability to pay for services sometimes at the level required. So I think taking into those – taking into account those factors would be beneficial.

MR GRAY: On the capital element, you've identified in your statement the challenges of creating a home-like environment and that's going to be a matter that's going to be necessary once the aged care module, which is out for discussion having been distributed by the Australian Commission on Safety and Quality in Health Care comes into force, which is due to be in mid-2021, isn't it?

MS DENTON: Yes.

MR GRAY: What's your position on the extent to which the Commonwealth should participate in the necessary capital funding of improvements of MPSs, and

you can limit it, if you like, to the Wheatbelt or you can extend that more generally to the other regional and rural MPSs under your supervision?

MS DENTON: I think, you know, historically I guess we've seen a number of funding reforms and changes over many years in the Commonwealth space in terms of residential care generally. And, you know, where it's a private provider, people are paying bonds or other contributions that would then support providers delivering on some capital investment. WA Country Health has been through a period where it has invested significantly in a range of infrastructure through our Royalties for Regions funded program and historically, again, MPSs have occurred in small locations where it usually was the old hospital that's been converted or transformed to provide a range of services, including residential aged care.

And whilst we can go some way to make, you know, refurbishments, make environments as homely as possible, in today's – in today's standards, we probably would struggle in a number of cases to fully address the standards required. I can think of numerous facilities where, you know, a whole ward has been converted into a residential aged care wing and it's lovely, but it doesn't meet standards so, you know, bathroom infrastructure is shared, people don't have their own outdoor areas, a whole range of things in terms of security mechanisms for people with dementia who may be wandering. That can often be challenging because of the infrastructure and the technology required to support that.

So I think it is, I guess, from a WA Country Health perspective, whilst we do what we can with limited State funds we see a role for the Commonwealth in supporting the delivery of aged care, whether that be residential or community based and a need for greater investment into infrastructure upgrades.

MR GRAY: Have you quantified what you need in order to meet the requirements that are likely to be in place by July 2021?

MS DENTON: We've – we have a raft of work under way currently, both in terms of a minor works program and also we've just been through a process of our strategic assets, looking at what the works are required. So I don't have that number in the top of my head. We could certainly look to provide that, but that would take some time to quantify.

MR GRAY: Would there be merit in a proposition that the Australian Government together with the relevant State and Territory Governments should agree upon an established – a capital grants program based on, amongst other things, detailed data of the kind that I just asked for to rebuild or refurbish older MPSs to ensure the MPS infrastructure is suitable for the provision of residential aged care, including the care of people living with dementia, and for that new infrastructure to be designed in a dementia-friendly manner?

MS DENTON: Absolutely. I think, you know, that would be the ideal solution, really, in terms of having that capital grant available for us to then delivers that residential care component.

MR GRAY: Are you aware of there being any discussions at an intergovernmental level towards such a goal or related to such a goal, or is that simply an idea that hasn't got any reality yet?

MS DENTON: I'm not aware of any governmental relations. I know we have had discussions on individual places where we've been – I'll give you an example, so Carnarvon residential aged care, we're just about to invest State funding into that to build a new residential aged care facility, and so in terms of that commitment there was numerous correspondence between State - - -

MR GRAY: State and Federal Government? Just pardon us for a moment, Ms Denton, we're having a little difficulty with our link. We're back. Thank you.

MS DENTON: Good.

MR GRAY: So with respect to Carnarvon there's a service-specific discussion that you've pointed to, but there's no – to your knowledge, no systemic intergovernmental discussion around capital grants to bring MPSs up to the standard that will be required when the new quality standards are the basis for their accreditation in July 2021. Is that a fair summary?

MS DENTON: Yes, that's correct.

MR GRAY: Yes. Could I ask you, again, at a reasonably general level, you say in your general statement, paragraphs 25 and then 35 and 37, you say that:

> *MPSs are established typically in thin markets where mainstream services will not be sustainable.*

And you say further that:

> *A move to mainstream MPSs –*

I think by reference to the way they're funded, would disrupt, would be disruptive and have a negative disruption – disruptive impact on them. What do you mean by that? When you express that concern about negative disruption, what do you have in mind? I'm happy to bring it up.

MS DENTON: Yes, I'm just having a quick read.

MR GRAY: Sure.

MS DENTON: I think the point - - -

MR GRAY: Did you find it in paragraph 35 on page 6?

MS DENTON: Yes. Yes. I think my point there was around – so if MPS can't – MPS residential aged care was funded through the current funding mechanism for mainstream residential aged care, I think that would inhibit the flexibility that's available within the MPS model because you would have a requirement, obviously, to maintain that funding level within the residential care environment, and you couldn't flex between community needs and residential care needs as they moved up and down.

MR GRAY: Is there some proposal that the MPS funding model should be changed to the mainstream funding model that you have in mind that you're expressing that concern about?

MS DENTON: Not that I'm aware of. I think we were making a point that whilst we recognise there needs to be something different around the MPS funding model, moving to that mainstream residential care funding model would not be effective either, because that would limit the flexibility that we would have.

MR GRAY: Okay. Thank you. Ms Denton, you've referred to those funding challenges that the program, at least in your area, faces. Could the MPS program in WA be expanded into areas of unmet demand where a non-government – government service might already be operating, but isn't meeting demand? Do you have any views on that? Or is it just there isn't sufficient resources available for expansion of the MPS program in WA?

MS DENTON: I think it's definitely something we've considered. We – in areas where we don't currently run an MPS program. I think there's a number of concurrent matters occurring. So with aged care reforms we're also reforming the disability sector with the National Disability Insurance Scheme, so concurrently we've got two forces coming into play where providers are moving out into markets in rural and regional WA.

And it's a bit of a tension between, you know, how do they develop a market when there's other competitors in that market and how do we encourage them to come in and deliver service and think differently about how they might deliver service across those sectors so it is a viable market for them. So I think WA Country Health in some instances has stepped into the market of aged and disability care where there has been no other provider or they're thin markets.

And in some locations we need to step out of those where they're bigger sites and where we historically wouldn't have an MPS in place. I guess Carnarvon springs to mind again, because it's quite a reasonable-sized population and it does have non-government providers in there in the community space. And so that MPS only delivers residential care component of MPS. And were we to be able to partner with an NGO to run that residential care component, that would be our preferred option,

because, obviously, usually NGOs are much better than doing that than us, you would hope, because that's their specialised area.

So it's quite a mixed picture, really. And I think, you know, there's always opportunity to consider ways of doing things differently. And we would consider the MPS model where there are other areas that are struggling to meet those service requirements. Many of our smaller locations are already part of an MPS.

MR GRAY: Do you conduct some sort of systematic review of localities within the various regions that WA Country Health looks after to determine whether the market is failing in particular locations? You do that on a systematic and regular basis?

MS DENTON: In terms of market failure, that would – generally, we are the only provider. And where we're not the only provider we would become aware of emerging issues. We work closely with – we try and work closely with most of our partners and stakeholders in our service delivery. So they would alert us to emerging issues for them in terms of their ability to sustain a service.

We, obviously, receive concerns in from consumers and community members, as well, directly about their service provision. People ultimately end up admitted to hospitals or presenting at EDs when they have service failure, if there's – if that's the cause of their reason for presentation. And we also have other mechanisms where constituents will go to their local politicians and come through a ministerial channel where there's a concern raised about emerging issues of either service failure or unmet service need. So there's those sort of mechanisms.

We also, through our aged care network, we have an aged care program in every region. And we have a planning and service modelling area, as well. So, working together, they would be looking at what are the demographics looking like, what's the epidemiology looking like, what's changing, and trying to manage and plan service delivery going forward with those key partners, whether that's the Primary Health Alliance, the NGOs that are out in those environments, the Aboriginal medical services.

MR GRAY: So on what unit of geography are those consultations and discussions taking place on a regular basis? Is that in the particular regions, the seven regions?

MS DENTON: The seven regions are all very different. So, yes, it is a regional discussion and sometimes it's even a district or a local site. Conversation where trends are emerging or we've become aware of changes in service provision. So it can happen at a site, base level, district, regional or all of WACHS level. One of the things we have just – we're just finalising is our latest aged care strategy, older person strategy, for the next five years. So some of that outlines the work required, as well, in terms of how we best support aged people remain at home.

MR GRAY: I want to ask you about a point you did touch upon, which is this idea of whether MPSs are competing and to what extent they're competing with provision

by NGOs, as you call them, non-government organisations, whether they be for profits or not for profits. And I want to specifically ask you about the space occupied by the Commonwealth Home Support Program, which has been implemented for only about a year under that name in WA, and also the home care package program.

In your statement relating to the wheat belt MPSs – so that's 0587.0001.0001 – at page 19 you have a section dealing with CHSP. And I just wanted to ask you to clarify an aspect of this. In paragraph 127.4, you refer to services after an assessment being delivered by WA Country Health Service staff in the regions. It's the case, is it, that – well, who are the WACHS in the regions who are providing those services? Are they MPS staff, the MPS having received a CHSP grant by agreement or are they not necessarily MPS staff? Who are they?

MS DENTON: In terms of the regions across regions, we have a variety of different service mechanisms. So through the MPS they've historically had home and community care funding, which, as you said, transitioned across to CHSP last July. So in some cases that would be our MPS staff. We also have some regions or specific locations where services have been contracted directly to WA Country Health. So there was a home and community care contract in some locations that were non-MPS and that has been transitioned to CHSP.

MR GRAY: There was supposed to be a handover or a phase out of the services represented by the CHSP program whereby WACHS would cease providing those services by July 2020. Is that right? And that phase out period has been extended. Is that a correct understanding?

MS DENTON: I think – my understanding is that there's a transition period for home and community care transitioning to CHSP. The initial timeline was to the end of June 2020. And that's been further extended for another period of time. That's not necessarily about WACHS transitioning out of delivering that service; that was to complete the transition from the HAC model to the CHSP model is my understanding.

MR GRAY: Okay. Thank you for clarifying that. The next point relates to home care, as opposed to entry level CHSP services, the higher level home care services represented by the home care package. And in paragraph 128 I'm not certain whether you're referring to those higher level services delivered in the community when you refer to community and home nursing:

> *Community and home nursing care can be provided to clients under Commonwealth funded flexible home packages.*

Is that what you're referring to at that point?

MS DENTON: Yes. So in that case I guess the use of the word "flexible" - - -

MR GRAY: Is that to represent the home care places that have been allocated to an MPS under allocation, rather than under consumer-directed care?

MS DENTON: Correct. Yes.

MR GRAY: Thank you. And when you say at paragraph 132:

> *York Health Service is able to provide an excellent home care service. However, the state of flux in the future with determination of Commonwealth home care packages has caused concern within the York community.*

Could you please just explain what is the nature of the state of flux you refer to and what are the concerns?

MS DENTON: I think within a number of communities, particularly York, there are other providers present, as well as the MPS program, obviously. And there's been challenges in terms of the delivery of home care packages and concern raised that people have been waiting extended periods of time for a home care package, as opposed to, I guess, a flexible package that we talked about. So it's trying to get that clarity around people's requirements and then matching that to the right service and how that will be delivered. And I think people are concerned that if they accept a Commonwealth home care package, as opposed to a MPS-funded service, how would that work from an integration and coordination perspective of their care?

MR GRAY: Okay. Thank you. Could I just ask the operator to put up on the screen a map of the wheat belt region, one of the seven regions under WA Country Health Service's jurisdiction, RCD.9999.0258.0001. We have some evidence that I will be raising with the Commonwealth later that if you search My Aged Care you – for home care package service providers in Kellerberrin, you actually get quite a list of providers and they include providers who aren't located in any of the towns in the wheat belt area. They include some as far afield with addresses in Victoria. Is this an issue that you have received any reports about? And, in particular, do you know whether there are interstate-based home care providers who are conducting operations in the wheat belt region?

MS DENTON: I'm not aware of any interstate providers in the wheat belt. I am aware that one of the large providers, you know, covers a greater part of Australia than just WA. So whether that's part of it, I don't know. I'm making a big assumption there. I'm certainly not aware of any interstate providers servicing any part of WA Country Health at all.

MR GRAY: All right. Thank you. When that search – when that search is conducted – well, I withdraw that. Can I ask you, with specific reference, if you like, to the Wheatbelt region, and in particular with regard to Kellerberrin and York, what occurs to you as the most important changes that would improve the delivery of services through the MPS program?

MS DENTON: It's a very good question. I think there's a number of things in terms of improving – is your question about improving aged care service provision in those two communities?

MR GRAY: Yes, but in particular through the MPS.

MS DENTON: Through the MPS program; I think there's a number of things, you know, as I mentioned before, you know, certainly we – our skill mix and our staffing profile for small MPS locations such as York and Kellerberrin are such that we have a registered and unregistered workforce. So we will have nursing staff, obviously, that are qualified as well as care aides, personal care assistants, allied health assistants delivering care. I think, you know, obviously ongoing education and upskilling for them is crucial. Part of our WA Country Health Service strategy going forward is to really strengthen our development of workforce locally and making sure that's a culturally appropriate workforce as well.

I think the use of technology is gaining in momentum, so how better can we support aged people to age well in their own homes through the use of technology but also having the staffing mix that meets their needs and people really understanding aged care as opposed to an acute care-type scenario. So I think they're two critical elements that we need to consider. I think also, in small communities, making sure if we're able to keep people within their own homes, that their own homes are suitable to do that. So, you know, do they have the right equipment in situ, are we able to technology-enable their homes so we can provide some level of monitoring into the household.

The challenge always is the small numbers and the distances to travel. So whilst they might be discrete towns, there will be people on the outskirts as well. So I think that's where technology can play a part in terms of delivering additional support into those locations.

MR GRAY: If we just have the operator display the map again of the region, we can see that, as you say in your statement, it's an absolutely vast area. In paragraph 6 of your statement you say it's 157,000 square kilometres, supporting an estimated residential population of about 76,000 people as at 2016, dispersed across 70 communities. How do you seek to coordinate streams of clinical services given the distances marked on the map there between the various physical infrastructure indicated by the circles? I mean, very few of those distances are less than about 100 kilometres, or at least 70 kilometres. So how do you actually, in practice, try to coordinate the collaboration, collaborative use and sharing of the labour force and, in particular, the clinical labour force?

MS DENTON: In terms of the key locations, so if you look at the map, the district hospitals obviously are our biggest centres, so Northam, Narrogin, Merredin and Moora; they'll have a substantial workforce. And then as you look at each small hospital, they will generally have a minimum staffing profile which would be in some cases two nurses rostered on every shift if we're talking hospital, and then a

raft of support staff and other staff that are configured to both work within the hospital environment, the residential care component of the facility and provide the community care services. So each of those – I think they're purple dots, will have a small workforce usually located in that town that would then provide support out to that local community.

They are overseen and managed by the health service managers at the larger district hospitals and then we have operations managers who oversee a group of those small localities. So it's a tiered approach in terms of oversight and governance. From an aged care perspective, we then have a regional aged care team who's usually based in the main centres, so in Wheatbelt's case, this is Northam, and that will be your Aged Care Assessment Team. In some cases what was the Carelink and Respite Centre coordinators, and a raft of other aged care professionals who will also have visibility across the whole region and an understanding of all the clients that are out in those communities.

But we also have an expectation that within each of the small locations that the district health service managers and the operations managers are fully aware of the vulnerable groups in their community, and by that I mean older people form one of those vulnerable groups. So we have an expectation that they will also be overseeing the care coordination and the service access for those people.

MR GRAY: I want to ask you about any workforce attraction and retention initiatives you have, whether they be in the population centres represented by the darker circles, such as Northam and Merredin. Do you have any linkages with RTOs to actually train the local workforce in those areas?

MS DENTON: Not that I'm aware of. We are running a pilot program. We have developed a number of in-house modules and we are currently piloting a couple of modules, so one is around upskilling unregistered workers. Also a medication administration module. So we do run pilot projects like that and we have been doing that in collaboration with the Primary Health Alliance. Most of the sites are subscribed to the Aged Care Channel so that's another opportunity for upskilling and education. We also have in the past run training with organisations such as Alzheimer's Australia, the Dementia Behaviour Management Advisory Service. So I guess there's been those individual opportunities.

More recently, I'm now on the board of the State Training Council, their subcommittee specifically related to community services, allied health and aged care and that's about looking at the needs across all of country in terms of what are the requirements for education for both the disability and the aged care sector. So I am having input and obviously that's about influencing the VET sector curriculum in terms of where our workforce needs are, how do we build capacity and capability out in those areas.

MR GRAY: In the statement about the Wheatbelt, 0587 at paragraph 73 you refer to some recruitment and retention strategies, and with respect to nurses, you say there's a novice nurse development program:

...Wheatbelt Initiative for Novice Nurse Development –

and you also mention a graduate nurse program, I believe. Perhaps it's the same - - -

MS DENTON: Yes, so WA Country Health runs a substantial grad nurse program. So post-grad – as nurses graduate from university we then offer them an extended period of time whilst they're working to further their upskilling and development. That's our graduate nurse program. So that happens – I think we generally, I think, have upwards of 120 newly graduated nurses in that program, and we seek to increase that number over the coming years because it does – has been found to work really well. The Wheatbelt Initiative for Novice Nurses, again, it's about, generally, the nurses who haven't been successful in getting into the grad nurse program but we want to encourage and support and mentor them, are accepted in at junior – I guess, base level nursing positions, and they're provided extended supervision and mentoring to support them through their journey. So similar but not quite the same programs that we offer.

MR GRAY: Thank you. Would there be merit in establishing some local scholarships with Commonwealth support if that became available so that nurses were encouraged to remain locally once they completed that program?

MS DENTON: I think that would be fantastic. I think one of the challenges that they face is while they're studying, or they're upskilling, you know, that how will they fund themselves, so to speak. So, you know, they're often stretched by having to work part time and then try and study at the same time so a number of our staff – going back to your RTO question, we have been supportive of staff who've gone ahead to do their enrolled nurse training and then transitioned to their Bachelor of Nursing degree where we've been able to do that. Often, you know, that's in our larger locations but we have had a number go through in some smaller MPS sites as well, where they've worked through that – worked through that process.

So that's been quite successful as well, but I think the idea of scholarships would be of great benefit. And I think that could equally apply to other opportunities, whether that's Aboriginal health workers or allied health assistant programs, those sorts of things as well.

MR GRAY: Finally, can I ask you about a disparity that exists in means-tested contributions for accommodation and certain other charges. The MPS program in WA doesn't charge means-tested contributions, as I understand it. Do you have a view – there's a report by UTS indicating that this has the potential to create competitive neutrality problems. Do you have a view on behalf of the WA Health Service on this matter? Is the WA Health Service going to move to trying to remove barriers to competitive neutrality where these disparities exist?

MS DENTON: I think we haven't probably seen any impact from that issue because in those locations where the MPSs are operating there isn't generally, in most cases, another provider of residential aged care. Certainly, it's something we have talked about, and we talk about inequity in country health from all sorts of perspectives, whether that's access to service or the cost of service or the need to travel to get service. In this case, it's the reverse in a way, isn't it, because they basically pay a flat fee regardless of their – their income and assets to enter a residential aged care facility within an MPS environment. So it hasn't certainly caused people to want to move to an MPS site for residential care for that reason, and to my knowledge I haven't seen where it's caused a ..... to any major issue in terms of clients accepting care, so but I think ultimately long term we would like, you know, equity across the board. I guess it's the mechanism of how we do that.

MR GRAY: Thank you. I have no further questions, Commissioners.

COMMISSIONER BRIGGS: Ms Denton, thank you very much. I could ask you zillions of questions, but I won't. Your last paragraph of your first statement to us talks about emerging demand for younger people who don't fit – they're not old enough for aged care and they don't fit the NDIS program, because of chronic conditions. What kind of conditions are we talking about? Is it cancer, as we heard, people that are dying from cancer? As we heard, in our young people with disabilities hearing in Melbourne a month or so ago – or what are those circumstances and what are you suggesting?

MS DENTON: Thank you, Commissioner. I think we – we're acutely aware of the epidemiology across country WA and the circumstances that people face in many locations. And in some cases it is a cancer diagnosis that contributes to them needing additional support and they do appear to be falling through the cracks, so to speak, between NDIS and aged care. I think, though, we also – these similar circumstances for people with chronic mental health conditions – and, again, where do they fit in the scheme of things?

We have a higher rate of cardiac chronic conditions, respiratory chronic conditions, particularly, for example, Aboriginal people who, from birth, and have a poor start in life and may have rheumatic heart disease or anaemia or a range of other factors that contribute to their earlier decline in health and that increased level of care required well before most older Australians require that. So I think there's a number of cohorts that fit into that group there.

COMMISSIONER BRIGGS: Thank you.

COMMISSIONER PAGONE: Thank you, Ms Denton. Thank you for giving your evidence. It's been very helpful. And you've excused from further attendance. Thank you very much indeed.

MS DENTON: Thank you, Commissioner. Thank you, everyone.

MR GRAY: Thank you.

<THE WITNESS WITHDREW [12.32 am]

COMMISSIONER PAGONE: Yes, Mr Gray.

MR GRAY: Thank you, Commissioner. Our next witnesses are witnesses from the Commonwealth Department of Health. We could commence them now, but we will then be rising for lunch in less than 15 minutes.

COMMISSIONER PAGONE: Or we might go on until 1 o'clock, I thought.

MR GRAY: Very well. I call David Hallinan and Graeme Barden to give evidence concurrently. Mr Free will announce his appearance while the witnesses are getting ready.

MR FREE: May it please the Commission, my name is Free. I appear with my learned friend MR DIGHTON.

COMMISSIONER PAGONE: Yes. Mr Free. Thank you.

<DAVID HUGH OLIVER HALLINAN, AFFIRMED [12.33 am]

<GRAEME PAUL BARDEN, AFFIRMED

<EXAMINATION BY ME GRAY

COMMISSIONER PAGONE: Mr Gray.

MR GRAY: Mr Hallinan.

MR HALLINAN: Yes.

MR GRAY: What's your full name?

MR HALLINAN: David Hugh Oliver Hallinan.

MR GRAY: And you're the acting deputy secretary of Aged Care Group - - -

MR HALLINAN: That's correct.

MR GRAY: - - - of the Australian Government's Department of Health.

MR HALLINAN: Yes.

MR GRAY: You haven't made a statement, but you're here to give evidence concurrently with Mr Barden.

MR HALLINAN: Yes.

MR GRAY: Mr Barden, what's your full name?

MR BARDEN: Graeme Paul Barden.

MR GRAY: You're the assistant secretary, Residential and Flexible Care Branch of the Australian Government's Department of Health. Is that right?

MR BARDEN: Correct.

MR GRAY: And you have made a statement?

MR BARDEN: I have.

MR GRAY: I'll ask for it to be displayed for you. WIT.0498.0001.0001. It's a statement dated 14 October 2019. Do you see it there?

MR BARDEN: I do.

MR GRAY: Thank you. You wish to make a correction to paragraph 29(b) – beg your pardon – (c). 29 (c) – amending the figure which appears there as a percentage for occupancy in mainstream residential care for the remote areas of Australia. It states 71.9 per cent. And you wish to amend that to state 87.6 per cent, I understand.

MR BARDEN: I do.

MR GRAY: Now, with that amendment having been taken to be made, do you wish to make any other amendments to your statement?

MR BARDEN: No.

MR GRAY: And with that amendment, to the best of your knowledge and belief, are the contents of your statement true and correct?

MR BARDEN: They are.

MR GRAY: I tender the statement.

COMMISSIONER PAGONE: Yes, the statement of Mr Barden will be exhibit 12-25.

EXHIBIT #12-25 STATEMENT OF MR BARDEN DATED 14/10/2019 (WIT.0498.0001.0001)

MR GRAY: Thank you. Mr Barden, I will ask you some questions by way of clarification – points of clarification about certain matters in your statement first and then I want to raise a series of propositions and test them with you – with you both. Mr Barden, in the statement you refer to an expectation of a 41 per cent increase in demand in regional, rural and remote areas over the next 10 years from 2019. And this is in response to a question that was asked of you about current demand and projected demand over the next 10 years. It's on page 0007 that you refer to the 41 per cent growth forecast, paragraph 31. What steps are the department taking to ensure that there will be services available to meet this level of demand in rural, regional and remote areas?

MR BARDEN: So the department continues to allocate, whether it's residential care places, through aged care allocation rounds. The Commonwealth has released home care packages and continues to release those into the market. We continue to release multipurpose service places through allocation rounds, including the one we have open now. And we continue to expand the NATSIFAC program, the National Aboriginal and Torres Strait Islander Flexible Aged Care program. And as we run the aged care allocations rounds in parallel we make available capital grants to the rural and remote sector, in particular, to assist with the development of residential care facilities in more rural and remote settings to enable the bringing on line of those places.

MR GRAY: Thank you. Could I just - - -

COMMISSIONER PAGONE: Mr Barden, can I just ask you about that. How does the department monitor that increase? I mean, I can see there that it says it's based on ABS projections. And I understand what that is. But is that something that you monitor – or the department monitors constantly?

MR BARDEN: So, for example, in residential care, at the – prior to running an allocations round then we undertake this assessment for every one of those allocation rounds.

COMMISSIONER PAGONE: So does that mean you do it annually, biannually, tri-annually?

MR BARDEN: It's typically annually, predicated on the decision to make places available.

COMMISSIONER PAGONE: Thank you.

MR GRAY: Could I ask the operator to display previous exhibit 10-1, tab 22, which is CTH.0001.1001.2642. This is one of the aged care approvals round forecast documents which you referred to in your statement by reference to earlier evidence of Mr Jay Smith. This is information in relation to the 2018 to '19 aged care approvals rounds for Innisfail in Queensland. If we can just have that brought up on the screen, in the schedule of documents previously tendered. It's CTH.0001.1001.2642. Well, I can – I will move on. If we locate that document, we will come back to the question. That projection that you refer to is a projection based on an aged care planning region, I suggest, and it isn't directed at particular towns; is that right?

MR BARDEN: Sorry. Are we talking about in respect of aged care allocation rounds for residential care?

MR GRAY: Yes, we are.

MR BARDEN: So that's typically undertaken at the SA3 level using ABS statistical areas. And occasionally we might drill a little deeper into the SA2 level.

MR GRAY: All right.

MR BARDEN: So - - -

MR GRAY: If we look at this document, this is a document that's made available to ACAR applicants; is that right?

MR BARDEN: Yes.

MR GRAY: And if we have regard to the data in the top row, this is, essentially, the level of detail that's provided to applicants, is it, and it doesn't go to any greater level of granularity than - - -

MR BARDEN: No.

MR GRAY: - - - this information?

MR BARDEN: No.

MR GRAY: All right. Is there a review done on a systematic basis by the Department of Health as to the level of access to home care services which people wishing to receive home care services are actually receiving in regional and remote areas throughout the country, so as to create a map of the degree of workability of the market in home care services?

MR BARDEN: To the extent of my knowledge of home care program reporting, the quality reports provide information on how people on the national prioritisation system align with the aged care planning regions, but not the construction of a map.

MR GRAY: Okay. So – and there are 71 such aged care planning regions, aren't there? So they're very large areas?

MR BARDEN: They are.

MR GRAY: There's nothing which within those regions would tell you whether people in particular degrees of remoteness from population centres are or aren't receiving – actually receiving home care services; is that right?

MR BARDEN: I don't know if that sort of analysis at that scale is done for home care.

MR GRAY: All right. You refer in your statement at paragraph 39 to a review that is being done to determine whether information displayed on the My Aged Care website in relation to coverage by CHSP service providers is accurate or not. You remember that evidence?

MR BARDEN: Yes.

MR GRAY: Now, a CHSP grant contract requires the CHSP provider to service a particular defined region. And that region is set out in the contract and it's reasonably clear whether they have coverage obligations for the region; is that right?

MR BARDEN: That's my understanding.

MR GRAY: When it comes to home care, on the other hand, the gist of your statement appears to be that there's no such obligation. It's intended to be, in effect, a free market mechanism, and there's scope for providers to provide services in whatever area they wish or not to provide them; is that right?

MR BARDEN: I would characterise it as the intention is to enable providers to be able to broaden the geographic range of the care services that they offer.

MR GRAY: When it comes to home care.

MR BARDEN: For home care, yes.

MR GRAY: All right. Now, with respect to CHSP, there's reference in your statement to the phenomenon, if you like, of information on the website which may not be accurate as to – as to coverage. Let me just – I beg your pardon. I might be thinking more of the home care side of things. In any event, there's a project referred to in paragraph 39 to review CHSP provider service delivery information to display it on the website against the provider's funding agreement. So it's thought

that there's a need to verify that information within the department, is there; is that right?

MR BARDEN: The department is working to assist CHSP providers ensure that their information is correct.

MR GRAY: Yes. And is that project under way in respect of only certain States at the moment? Is that a correct reading of your evidence at paragraph 39?

MR BARDEN: Yes.

MR GRAY: And when is that project going to be completed in its entirety for all States and Territories?

MR BARDEN: I don't have that information.

MR GRAY: Do you know how many people are working on it?

MR BARDEN: No.

MR GRAY: When we come to home care, at paragraph 42 you refer to this point that we just discussed to the effect that providers of home care are not contractually bound to deliver services in a specific location. In paragraph 43 you refer to a fact sheet which has gone out about certain issues concerning the accuracy of information on My Aged Care. Looking at the fact sheet – I won't ask for it to be brought up unless you need it – but looking at the fact sheet it seems clear that the issues being addressed are not related to the verification of claims of coverage in particular locations, but they're related to other issues. Do you agree with that?

MR BARDEN: I would need to see the fact sheet.

MR GRAY: All right. It's tab 8 of the general tender bundle, please. Take a moment to read that to yourself. Operator, is there a second page? Have you finished that page, Mr Barden?

MR BARDEN: I have. Thank you. And if I might just check my reference in the statement.

MR GRAY: Certainly. I'm just going to ask you about - - -

MR BARDEN: Yes.

MR GRAY: - - - whether there's a program underway to check the verification of claims of coverage of home care services, made on My Aged Care, because that appears to be an issue as well as the matters raised in the fact sheet.

MR BARDEN: Yes, on the fact sheet. I'm not aware of any other.

MR GRAY: All right. Are you aware that there are problems with respect to the accuracy of information on My Aged Care and the nature of claims about coverage?

MR BARDEN: Only anecdotally and not in any detail.

MR GRAY: Right. Are there any plans underway to verify claims of coverage made on My Aged Care?

MR BARDEN: I don't know, beyond what I've indicated in my statement, and which I've indicated in my statement I've been reliant on others in the department to assist the Commission through these questions and I don't really have other information beyond that which I've tendered.

MR GRAY: When you say "anecdotally", you've heard it of being raised?

MR BARDEN: Yes.

MR GRAY: How often have you heard of this issue? That is, have you heard of complaints that there's inaccurate information about home care coverage on My Aged Care?

MR BARDEN: I've heard of complaints but not in specific detail and, of course, I've heard mention of it this morning.

MR GRAY: Well, I will just put up tab 58 of the general tender bundle, please, operator, and we will just ask Mr Barden about this. I beg your pardon, tab 60. Thank you. If one conducts a search for in-home services at Kellerberrin which is in the Wheatbelt, one gets results that include providers located in completely different locations such as Melbourne. If we track through this document, please, operator, just stop. Malvern East, Victoria at the foot of that page, for example. Do you have any comment to make about that? Is it possible that there could be a provider located in Malvern East who's somehow providing services in the Wheatbelt in WA?

MR BARDEN: I can't make any comment on the specific. I would only note, hearing your reference with a prior witness, we just had a quick search and only found WA providers and so I don't know if that reflects a response to whomever this particular provider is to some of the interventions that the department has made to try and help them understand how to have a more accurate service finder information.

MR GRAY: With respect to those interventions – thank you, operator, we can put that away – with respect to those interventions, is the department responding to particular complaints about this issue by contacting the provider directly and seeking verification?

MR BARDEN: So I understand that's a part of the – the project that we discussed earlier that commenced in July, that that does involve – my understanding is that that

involves a direct contact and then otherwise we engage all providers through our usual bulk information distribution service.

MR GRAY: All right. So the point I raised about the project in July was restricted to CHSP and you weren't saying it related to home care package - - -

MR BARDEN: No, I wasn't.

MR GRAY: No. So it sounds like, given the answer you've just given, there isn't actually a mechanism for dealing with complaints about accuracy of coverage claims related to home care package, compared with – as compared with CHSP; is that right?

MR BARDEN: No, I think I'd have to say that I don't have sufficient knowledge to be as categorical as that.

MR GRAY: All right. Now, in your statement, you've referred to – I will just give you the particular reference – you've referred to the effect of the reforms in 2017 – the increasing consumer choices reforms – to the service delivery model of the home care package program, and you've identified certain trends in percentage terms and by reference to raw figures in the distribution of home care packages to people living in inner and outer regional and remote and very remote areas compared with other areas or compared with Australia generally; is that right?

MR BARDEN: Yes.

MR GRAY: And I will just direct you to that part of your statement. It's on page 10 and you set out a table of that information on page 10 and then you move on to an analysis of that information on page 11, paragraph 49. You say:

> *On the basis of the research that's been done and the information available to the department –*

This is paragraph 49 –

> *...the impact of the 2017 reforms has been to increase access for people who are living in outer regional areas in absolute numbers but has reduced access as a proportion of the number of available HCPs and access to home care for people who are living in either remote or very remote areas has decreased in absolute numbers and as a proportion of the number of available HCPs.*

If we go back to the table on page 10, we can see the figures in question in the – if we look at the left-hand column, the cohort column, we see, first, outer regional and that then – is it that description outer regional is adjacent to two rows, one, number of people and the other percentage and they're the matters that you were then referring to in your analysis; correct.

MR BARDEN: Correct.

MR GRAY: And if we look at outer regional we see from 2016 to 2017 the number of people receiving, that is, receiving a home care package in the sense of it having been assigned to them; is that right, Mr Barden?

MR BARDEN: So they've been allocated their package and the number represents that number of people on 30 June in each relevant year.

MR GRAY: Right. And there's a slight increase of a little less than 300 people from the end of June 2016 to the end of June 2017, and then an increase of about five hundred and – almost 550 people the following year, and an increase of about 500 people the following year, but in percentage terms that represents a shrinking proportion of the people who around the country who hold assignments of home care packages; is that right?

MR BARDEN: That's right.

MR GRAY: Yes. Now, you attribute the increase in the raw numbers to the impact of the 2017 reforms, do you, in paragraph 49. You say:

> *The impact of the 2017 reforms has been to increase access for people who are living in outer regional areas in absolute numbers.*

What I want to suggest to you is that it's probably not the impact of the 2017 reforms that's caused that increase but, rather, just the quite large gross increase in the number of packages that have been released by the government to the population at large that's caused that increase in the raw numbers or absolute numbers of people who hold packages in outer regional areas?

MR BARDEN: I could accept that as an alternate proposition.

MR GRAY: Yes. I won't go to the report on the home care packages program but you're familiar with the quite large increases year on year in the number of packages that have been released to the population at large?

MR BARDEN: I am.

MR GRAY: Yes. So for the record that's tab 58. Can we – is that a convenient time, Commissioners?

COMMISSIONER PAGONE: All right.

MR GRAY: I'm going to another topic after lunch.

COMMISSIONER PAGONE: All right. Thank you, we will adjourn until 2 o'clock.

MR GRAY: Thank you.

ADJOURNED **[12.59 am]**

RESUMED **[2.00 pm]**

MR GRAY: Thank you, Commissioners.

COMMISSIONER PAGONE: Mr Gray.

MR GRAY: Mr Barden, I want to go back to the point of projection of demand for home care services. This was a point raised on page 0007, paragraph 31 of your statement. And you say there that:

> *Based on ABS population projections, the department expects that demand for residential care and home care in the relevant areas will increase by 41 per cent by 2029 compared to 30 June 2019. This projection assumes that the proportion of the people receiving care by age and sex remains constant.*

In short, the method for forecasting demand is simply to take the current level of supply and apply just a basic ABS population projection based on total aggregate population, without considering the acuity of the population; is that right?

MR BARDEN: I must apologise. I have a medical condition that flares up from time to time and it's now doing it, so I apologise for my voice. The – and now I'm going to ask you to repeat the last bit of your question.

MR GRAY: That's all right. The assumption that is made for the purposes of making that projection doesn't seem to have regard to acuity; it's just a gross population based - - -

MR BARDEN: At that level it is a population based estimate.

MR GRAY: All right. And can I direct the question to you, Mr Hallinan. It would be far more appropriate, wouldn't it, to conduct a review on a locational basis of the degree of access that people are getting in rural and remote areas to the suite of services covered by the home care package program. There doesn't appear to be any sort of demand projection trying to encompass need that is currently being met or need that's unmet because people are on waiting lists or haven't applied on a local basis.

MR HALLINAN: I would agree with the proposition that a more granular analysis would be better, yes.

MR GRAY: And did you – did you have a chance to review the evidence yesterday of Dr Winterton? She refers to the recommendations of the AAGs regional, rural and remote interest group from 2017 on the idea of having, in effect, a national review in the nature of a stocktake trying to assess the level of access that people are receiving in rural areas to care in the community, including, in particular, perhaps most critically, that high level of need represented by the HCP. Should that happen?

MR HALLINAN: I think it would be a good idea. Yes. It would be a good proposal to pursue. And to the extent that you did it, I would probably expand it beyond simply aged care and ageing and contemplate broader health issues within communities, as well. The datasets for us to be able to do that haven't easily been consolidated in the past, but we may have opportunities to do that in the not-too-distant future, I think.

MR GRAY: Would it be possible to organise that sort of data on a primary health network basis?

MR HALLINAN: Yes, but I'm not sure the primary health network would be the best basis. There are 32, thereabouts, PHNs across the country, which is – it's an even larger basis than the aged care planning regions. I think there would be other methods that you could use to specifically identify local areas.

MR GRAY: Yes. I beg your pardon. I should have said using the private health networks to try to coordinate the collection of that data, not to only aggregate the data at a PHN level; the data should be aggregated at a much lower level of granularity than that, shouldn't it?

MR HALLINAN: Yes. Yes, that would be one legitimate way of doing it. Yes.

MR GRAY: Yes. So you could set up some sort of governance arrangements through the PHNs to achieve that?

MR HALLINAN: You could. You could, yes.

MR GRAY: Should that further recommendation that that special interest group made be adopted, that is, a recommendation to try to establish nation-wide uniform standards of minimum service access, so that there are clear expectations, depending on your degree of remoteness from population centres, you would have an expectation for a particular level of care in the community and everybody would know what that expectation is and everybody would know if there were regional variations which fell beneath that standard. Is that an appropriate proposal or proposition?

MR HALLINAN: I think so. It would be a very complex piece of work. And the regional variation would – would be quite meaningful, I think, in the different contexts of health services available in any particular community or other factors like that, as well.

MR GRAY: All right. Thank you. Mr Barden, if I'm able to return to just a couple of other points relating to your statement, but let me know if you're having difficulty - - -

COMMISSIONER PAGONE: Just before you leave that topic, Mr Gray, can I just ask Mr Hallinan if he were able to assist us. So some questions have been asked about that brief sentence that appears in paragraph 31. I know it's not your statement; it's Mr Barden's statement. And what paragraphs 31 and 32 are partly about is trying to work out what the expectation is about future health or future aged care needs, so that the provider and the department in connection with the provider goes about working out what it can expect to be needed in a period of 10 years, say.

And, as I understood the statement and the evidence this afternoon, it is more or less that you begin with the ABS population projections and you make some assumptions. Now, that kind of information, obviously, is useful to the department in making out – working out what it is that you need and don't need and how the department, that is, say, the Commonwealth Department of Health reacts to the expectations.

And it's a matter of interest to us, because in our work in trying to make recommendations, we need to have some foundation for what is a good basis for making recommendations. So it's one of those areas where there's a confluence of interest between the department and the Royal Commission. So may I ask you to help us and help yourself at the same time by telling us what you reckon should be the basis upon which projections should be made?

MR HALLINAN: There's been some pretty good work, I think, on health service demand modelling across the country in the last few years through the health workforce division of the Department of Health, and, in particular, the establishment of a tool which we call Heads Up. And it includes information about populations in any particular area: age, sex, demographic, socio-economic status and other things, so the demand side. It also includes information about the services that are available, what type of health services are available.

I think, to the extent that you're going to establish effective planning for aged care, you would want to understand and share information between the Commonwealth and the states that went to all of the different type of service available in any given location and potentially establish a benchmark level of service or a level of standards that you may wish to apply in any particular area. So we know, for instance, that health services are delivered in sort of a tiered fashion from your acute hospital settings and your tertiary hospital settings in major cities down through to local GP-led subacute hospitals in rural and regional towns and combined with multipurpose services.

So too I think for aged care, there is some point at which you would need to make judgments about, well, where's the right point to be providing multipurpose service, where's the right point to be providing a market-based solution and at what stage in a

planning framework do you apply principles of a market-based solution or principles of a supply-based government contracted or MPS-type solution.

And I think that differs depending on the location and I think it would differ depending on which providers, whether they're government or NGO or privately provided services, are embedded and have deep roots in the community. And local community engagement, I think, would be the most important aspect of determining in each circumstance what your best solution is. But I think in all circumstances some level of cooperation between service providers at a minimum would be necessary.

COMMISSIONER PAGONE: It sounds as though there isn't an existing model that either the Commonwealth or the states have got up and running. Is that a fair summary?

MR HALLINAN: I think that's fair. We've got good and improving cooperation around data sharing and around the sorts of information that you would use to make those projections from. But it's not yet perfect and it's a work in progress.

COMMISSIONER PAGONE: And is there – when you say it's a work in progress – and I understand about the cooperation being active, but is there an active project to come up with a model that will more confidently predict what the aged care needs are likely to be from a government point of view?

MR HALLINAN: Not specifically for aged care at this point.

COMMISSIONER PAGONE: No.

MR HALLINAN: But I would – I would suggest using the existing frameworks that are being built as the basis on which you would then undertake that piece of work.

COMMISSIONER PAGONE: And do you want to have a last shot at telling us what you think the contents of such a model should be?

MR HALLINAN: It's quite a hard thing to make very hard – to make very clear-cut calls on, but I would say the modified Monash planning framework is probably your best high level geography model to use for setting of, you know, what levels of services you might wish to expect in any particular community type. I think it does the best job of managing the reality challenge of both distance and population out of the geographic planning tools we've got.

And I think those are the two most important factors for determining the level of service that you might wish to have. It's probably also an area where we would have enough data to do reasonable population projections and also to source information from local health providers, local aged care providers about what their anticipations are for the community needs, as well. But - - -

MR BARDEN: I think I – I'm sorry, Commissioner. I think I should just clarify one point, that there is one project running in the department to look at factors affecting demand in Commonwealth Home Support Program, but I have no details about that project itself. And I just wanted to bring that to your awareness.

COMMISSIONER PAGONE: Well, upon the assumption that such a model would be a useful thing to do, do you want to share any views about why there isn't one so far?

MR HALLINAN: I think there's probably been a lack of information. So if you look at the history of – just take, for instance, the history of geographic measures and as they've applied in both of the health or aged care delivery systems. We've relied on some pretty high level pieces of information. The Bureau of Statistics will give us population estimates. The – we will then turn those into some form of geographic model, whether it's the RAMA index from the mid '90 through to something we called ARIA and then the geographical classifications of the Bureau of Statistics through to now modified Monash.

Each one of those steps, I think, has been a step towards better disaggregation, a better understanding of what local community might need or might mean. And then actually sharing information, sharing of data around health service delivery, age, sex, demographics and interactions with health systems. I think that's probably where you would get your best estimates or your best information for the future around requirements for aged care.

My feel, and it is just a feel, would be there would be some pretty clear indicators of need for aged care based on interactions with the health system at various points in a life journey. And, to the extent that you could get that, which was – which is quite a substantially different way of looking at the world, you might be able to get some pretty good predictive information out of our health system, in particular, to support planning for aged care services, frailty and infirmity.

COMMISSIONER PAGONE: Well, just one final question. It doesn't matter who answers it, but what concerned me about the sentence that Mr Gray had asked one of you about in relation to paragraph 31, is that there seems to be a secure assumption that the demand is going to increase by the 41 per cent but the presumption is that acuity will not actually change. And such evidence as we've heard so far seems to indicate that, actually, acuity is likely to be much worse as time – as the years go on so that an assumption that that seems to be making seems unlikely to be accurate.

MR BARDEN: If I may, Commissioner. It may have been more helpful if my statement had have noted information that is provided in the reports of the Aged Care Financing Authority which provides information demonstrating a very strong association between population demographics and the demand for aged care services. So it's on – that is what that assumption is based on. Obviously, I've heard your comment and other witnesses around the acuity side of it.

COMMISSIONER PAGONE: Thank you. Yes, Mr Gray.

MR GRAY: Thank you, Commissioner.

Mr Hallinan, if we move our focus from CHSP and the Deloitte study to which Mr Barden referred to a moment ago when he referred to a study of demand being conducted in relation to CHSP, and we look at the higher level of in-community and in-home care that's needed, and which is intended to be serviced or met by the home care package program, I just want to put a couple of propositions to you. The first proposition is that government policy is that demand for those sort of services is to be met through the service delivery mechanism of a market – a market approach called consumer-directed care, and that's being done without a detailed analysis occurring as to areas of the country where markets are too thin to support a workably competitive mechanism of that kind. What do you say to that?

MR HALLINAN: I think you have heard evidence to that effect from my colleagues as well as people attending here in past hearings. So while I wasn't around for the implementation of the consumer-directed care model I think there's – there are challenges particularly for remote or small rural locations around whether or not there is, in fact, a market available to provide those services.

MR GRAY: And the next point is that the data is actually telling us that there's an increasing divergence. It's certainly in terms of the proportion of all aged care packages that are available, and in certain categories in absolute terms whereby metropolitan and inner regional areas are winning out under this market mechanism at the cost of outer regional and remote areas; agreed?

MR HALLINAN: It looks like that from the data presented in Mr Barden's statement. The – the one thing I would add though is I don't think that takes into account growth in MPS flexible service delivery or NATSIFACP places which may go some way to explaining it. I don't think it would go all the way though.

MR GRAY: Well, NATSIFAC program places are – it's an important program in the areas where it exists but it's only servicing people numbered in the hundreds as opposed to the thousands; correct?

MR BARDEN: Correct.

MR GRAY: And MPS is, of course, a central focus of this hearing but again that's not an enormous program. It's an important program but it's not enormous. The Commonwealth seems to be willing to consider the expansion of the MPS program on application from the States and Territories in areas where markets are demonstrated to be thin; is that right?

MR HALLINAN: Yes.

MR GRAY: Yes. Now, could I just ask you to consider the following proposition: your department should assess the markets for the services covered by the home care package program in regional and remote areas along the lines that we've been discussing, and in the absence of compelling evidence that there's a working competitive market for the entire suite of those services in particular locations of reasonable granularity - - -

MR HALLINAN: Yes.

MR GRAY: - - - the department should vary and augment the home care allocation model in that area to ensure a sufficient supply of services to meet demand in the area. What do you think of that proposition?

MR HALLINAN: I think it's a reasonable proposition. It would – coupled with the earlier discussion around establishing certain levels of service and expectations for communities, I think that would work reasonably well, yes.

MR GRAY: Thank you.

COMMISSIONER BRIGGS: Could I just ask a question that follows on from the previous arrangements. And it's really – it runs to the question of the national prioritisation system. I don't understand with the national prioritisation system why outer rural and remote areas lose out. I would have thought the very idea of a national prioritisation system was to ensure fair allocation of home care packages?

MR HALLINAN: Well, I'm not sure why the national prioritisation system is leading to a – the outcomes that it's leading to. It should only be taking into account the factor of need and priority, so the assessment of an individual and the date at which the assessment is undertaken and then the priority with which the assessment is given for that individual's care needs. So to the extent that there might be – there might be a delay in allocation of places by comparison to metropolitan locations; it's not clear to me why that would be the case.

COMMISSIONER BRIGGS: Well, could I ask you, Mr Hallinan or, indeed, Mr Barden, if you could research that and let us know, please. Thank you.

MR HALLINAN: I can.

MR GRAY: Thank you, Commissioner.

Mr Hallinan, I will direct this primarily to you, but Mr Barden, please respond if you wish after Mr Hallinan has responded. I want to propose some – well, tests, some potential mechanisms by which the proposition that I advanced a short time ago could be implemented, that is, by which there could be a variation or augmentation of the market-based mechanism known as consumer-directed care for the delivery of home care packages. Firstly, could you consider, please, the following proposition: there could be a system of block grants through a competitive tender process,

location by location, to address the issues of thin markets in those locations and scale diseconomies in those locations.

And as a condition of receiving a grant the provider in question would have a provider of last resort obligation. So one would in effect be moving to something more akin to the way CHSP is administered, although it needn't be strictly speaking a block grant. It could be a grant based on an estimated number of clients. What do you say to that proposition?

MR HALLINAN: I think to the extent that there's a thin market or no market available then that makes sense. The – the little caveat I would put on that is where we rely on markets to do some work for us for quality, so competition and individuals can move between providers, does certainly do some work around quality of service provision. I think you would need to have a different governance structure that would sit on top of any model that provided services on a cashed-out basis, probably with greater transparency than is currently the case to ensure quality and a different – slightly different approach than is currently taken.

MR GRAY: Because at present the governance structure is relying on competitive forces to create incentives to – toward quality improvement. Is that what you mean?

MR HALLINAN: Yes.

MR GRAY: Next, could you please consider this as a possible mechanism: periodic block or pooled funding for providers based on allocated home care places, as opposed to packages, so something akin to the present manner of allocating flexible residential places to MPSs, and something akin to a methodology by which those places used to be allocated in the home care space prior to 2017. This might deliver sufficient annual or three-yearly certainty or, indeed, ongoing certainty and the necessary economies of scope and scale to ensure establishment of services in areas where the markets are currently thin and their viability. What do you think of that as a potential mechanism?

MR HALLINAN: I also think that's a reasonable mechanism. Both that you've described would have benefits in different circumstances so I think you wouldn't want to rule either of them out. You would want to have a good understanding of the need of the community and what sort of providers or services were available in those settings before you made a judgment about which you use.

MR GRAY: And I want to raise one more which is a little different. It's an idea for a mechanism based on the selection of a preferred provider, but otherwise leaving the market mechanism known as CDC in place for the relevant location. The question of who would be the preferred provider would have to be addressed in detail, of course, but it might involve consultations with local government, with an appropriately organised representative group of stakeholders in the locality, perhaps organised through the primary health network, and if – if a provider is chosen as preferred provider, they are in effect the default provider of home care package services for

that location, unless the customer, the person receiving the package, opts out and decides to go somewhere else.

That preferment, however, might provide sufficient confidence in one's annual budget to be able to overcome barriers to entry into that location. Do you have any views on a mechanism of that kind?

MR HALLINAN: I think that would also have potential and, again, it depends on local circumstance. So just thinking that one through off the top of my head, if you're in a location that was potentially growing and there was potential – in the future, it might be a coastal market; there might be a growth area there for retirees in establishing services, a preferred provider might be a very good way to establish services. But as that market grew and other providers moved in, it might be a good mechanism through which to also phase out preferment on a sort of tiered basis.

MR GRAY: Yes. I should have said under each of the other two mechanisms one would consider service provider of last resort obligations. What do you say about that?

MR HALLINAN: Yes, I think to the extent that you're providing a – you would be providing a specific agreement for somebody to provide services in an area, provision of services as a last resort would be a very sensible thing to include in those arrangements. It would be – no matter what you did in those three options you would have a market – a clear market dominant player to the extent that you had a market available.

MR GRAY: Yes. Thank you. I want to turn to some other topics now, Mr Hallinan and Mr Barden; if you wish to contribute to the answers, please feel free. This is a set of propositions about, in effect, assistance to rural and regional providers where there's a case of difficulties, either financial or managerial, which have led to outcomes that are not necessarily in accordance with the standards, but maybe not so egregious that immediate sanction action is necessarily warranted. I want to ask you specifically about the following proposition first of all, Mr Hallinan: in the regions where there are shortages of aged care service supply, in particular, in certain outer remote and – I beg your pardon – outer regional and remote areas but perhaps in some inner regional areas, there's quite a lot of variation in inner regional areas.

In these sort of areas where there's a demonstrated – assuming there is – a demonstrated scarcity and potential shortage of aged care services and you have a service provider of residential care services which has a need for additional business, governance or managerial expertise and capacity, should the Australian Government have a program in the nature of the SDAP program available for such service providers, fully funded by the government, by which it could enable flying squads of consultants to go and assist those providers to increase their managerial governance and, if necessary, clinical capacities?

MR HALLINAN: I think that would be a worthwhile tool to have in the toolkit for ensuring services are available in local regions. There would be a couple of caveats I would probably place on that, though. We have just introduced business advisory services which very much goes to financial management practices but is an available service for anybody through PricewaterhouseCoopers partnered with a relevant aged care accounting firm. The critical caveat, though, would be the extent to which managerial services or managerial support was provided by government to a local facility. You would need to be quite careful that you didn't remove or reduce capacity or sustainability of that service by in effect replacing what should be core management capability in a facility.

So – and by that I mean you wouldn't want to return to the same provider again and again and again in those circumstances. You would need to have care for the extent to which that service provider was in a sustainable and self-sustaining model of care.

MR GRAY: That was going to be one of my other propositions. In a very extreme case, should the government be able to appoint a manager to ensure continuity of service? It sounds like you're cautious about any such move.

MR HALLINAN: I think you'd just need to be quite careful about how and in what circumstances you did that.

MR GRAY: What about the question of funding? The ACFA report in 2016 suggested that there's a pretty large gap between the financial performance of rural providers, if I can just use that expression, and metropolitan ones, and while the viability supplement has been raised as of March this year by 30 per cent, does the department have hard data on the exact disparities driven by the higher apparent cost base that rural providers seem to have on the ACFA – on the evidence of the ACFA report?

MR HALLINAN: I don't think we've got hard data on the cost base but I think we've got pretty clear data on financial performance. So end of financial year statements are something that we collect and do assessments of and we will be doing an assessment of last year's financial statements now, actually, I think, for the whole of the sector which will allow us to do some comparisons between regional performance, remote performance and metropolitan performance.

MR GRAY: The viability supplement, the base amount before March 2019, it's a fixed – in effect, a fixed amount based on certain points scored which depend amongst other things on remoteness and whether one is in MMM category 4 and upward. Now, there doesn't seem to be a great deal of science behind it. What is the genesis of that figure; was there a detailed cost study on which that was based?

MR HALLINAN: I – like a lot of things in aged care it's quite complex. I don't have a great background on how the viability supplement was developed, but I do know that it's been around for quite some time and it's been increased on numerous occasions. So I don't think we have a detailed cost study that supports the basis for

the viability supplement. But more broadly, we have been working on alternative funding models for mainstream aged care services as well, so the RUC study that was developed by the University of Wollongong and the Australian National Aged Care Classification, so we've been working on alternative mechanisms using cost studies to figure out exactly how we should fund residential aged care service provision.

MR GRAY: Well, are you saying that if and when implemented, which might be some years down the track, I understand, the advent of a RUCS-based system will actually replace the need for the viability supplement?

MR HALLINAN: I think to the extent that you could rely on the cost study data it would be an improvement, certainly, on the existing ACFI plus viability supplement model.

MR GRAY: Is the RUCS study truly a cost study? Has it actually estimated the basal costs by reference to labour costs, etcetera, and is it calculated to meet those costs or is it rather just intended as a more efficient way of classifying a residence so that the available funding can be distributed more equitably and with less transactional cost?

MR HALLINAN: It's certainly the latter, but to the extent that you're able to identify relative cost bases and relative allocations of cost across the 13 different classifications, that was built on cost study information, I believe, by the University of Wollongong but it's well before my time that that activity occurred.

MR BARDEN: I could just add, to the extent that I had visibility of the detail of the study – apologies – the study did look at elements of cost and was able to differentiate different levels of cost in different – different contexts of care, but I couldn't provide any information here today about what elements went to or may have gone to driving those cost differences.

MR GRAY: Thank you. Perhaps first, Mr Hallinan, and then Mr Barden, if you wish, is there a case here for, on the basis of a proper series of cost studies which could be renewed regularly, is there a case here for an independent authority, along the lines of the recommendations of the Productivity Commission in 2011, to do costs studies identifying the varying cost base dependent on degree of remoteness and, in effect, calculate and renew on an annual basis the – the loading that should be applied to mainstream subsidies in the aged care system so that it is going to keep track annually with increases or decreases in the cost base rather than being subjected to these ad hoc, if I can say so, ad hoc changes to the viability supplement?

MR HALLINAN: Look, I think there is a case for annual cost studies, or cost studies on a regular basis that would inform the basis under which the services are funded, yes.

MR GRAY: Should it be done by an independent authority along the lines of the Independent Hospitals Pricing Authority?

MR HALLINAN: That – that model makes sense, yes. It's an existing structure, it works and it's how we fund hospital services.

MR GRAY: With respect to – and perhaps I will direct this question to you, Mr Barden, with respect to, again, this idea of targeted assistance for rural and regional approved providers who may be having difficulties, particularly if it's a case of difficulties in respect of challenging and complex needs, should there be a role for the department to be able to intervene separately from the regulatory framework which will be henceforth administered exclusively, as I understand it, by the Quality Commission, and to intervene in a different way, in an advisory and assisting capacity to give a leg up to approved providers who are struggling with difficult and challenging and complex needs in areas of short supply such as rural locations?

MR BARDEN: Yes, the Service Development Assistance Panel to which you referred earlier is one of the areas of responsibility that I have, and that's exactly the way that we try and use that, is to help service providers. If they're a bit lacking in some areas, whether it might be around governance or other things, essentially give them some assistance alongside them and not in place of them, so that they can develop capacity and capability within their service, and it's fair to say that the – this is fully subscribed and if I were able to deploy that further, I most definitely would.

MR GRAY: So are you making a plea to those in government for a bigger SDAP and one that can be extended to more services in rural and remote locations?

MR BARDEN: I would say that I think that the sector would benefit from a broader reach of a program like SDAP.

MR GRAY: Can I just ask about a very difficult topic which is – and this is, in effect, resident-specific. If there's a particular resident who's presenting such challenges to the service that although the service is able to cope with a certain, you know, perhaps even 90 per cent of the needs of people living with dementia, say, there are a certain percentage of residents who may present such difficult behaviour that it just may not be possible for the service provider with its – with its skillset and with the level of expertise and staff that it has to be able to cope, should the government be able to step in and be able to facilitate transfer of a resident to a more appropriate facility?

MR BARDEN: In principle, so long as there was a net benefit to the individual concerned over the provider, I would tier it in that way. But I would caveat that with a desire that there be a very close intimate engagement with the family or other representatives of the individual or individuals concerned for – or who may be moved.

MR GRAY: Thank you. Mr Barden, can I just ask you briefly – we're running out of time – but I'll ask you briefly about the capital grants idea in respect of MPSs. MPSs are facing the new quality standards. They're going to progressively have to comply with the content of those standards, if not as a matter of delegated legislation, then as a matter of contract under their grants; is that right?

MR BARDEN: That's correct.

MR GRAY: And to that end the Australian Commission on Safety and Quality in Health Care has promulgated a discussion draft of an aged care module in support of the Australian standards on safety and quality in health services. And we've heard evidence that it's going to take effect from July 2021.

MR BARDEN: If I could clarify that, it's January 2021.

MR GRAY: Thank you very much. So there's evidence before the Royal Commission that one of the challenges that are faced by MPSs generally in complying with the Aged Care Quality Standards, and it will be particularly acute once those new standards come into effect and that aged care module comes into effect, is providing a home-like environment because these are often, in effect, old rural hospitals that have been converted.

MR BARDEN: Yes.

MR GRAY: Should the Commonwealth Government be agreeing with the States on a systematic capital grants program to bring those old rural hostels or hospitals into compliance with the new standards, and in particular the home-like environment requirement?

MR BARDEN: I would offer a personal view which is that I think that a shared capital funding arrangement recognising the shared service delivery through MPSs would be an appropriate consideration.

MR GRAY: Mr Hallinan, is this a topic that you have any direct knowledge of? Are there any moves to agree with the States on a systematic grants program to bring the MPSs into compliance, if you like, with the home-like environment requirement?

MR HALLINAN: Not that I'm aware of.

MR GRAY: Just pardon me a moment, Commissioners. Should there be such a grants program – obviously subject to agreement presumably at a intergovernmental ministerial level, should there be such a grants program in your personal opinion?

MR HALLINAN: It's certainly worth considering. It would require agreement from the Commonwealth and States. The other thing that I would couch it in is to the extent that there are different charging arrangements in MPSs as well, we should also consider that – that issue at the same time.

MR GRAY: Are you speaking of the different contribution arrangements from jurisdiction to jurisdiction whereby entrants coming into MPSs as residents don't get charged accommodation payments or means tested payments in, say, New South Wales and WA, but they do in some other states?

MR HALLINAN: Yes. Yes. So differences between jurisdictions and differences between approved providers in the aged care system and MPS providers, as well.

MR GRAY: Yes. The mainstream aged care system imposes those co-contributions.

MR HALLINAN: Yes.

MR GRAY: And it's the Department of Health's position that there should be equity and parity; is that right?

MR HALLINAN: We have negotiated agreements with the states at the moment and we're reasonably comfortable with those, but, to the extent that you were attempting to expand MPSs into other areas – and I think one of the limitations on being able to do so is the notion that there are different charging arrangements for consumers and that can lead to perversities in outcome for both residents and other providers. So it creates a market dynamic that doesn't - - -

MR GRAY: Ms Denton said in one of the seven regions she helps administer, the wheat belt region, she just didn't know of a case where this had ever caused a problem, because it wasn't the case that there was a competitive neutrality in any particular location. What do you say to that? I places where there isn't a competitor from the private sector, does it matter?

MR HALLINAN: Well, if you can drive someone down the road to put them in an MPS, there's no residential accommodation deposit or other fees that applied, for some people that will be a factor that they take into account, rather than a local residential care facility. If you would like, I can try to find some examples from providers where they argue that that has occurred.

MR GRAY: Perhaps if we could add that to the information that you're going to provide in response to Commission Briggs' request, I'd be grateful. Thank you. Commissioners, I will just check my notes. I'm near the end of my questions. If you have any questions, please go right ahead while I check my notes.

COMMISSIONER BRIGGS: I think I do. Just one. Does the department have a view on whether home care package money, which, as you know, is assigned to an individual, could be pooled as part of an MPSs resources?

MR HALLINAN: To the extent that there are benefits to be gained from both scope efficiencies and flexible care arrangements, which we recognise do occur already through our NATSIFAC program and through MPSs to some extent to the level that

there are flexible home care services provided, yes. So having a single provider that can use their staff flexibly across home care, residential care, hospital and other settings could be a very good outcome for a local community without other access to services.

COMMISSIONER BRIGGS: Thank you.

MR GRAY: Two final topics. One I omitted to deal with when I was asking you about propositions, Mr Hallinan, concerning the potential for targeted assistance for providers in areas of short supply where the provider might have either a financial or a – or a managerial or a service delivery problem of some kind. If it were a financial problem, but there was – and there was a threat to continuity of supply of services in an area of short supply, is there merit in the proposition that the Department of Health should have emergency powers to simply inject additional subsidies into that organisation to ensure continuity of supply?

MR HALLINAN: To the extent that there's a sustainable outcome or solution, then I would say yes. But you would need to be quite careful about the circumstances through which you might provide such an emergency funding stream.

MR GRAY: Indeed. And it might be for an orderly transition or an orderly transfer or, if there was a sustainable outcome on the horizon, it might be for those purposes, but, subject to criteria of that kind, is there merit in conferral of power on the secretary to, in effect, just grant additional subsidy?

MR HALLINAN: I think there is. The couple of risks are one around learned helplessness. You wouldn't want to create a situation where you established a reliance on government special circumstances as an ongoing basis of service provision. And I think you've already addressed the concerns, so I will stop.

MR GRAY: Yes. Thank you. And, finally, on workforce, you might have heard me floating the proposition a number of times to a number of witnesses about some specific ideas relating to recruitment and retention initiatives in rural areas. Firstly, do you agree, Mr Barden, that there should be a joint Commonwealth/state approach to developing initiatives designed to increase the depth and skills of the rural workforce? And to what extent – if you do agree with that, to what extent is that happening now?

MR BARDEN: To answer the second first, I don't know. But to the extent to which the future aged care system sees continuing, if not further, cooperation between Commonwealth and states in the shared delivery of service through shared infrastructure, the concept of shared facilitation of a workforce that's suitable for rural and remote areas makes sense to me.

MR GRAY: So you're limiting that to the MPS program?

MR BARDEN: No, not necessarily. No. I think, for example, if I were to think of the NATSIFlex program or NATSIFAC program being able to have training opportunities for young people, particularly young indigenous people in community supported by education structures with some sort of career pathway through the NATSIFlex service, both in terms of how they develop their skills, but then attain employment, is something one, personally, that I think is just a good thing, and (2) I know is part of the aspiration of a good number of the providers who operate out in the very remote parts of the country.

MR GRAY: I think I misunderstood your answer. You weren't saying there needed to be state owned infrastructure per se in order for your support for a joint approach to deepening the workforce - - -

MR BARDEN: No.

MR GRAY: - - - to be valid? No. Mr Hallinan, do you consider that there should be more done with respect to the development of mechanisms between Australian Government and states and territories concerned aimed at increasing the number of qualified aged care workers in regional and remote areas?

MR HALLINAN: I think we could do more. And some of your earlier propositions to people around scholarships makes sense. If I link this question back to the earlier discussion around what might be a reasonable level of services that people could expect in different circumstances, just to go out thinking, you might want to contemplate what would be an appropriate circumstance under which a telehealth service for some clinical service might be a reasonable outcome, what might be a circumstance through which an outreach model for allied health or specialist geriatric care might be reasonable and what might be the sort of circumstance where combining those resources of, you know, the MPS model or a collaborative model might provide those services on-site through shared workforces across the health and aged care setting.

MR GRAY: So they're going to augment the capacities of the workforce, but they're probably not going to be ever a substitute for real people on the location, are they?

MR HALLINAN: No. That's correct, yes.

MR GRAY: And do you agree with – I think you just mentioned some support for the idea of regional scholarships. What about the idea of Commonwealth Government providing subsidy for the kind of program that was mentioned by Ms Rivett in the Shepparton context, that is, for a linked RTO and aged care provider arrangement whereby there's a pathway from the RTO into on-the-job training within the aged care provider, but it would need some Commonwealth subsidy to support it. Is there merit in in looking at that idea?

MR HALLINAN: I think there's merit in looking at it. The extent to which an aged care provider could become a training provider or could have a specialised vocational stream and be partnered with an RTO might create value for the workers in that facility or in that provider, as well as also providing a locally-sourced solution for workforce. I think if you can – to the extent that you can do locally-sourced workforce solutions they should be – they should be followed. The challenges around visiting workforces, agency staff, migrating workforces, as well, they do great work for the sector and for the community, but they're often not there for very long. So that locally-sourced solution might – might have some – some benefits to explore, yes.

MR GRAY: Thank you. Commissioners, I've run over my allotted time. I have no further questions.

COMMISSIONER PAGONE: Thank you, Mr Gray. Gentlemen, thank you for your thoughts and comments. It has been very helpful. We urge you to be even more helpful, though. This is an important undertaking that has been started. At the end of our term we will go our respective ways. You, or at least the department, will continue thereafter. You've been asked to produce a few things. Can we add to that by saying it would be really very useful for the Commission to hear what the department thinks needs to be done to produce something that is viable and also, rather, ensures the viability of those providing resources and facilities to the aged in communities like this which is both viable and also meets the needs of the people. It would be very helpful if we receive that soon. Thank you.

Thank you. May they be excused, Commissioner.

COMMISSIONER PAGONE: Yes. Of course. You are excused from further attendance. Thank you, Gentlemen.

<THE WITNESSES WITHDREW [2.56 pm]

MR GRAY: Thank you, Commissioners.

MS HILL: If the Commission pleases, I call Peter Harris.

COMMISSIONER PAGONE: Yes. Thank you, Ms Hill.

<PETER VINCENT HARRIS, SWORN [2.57 pm]

<EXAMINATION BY MS HILL

COMMISSIONER PAGONE: Ms Hill.

MS HILL: Mr Harris, could I ask you to please state your full name.

MR HARRIS: Peter Vincent Harris.

MS HILL: And how old are you?

MR HARRIS: I'm 72.

MS HILL: Where do you live?

MR HARRIS: Nyngan, Western New South Wales.

MS HILL: And how far from Mudgee is Nyngan?

MR HARRIS: About 290 k.

MS HILL: And, Mr Harris, you're married to Beth?

MR HARRIS: That's correct.

MS HILL: And you've prepared a statement that talks about your experience and Beth's experience of aged care services, haven't you?

MR HARRIS: Yes, I have.

MS HILL: And you've got a copy of that in front of you in two forms. One has got slightly larger text.

MR HARRIS: Correct. Yes.

MS HILL: And do you see the document displayed on the monitor, document ID WIT.0593.0001.0001?

MR HARRIS: That's correct.

MS HILL: Were there any changes you would seek to make to that statement?

MR HARRIS: There's only one change. Paragraph 13, the last sentence, which it says "whether" and should be "when".

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

MR HARRIS: They are.

MS HILL: Commissioners, I tender the statement of Peter Harris.

COMMISSIONER PAGONE: Yes, the statement of Peter Harris will be exhibit 12-26.

EXHIBIT #12-26 STATEMENT OF PETER HARRIS (WIT.0593.0001.0001)

MS HILL: Mr Harris, the plan for your evidence this afternoon is that I'm going to ask you some questions about Beth and your life together with Beth, your experience caring for Beth at home and then your and Beth's experience of Beth living at the MPS in Nyngan. Does that sound like a plan?

MR HARRIS: That's .....

MS HILL: When did you and Beth marry?

MR HARRIS: 16 October 1999.

MS HILL: And how would you describe the woman that you married?

MR HARRIS: Other than my best friend, strong intelligent and articulate.

MS HILL: In the mid-1990s, you and Beth entered into a business together, didn't you?

MR HARRIS: That's correct.

MS HILL: What was that?

MR HARRIS: We purchased a bookshop – independent bookshop in Bateman's Bay, south coast New South Wales.

MS HILL: And what was life like together at that time?

MR HARRIS: Hectic, mad, fantastic. We worked seven days a week. We lived together and worked together 24 hours a day. We certainly had our spirited arguments but we got on really well, and life was enjoyable. We trained our staff so that we could get away and, basically, we travelled with the book industry through parts of the world and throughout Australia.

MS HILL: Can I take you to 2009. In your statement you described that in 2009 you started to notice some changes in Beth. How did that come about?

MR HARRIS: The changes were initially empathy, emotion; changes in those two areas. From – also there were – there was one major incident with a – in a car, with a

car where Beth had an accident. Also, since the introduction of GST, Beth, being the daughter of an accountant, took over the control of – you know, happily took over the control of all the accounts. By that stage in 2009 she was starting to ask for support. We used to have authors every six months – sorry, six weeks, four to six weeks. Beth revelled in being involved with that and the preparation, and the organisation and the introduction. It got to the stage of asking for my – that it was about time I got involved rather than asking for support. It was more a case of it's now time for me to get involved. And they – they are a number of the changes that started to occur at this stage.

MS HILL: And ultimately in 2013 you describe in your statement that Beth was diagnosed with early onset dementia.

MR HARRIS: That's correct, as an initial diagnosis, yes.

MS HILL: And in 2015, Beth was diagnosed with Parkinsonian-plus syndrome.

MR HARRIS: That's correct, yes.

MS HILL: What did that mean for the care that Beth needed at that time?

MR HARRIS: At that stage, other than changes in speech, a slight change in balance, it didn't require, initially, involving support with dressing and showering and toileting, but one of the – the diagnosis was – resulted from some years with a neuroscience research group out of Prince of Wales and New South Wales University. That changed over a period of time from early onset dementia to corticobasal degeneration, and of the caveats on that was that in spite of the advances of medical science there is no medical support for Beth.

MS HILL: How old was Beth in 2015?

MR HARRIS: 63.

MS HILL: Were you working at this time?

MR HARRIS: Yes, I was. We had moved to Nyngan at that stage. Beth's daughter – Beth and her daughter, Skye, were very close and we had spent a lot of time and her four grandchildren were in Nyngan so we decided to move to Nyngan and within a week of moving to Nyngan I was offered a job in a funeral parlour.

MS HILL: And were Beth's care needs increasing at home?

MR HARRIS: Slowly. I think that you – I was probably pedalling fast and her changes were occurring but in a sense you didn't notice it initially, but yes, they were changing.

MS HILL: And what sort of things were you doing or increasingly doing for Beth?

MR HARRIS: Food, because food is an issue. There's going to always be an issue, but food, dressing, housework, preparing of clothing for her, not so much washing and toileting at that stage but it was progressively getting to that point. Balance. Beth's basic issues are balance, dexterity, vision; all things that affect her daily life. One thing that hasn't affected is her brain. She is non-verbal but she understands everything that's going on.

MS HILL: And did you ultimately receive a home care package for Beth?

MR HARRIS: Yes, we had an ACAT assessment done in, I think it's 2014 and two thousand – around 2014 for a level two package, and at that stage we were given support through the Commonwealth Respite and Care Centre in Dubbo which provided support with us for wheelchairs – sorry, a walker at that stage and within 12 months a wheelchair, and pointing us in the direction of other agencies that could support us, and this was before My Aged Care.

MS HILL: Can I take you then to August 2018. What's happening with Beth's health at that point in time?

MR HARRIS: August 2018, Beth had – the issues had progressed to the point where she was using pureed food and thickened water only. And it got to the point where she was having – at that stage July – the winter of 2018, she had three or four bouts of aspirated pneumonia, three of those in hospital. It got to the point where we realised that she was having – there were going to have to be other interventions. Her weight had gone down to 37 kilograms. We – the last three bouts, the last bout of aspirated pneumonia was in late July, early August. We had been planning to contact a – we had arranged appointment with a surgeon in Dubbo for the insertion of a PEG tube.

That had been put off on two occasions because Beth's infection levels were far too high for an operation, but the VMO and the surgeon in Dubbo decided that they would work together with weekly X-rays and blood counts to get her level to an acceptable level, and accepting that her condition had become chronic, and they would get her straight to Dubbo once they reached that level and do the operation that day.

MS HILL: And that ultimately takes place in August 2018?

MR HARRIS: In August 2018.

MS HILL: After the surgery that Beth has that you've described, Beth gets discharged to the Nyngan MPS?

MR HARRIS: Yes, I – I was there. It was day surgery. Beth stayed overnight. We made sure that the PEG tube was working in Dubbo, then I drove her back home to the MPS to – for another period of time so they made sure – to make sure that the PEG tube was working and that Beth had recovered fully from the operation. And at

that point in time everything seemed – everything was working fine. At that point in time the manager of the MPS took me aside and said "Beth's not coming home".

MS HILL: Using – and drawing on your and Beth's experiences, what is the MPS in Nyngan? What does it offer Beth and what does it offer you?

MR HARRIS: It offers me a life. It offers Beth a life. I – once Beth had – had been – had gone into high care in Nyngan – she was moved from the hospital's part of the MPS to the – directly to the high care and thank goodness they had a placement at that point. I at one stage, probably the first few weeks, I was sleeping 10 to 14 hours a day in between, you know, seeing Beth each day. I even went to my doctor at one stage concerned that there was something wrong with me, and he basically said, "Go home, have half a glass of wine and go to bed because you're okay. Your body's just – you're exhausted". And I think that's probably – that's the difference. It's given me a life and it's given Beth a life.

The – where I am – we are so lucky to have the MPS at Nyngan because the community – it's a community-involved organisation. Everybody that works there – well, Beth has taught two of the nurses' children, where she used to be an English teacher and a maths and English consultant and a deputy principal of the school, and she was working part time in Nyngan. And she was able to get her life back. I – the nurses can look after Beth for eight hours a day and do it well, and they can go home, where I envisaged I could do this for 24 hours a day, seven days a week and it just was not going to happen. I think the people I work for would probably bury me within six months.

MS HILL: You've described Beth as presently being – her present state of health is that she's non-verbal.

MR HARRIS: Yes.

MS HILL: How do you communicate with Beth?

MR HARRIS: Thumbs up, thumbs down, there's one other finger – hand signal I won't give you that the nurses taught her to give to me. We use an app. I discovered an app out of England called Predictable which is using an iPad. Through an Australian Unity as part of our package we worked out – we found out a way of paying for that using iTune cards because Australian Unity – their system required raising an invoice but we worked around that. We worked around most of our problems. And that as part of the app has a keyboard, but now with Beth's physical issues, she has dexterity, double vision, depth perception.

She can't use a keyboard so we break the alphabet up into five groups, A, B, C, D E and she will raise her hand, and sometimes she anticipates, sometimes she doesn't, and that can be a very challenging time but I think the last time was before Melbourne Cup day, she wanted a dress. Okay. I had no idea as a male what she was talking about, but, of course, they were getting dressed up for Melbourne Cup

day at the MPS. Dress is me, so I ended up bringing four different types of dresses so she could get dressed up for the Melbourne Cup. But that's how we – for anything other than – you know, I get terribly frustrated, Beth gets terribly frustrated, but it works.

MS HILL: And do you have much to do with the staff at Nyngan MPS?

MR HARRIS: Sorry?

MS HILL: Do you have much to do with the staff at Nyngan MPS?

MR HARRIS: I visit Beth from about 3.30 to 4 till 6 – between 6 and 7 every day. I have – I take Beth to craft on Tuesday with a lovely group of ladies who ..... talk with her for two hours a day – two hours on Thursdays. I take her home and I take her home on Sunday. I have got to know all the staff in Nyngan and in 2014 there was a vacancy on the health council and I applied for that vacancy, telling the manager that there was certainly the reason I really wanted to get involved, because there's not much I can do in the community but also as a – I wanted to know what was happening in the – the hospital and as part of that also a delegate on the – the health – the safety committee in the hospital. So yes, I know every one of them by name. I know their families. Unreservedly, I put my life in their hands.

MS HILL: You have provided the Aged Care Royal Commission with two photos of Beth, haven't you?

MR HARRIS: Yes.

MS HILL: Operator, could I ask you to please display – thank you, operator. Mr Harris, they're the two photos that you've asked for us to display this afternoon.

MR HARRIS: Yes.

MS HILL: Why did you want to share those photos with the Commissioners?

MR HARRIS: I hesitated to. I broached the subject with Beth, and I said, well, "Would you want to?" and "Yes". Well, "Which photo do you want?" And she can slowly shake her head, and put two thumbs up, and I thought – and I got the wrong idea but it took about 15-20 minutes to work out that she wanted two photos and basically we used Predictable to work out the fact that she wanted a photo – the first photo was taken 12 months before her definitive diagnosis, 12 months – 2012. And the last one was taken at a mock wedding which they had in the MPS in October this year; that's why she looks so gorgeous.

MS HILL: Did you talk to Beth about coming along and giving evidence today?

MR HARRIS: Yes.

MS HILL: How did Beth feel about you coming along?

MR HARRIS: I – it started out as a – with the people who visited the MPS at Nyngan, it started out just an eight-minute conversation, then I prepare a statement, and it's come to this. Not that I was reticent to come and talk. I just felt it would be fairly difficult for me, but I had no choice. I was forced by that lady to – yes, I had no choice, yes, you have to do it. Using Predictable - - -

MS HILL: You're referring to Beth when you say - - -

MR HARRIS: Yes, that lady. I asked, "Why do I have to do it?" And she – okay. So I got the iPad out. It took about 25 minutes. And it boiled down to because of people like me. I can't answer any more than that.

MS HILL: And, on your own experience, why was it important for you to come and tell your and Beth's story?

MR HARRIS: Because I think carers are underrated and we underrate ourselves. And I think at some point when – in this situation where our lives have changed dramatically and Beth not being able to come home permanently, you've suddenly – when the weight has been taken off you, you realise how you've been travelling. And I think at one stage in my report I talk about you feel like – the analogy is a frog in cold water, the power turned on very gently. You don't know when you're cooked. You don't know when you're finished. But the main reason I think I've come here today and persevered with this is that our story's a sad story, but it's also a very good story and it's a good story because of the caring community we live in, because of the MPS system we have and because of the people who work in that system.

MS HILL: Commissioners, they are the questions I have for Mr Harris.

COMMISSIONER PAGONE: Mr Harris, thank you for coming to share your experiences with the Commission, not only with the Commission, but with the entire Australian community that's been watching. These stories are more important than you might realise. They have a deep impact upon us and the community generally. Please pass on our thanks to Beth for having asked and possibly required you to be here. Thank you. You're free to go.

MR HARRIS: Thank you, Commissioners.

<THE WITNESS WITHDREW [3.17 pm]

COMMISSIONER PAGONE: Mr Gray.

MR GRAY: Thank you, Commissioner. Commissioners, I would like to make some brief closing remarks. I began this hearing with a basic proposition about equitable access to aged care for people living in rural, regional and remote areas. In our submission, Commissioners, the current aged care system is not meeting the objective of equitable access to aged care in rural, regional and remote areas and this needs to change.

As you heard in the opening, it's indeed been the case that during the hearing we've focused on four broad topics or issues. First, the sustainability of the mainstream model for delivery of aged care in regional and remote areas. And, in particular, we focused on home care. But we've also had regard to some of the challenges faced in residential care.

Secondly, whether existing policy approaches to supporting the provision of aged care in regional and remote areas require improvement in order to close what appears to be a widening gap, particularly in home care, and to remove inequities that exist.

Thirdly, the efficacy of the system since 2017 for allocating home care packages in what appear to be prevalent thin markets in particularly outer regional and remote areas. And, fourthly, we've had some regard to some strategies and mechanisms to improve the depth and quality of the aged care workforce in regional and remote areas, but that's a big topic and we've probably barely scratched the surface of that topic.

So over the three days of the hearing we've been endeavouring to, and we have tested, a number of propositions relating to these four broad topics. And in these closing remarks I will briefly outline a selection of the themes that have emerged and I will refer to some of the evidence, certainly not all of it, that's emerged during the course of the hearing, including in written form.

At the outset of the hearing I raised for your consideration the potential need that exists for the funding of aged care services delivered in particular regional and remote areas to a level that accords with the additional costs of service provision in these areas. And, in particular, I raised the proposition that perhaps the Australian Government should be establishing an independent authority to, firstly, conduct a cost study to determine the appropriate level of subsidies in these contexts and, secondly, to update that cost study and determine loadings annually.

And that proposal has met with a good deal of support from the witnesses you've heard from, including, perhaps to some degree in a qualified way, but including from Mr Hallinan and Mr Barden.

The point has been acknowledged that various governments and industry reports have reported that there are higher costs providing aged care in rural and remote areas. The ACFA report of 2016, in particular, is noteworthy. And it identifies lower income. And there's also the issue of lower ACFI levels. It appears, in

particular, from that report that aged care providers in regional and remote areas are facing cost and financial performance disparities.

The drivers include costs of staffing, perhaps higher rates of agency staffing at a premium, travel and transport, freight costs, driving up the cost of commodities, consumables and maintenance. And it seems clear that there is a lower workforce pool available as a general proposition in these areas that can have the sorts of implications that you learnt about during the Pioneer House case study.

In its 2019 report on the funding and financing of the aged care industry, ACFA stated that even with the 30 per cent increase in the viability supplement, of which you've heard, which takes effect – which took effect from March this year, the number of providers facing financial pressure and seeking to exit the sector remains significant. And that is a matter of great concern.

The Australian Government pays both home and residential care providers that viability supplement, but it – there's a good case for considering that it should be replaced with a more methodical cost study-based and regularly updated series of loadings determined by an independent authority.

Further, if a key driver of increased costs is workforce costs, as seems logical and seems consistent with ACFAs analysis, then this should increase proportionally with the time spent on the care needs of the care recipients; that is, one would think that the loading to take into account the increased cost base should operate in some way as a proportion of the basic care needs subsidy and it shouldn't be a fixed amount. In our submission, there needs to be a robust and independent mechanism along the lines that I've outlined. The detail of that mechanism will need a good deal of attention.

Moving to a related but separate point, as I've raised at the outset and as I've tested with a number of the witnesses you've heard from, there's a good case for a proposition that the Commonwealth should conduct a review of the degree of service access in regional, rural and remote places. There are ways and means by which that could be done. No doubt the details of the review would need a good deal of attention, as Mr Hallinan said in his evidence, but in principle such a proposal is appropriate and it should occur.

And on the basis of a review of that kind, it would be possible, in a systemic manner, to determine where are the places where the market is working for those higher level home-based care services, currently represented by the home care package program, and where is the market not working.

And in areas where there's no compelling evidence of a workably competitive market, we've been testing the proposition that the department should vary and augment the current market mechanism for the allocation of home care services to ensure a sufficient supply of services to meet demand in that area. And I floated with Mr Hallinan, in particular, three potential mechanisms by which that could be done.

And, again, in an appropriately qualified way, Mr Hallinan acknowledged that each of those mechanisms warrants further attention and could be a workable and appropriate method for addressing that problem. And he also agreed that the problem should be addressed.

In addition, Commissioners, yesterday you heard from three providers of home care in regional and remote New South Wales, and all three gave evidence that control and consumer choice are very important to ageing in place with dignity. Counterbalanced against that important point, it's necessary also to consider that they gave accounts of the limited number of home care providers operating in outer regional and remote areas in New South Wales. The choice of a provider decreases the further away from a major town you go. Mr and Mrs Dunlop described the challenges they experienced in finding a provider prepared to travel to their rural property to deliver care.

This is evidence that raises another important point. These additional travel costs, it seems on the evidence the Royal Commission has heard before, are absorbed into – or absorbed by the home care package and become, in effect, an impost on the recipient of the home care package which they've not necessarily budgeted for at the outset. And it will, no doubt, with increasing remoteness, cut into the ability of the package to fund their actual care needs, if I could put it that way.

And choice of providers in regional and remote contexts may be even more limited than it might appear at first glance when one searches the My Aged Care portal. Providers can be listed as delivering a service on the My Aged Care website, but, in fact, be based in a city. And it's at least doubtful, and it at least raises a line of inquiry, whether all of the providers who might appear on a search of My Aged Care for a particular locality actually have any presence in that locality at all. This is a matter, of course, I raised with Mr Barden. It seems that the measures being taken by the department at present on the question of verification of certain contents of My Aged Care do not extend to verification of claims of coverage of service.

Commissioners, you heard this week that where a provider can't recruit locally to deliver services, they may broker to another regional provider. And that original provider, who's seeking an intermediary to provide the services, may not be located in the area. But that, again, raises an interesting question about the on-costs of that transaction and whether that is eating into the budget provided for under the package and whether there's full disclosure of these matters when aged care recipients are trying to make their budgeting decisions at the outset.

The issue is deeper and more problematic than just a lack of choice in service providers and the cost of travel. The current market-driven mechanism relies on competition between providers, but that competition may be entirely absent in certain regional and remote areas. Dr Winterton told you yesterday of the recommendations of the regional, rural and remote special interest group of the AAG that she chairs for a review to be conducted a nationwide basis as to the degree of access of aged care services in all the localities of Australia. She wasn't able to provide a concrete

proposal for just how granular that review would have to be, and when I raised this with Mr Hallinan today he agreed in principle that a review of this kind would be an appropriate measure.

Again, attention would need to be given to the degree of granularity with which it's conducted but it should be done and it should be done soon. Mr Hallinan also agreed with the proposition that had been raised by Dr Winterton concerning using that knowledge to create minimum service access standards so that one can engender reasonable expectations about the level of service one can expect depending on degree of remoteness, and also one can identify variances and disparities where they occur, more readily.

That resource could be updated, regularly kept updated continually by data fed, presumably, through structures such as local health districts in New South Wales, or primary health networks throughout the country. The evidence and the data about coverage of services for Australians who need home care are patchy but this conclusion can be drawn: the 2017 reforms which allocated control over spending of the home care package funding to the consumers on a national basis according to priority across the country, have favoured metropolitan and inner regional areas over outer regional and remote areas. The data is clear on that.

That evidence suggests that moving to a national allocation process has, for some reason we don't fully understand, led to a negative impact on access to home care in rural areas and we await with interest the response to Commissioner Briggs' question on that topic. The Department of Health acknowledges that – and this is a reference to Mr Barden's evidence and also Mr Hallinan didn't disagree – the department acknowledges that the reforms have reduced access in that sense, and they've reduced access in regional and remote areas, at least as a proportion of available HCPs and in remote areas in absolute terms; this needs attention.

There's no provision within the current system for a provider of last resort mechanism in the home care space. This question of patchy or thin markets and the absence of workably competitive markets has had at least these consequences: there's uncertainty and in all probability there's an absence of full coverage of the level of higher – higher need services represented by the home care package. And there's limited – and perhaps there's no systematic active monitoring at an appropriately local level of where those patches are. The department conducts forecasting exercises in relation to need for aged care services including home care services, but the indications from the evidence today are that this is done on the basis of pretty broad population – aggregate population-related assumptions, and there's really no evidence before you of a detailed locally based review of where those thin markets are.

This, in my submission, represents a lack of the appropriate level of stewardship that the Royal Commission should be able to expect and it needs remedying. It can't be allowed to continue on into the future. It's an untenable situation to rely on a market mechanism when the data is suggesting, and the anecdotal evidence is also

supporting, the proposition that there simply aren't competitive markets in a number of these places. We need to find out where they are and to address them. Our witnesses from the Department of Health pointed to the MPS system as, to some extent, a stopgap in such areas but there's no basis for any confidence that on a systemic level the MPS – the presence of MPSs in the 180-odd locations they inhabit around the country are sufficient to cover all of those areas.

Turning to the anecdotal evidence that we must go to in lieu of the absence of systematic quantitative evidence, Ms Attridge of Uniting NSW/ACT told you yesterday, and I quote:

> *It's just heartbreaking to know of consumers that have need that's not being responded to. I think it adds complexity into the system, making people become frailer far quicker than they should.*

The evidence you've heard in Mudgee this week, Commissioners, and in our previous hearings is supportive of alternative and more flexible funding models to address the issue of thin markets, particularly in relation to home care services. And Mr Barden has agreed in his written evidence that flexible, collaborative and pooled funding arrangements will assist in meeting some current challenges associated with aged care service delivery in regional and more remote areas, including where there's uncertain demand and irregular income and high unit costs of goods and services.

The options for variation or augmentation are potentially numerous. I've raised three in particular, as I've said. We're not in a position now, and it would be premature to advance a particular mechanism to address this problem, and it's going to be a work in progress over the – over future months to develop the proposals in detail. I had said in my opening that I would spell out in precise terms in my closing the exact terms and scope of these propositions. On reflection, I won't do that. We need to take stock of the evidence we've heard in this hearing. We need to analyse it in combination with other evidence that will be received and develop these proposals with the benefit of that reflection.

Can I turn to this topic of potentially conferring on the secretary greater powers of intervention in support of approved providers in regional and remote areas, where there's evidence of scarcity of supply of services and a public interest in ensuring continuity of service. Now, on Monday, you heard a limited case study examining the experience of Pioneer House, a local residential aged care facility here in Mudgee. I'm not going to advance now, in these closing remarks, any particular proposed findings in relation to Pioneer House. At the end of this address in a few minutes, I'm going to seek a direction for written submissions to be provided by counsel assisting and they will be made available to all of the parties who have leave to appear.

Those written submissions will at least cover any proposed findings. They may cover certain other matters that have arisen from this hearing. Without making any particular connection to what may be findings or other matters that arise from the

case study, I've been testing certain propositions during the course of the hearing about enhanced intervention powers on the part of the department. One of the sets of propositions I've been testing is a proposition for intervention in the form of advice and assistance and capacity building along the lines of an expanded suite of interventions that are currently available under the Service Development Assistance Program and that's a suite of proposals that have received general support from, I think, all the witnesses in the hearing, Commissioners.

There's again – perhaps in escalating – in an escalating fashion, a series of other interventions that I've been proposing. They've met with somewhat less than general support from the witnesses and in some cases probably no support whatsoever. However, I will mention them briefly. One is emergency short-term subsidies, and Mr Hallinan sounded a cautionary note about the learned helplessness aspect of that and we will need to reflect on that. Another is the concept of, perhaps with the concept of the approved provider concerned, perhaps without it, the ability, if it's necessary in emergency circumstances, to ensure continuity of supply of services, the idea of the Commonwealth funding a manager to continue to run a service.

And another is the idea of the department being able to intervene and to facilitate the transfer of a resident if an approved provider in a rural setting is just not capable of providing safe care to that person anymore. Now, these are all ideas that have been merely floated as propositions during this hearing and, I repeat, they don't have any particular connection to Pioneer House; they're not intended to. And they all will need a good deal of reflection before anything concrete will be proposed by your counsel assisting team, Commissioners.

Can I turn now to the multipurpose service program. Much of the evidence you've heard, Commissioners, focuses on the positive aspects of the model. It does, on the evidence you've heard, appear to be supported by a consensus amongst experts and officials and, indeed, I'm thinking now of the eloquent evidence of Mr Harris. This is a program that has a good deal of support behind it, and a lot to be said for it. It is, in part, a stopgap solution to this problem of scarce supply of services in rural and remote areas. That said, there are some aspects of it that have been the subject of attention in the UTS report. There are real questions raised by the disparity between some of the co-contribution requirements that apply in some jurisdictions but not others and which apply in mainstream residential aged care but which don't apply in some jurisdictions in the MPS scheme.

I've been testing a proposition that these conditions of entry into MPSs should in principle be on par and equitable across the country. That's not met with universal acceptance by the witnesses. Ms Denton said that there would need to be a local consideration given to that issue on a case-by-case basis. Even our Commonwealth witnesses this afternoon weren't necessarily emphatic in adopting any position that those conditions would need to be uniform across the country and across the modalities of residential care. So, again, we will need to give careful consideration to that.

But on the evidence before you, including the UTS report, while preserving the rights of existing residents, there's a need to consider the introduction of more uniform co-contribution requirements in the MPS program. Now, this hasn't featured in oral evidence but it's present in abundance in the documentary evidence. Another difference between the MPS program on the one hand and mainstream residential aged care on the other and, indeed, home care on the other, is that there's no formal requirement for assessment by an ACAT or a Regional Assessment Service before a person receives residential care or home care from an MPS. We heard that by policy, in the jurisdictions you've heard from, an assessment does occur but it's unclear whether it's actually a precondition of eligibility for those services, even in those jurisdictions. And in some jurisdictions it appears to be absent.

There's a good case for a proposition that there should be uniformity across the country and that it would be more equitable, having regard to the impost on the public purse represented by the MPS program, that there should be an assessment of need before people can enter MPS and receive either residential or home care services through MPSs. And this is consistent with recommendations in the UTS report.

There's an aspect of the MPSs that does need quite urgent attention. It's linked to the notion, again picked up in the UTS report, that MPS managers by majority report – majority from a sample of 54 who were surveyed report that their facilities are not – I'm paraphrasing, but not appropriate for the provision of proper dementia care. And this is linked to the requirement which must be met under the new quality standards to provide a home-like environment. It's not by any means the same proposition, but it's linked to it. And there's going to need to be, on the evidence before you, a good deal of infrastructure improvement in order to get the physical infrastructure, the MPS program, to the state where it can provide appropriate dementia care and can provide a home-like environment.

I've been finding a proposition that there should be a joint approach by the states and Commonwealth hammered out to agree on a capital grants program on a systematic set of criteria and assessments and design principles. And that's, again, another proposition that we will be giving thought to in the months ahead as we work up proposals to put before you, Commissioners.

We also submit that there's a case for the proposition that Commonwealth and state and territory Governments should work together to expand the MPS model. Now, that's subject to the improvements that I've outlined in earlier propositions. But what would be the purpose of this expansion? It could be a better answer to this problem about the patchy delivery of aged care in regional and remote areas. One can see immediately that there are interdependencies between that proposition and the earlier propositions I've advanced about the need to find out what those patchy localities are and to come up with a systematic solution for them. But this is one possible mechanism that might be developed to address that problem.

I'll leave it there. One can see that, depending on whether those other mechanisms are to be advanced, there might be less of a need for this mechanism. And that's what I mean by interdependencies between these issues.

Finally, Commissioners, I want to speak about workforce issues in regional and remote areas. Again, if I can mention Pioneer House without saying what the findings we will be proposing in that case study will be, it's clear that there are general workforce challenges in rural and remote areas and that they get more and more challenging the further one gets away from regional hubs. It's plain common sense, really, that you can't provide aged care without a suitably numerous and skilled workforce.

And there are issues concerning the proportionally greater progression of the ageing society phenomenon in rural areas. And there are difficulties in retaining a youthful workforce. You've heard evidence about, in effect, the preference of some providers to, in fact, recruit older workers, because there's a perception that the younger workers, after there's been an investment in their training, will not wish to remain and there will be costly churn in the workforce and phenomena of that kind.

All of these issues need to be considered in a systematic way. We haven't attempted to establish a full suite of systematic propositions that might address these problems in the rural setting, but we have floated and tested some specific propositions around recruitment and retention relating to conditional scholarships, linkages with RTOs. And those propositions have received, I think, universal support from all witnesses you've heard from.

But there are a number of other issues that will need to be considered. And the big one is remuneration gap. And you heard concerning evidence from Dr Winterton yesterday about studies. They're only qualitative, but they're what we've got, and they're suggesting that there's an erosion of what might have been a sort of an altruistic and rewards-based incentive for retention in this workforce. And that just highlights the importance of bridging the remuneration gap as soon as possible. That's, of course, a matter that's going to need a good deal of work in the months to come.

Within the broader scope of workforce reform, it's also apparent there needs to be a greater focus on attracting people who are caring and who might – I might use the expression – have the values that are appropriate for the provision of aged care. And we've heard evidence about an increasing interest in this form of recruitment with training to follow afterwards.

In Mudgee, there's, we've heard from the evidence, significant support for local training and development that includes a local workplace learning component. Although concerns have been expressed that in-house training might place additional responsibilities on providers with workforces that are already stretched, a commitment by an employer to such opportunities is quite a powerful thing. And I'm referring to Ms Goode's evidence, in particular.

While Ms Goode didn't give support to the idea of government subsidy for scholarship programs, other witnesses have. And perhaps there's an appropriate mix of offerings to be formulated in this area and to create incentives along the lines of scholarships and local training that would help address the issues. Ms Goode, and also Mr Lyndon Seys of Alpine, have provided evidence of collaborative programs targeting at tackling the particular issues of workforce shortages in rural areas. And the evidence of both of those witnesses was positive and encouraging on that score.

The Loxton Districts Health Advisory Council, Ms Goode's body, has established a local scholarships program targeted at local community members as a response to local aged care workforce shortages. And Ms Goode said that scholarships for members of the community to undertake a cert III in individual support had raised the profile within the Loxton community of the important role of care workers. And, as a practical matter, in the first year of offering the scholarship program, it resulted in seven graduates obtaining employment in the local aged care unit.

Mr Seys of Alpine Health described how his organisation had established an RTO to provide training of staff of alpine and other members of the community. And Mr Seys told you that people undertook training were employed locally after that training. Since its inception in 2012, Alpine Institute expanded the range of courses that it offers.

In summing up, Commissioners on the importance of ensuring people have the most equitable access to aged care services possible, I want to quote Ms Dunlop, who gave evidence yesterday. When describing her property, her home, she said:

> *I do love it. I don't want to move. I love having animals around me, but it is so, so hard when you can't get any help out there.*

Commissioners, those are our submissions. I now seek leave to add five tabs to the general tender bundle, numbers 58, 60, 61, 62 and 63. And each of these documents has been referred to in evidence today. May I have that leave?

COMMISSIONER PAGONE: Yes, you do have that leave, Mr Gray.

MR GRAY: Thank you, Commissioner. And, finally, I seek the direction that I foreshadowed a short time ago.

COMMISSIONER PAGONE: Yes.

MR GRAY: I think you have it before you in written form. I'll briefly summarise. That written submissions may be provided by counsel assisting within two weeks time by 20 November, with any written submissions to be provided to the Royal Commission by parties with leave to appear at this hearing by no later than 5 pm on Wednesday, 4 December 2019, and a right of submissions in reply five business days thereafter.

COMMISSIONER PAGONE: I make those directions, Mr Gray. They've been signed and I will hand them down to you.

MR GRAY: Thank you. Those are our closing submissions.

COMMISSIONER PAGONE: Mr Gray, thank you. We want to thank counsel for their assistance during the hearings here in Mudgee. Particularly, we would like, also, to thank the Mudgee community for having hosted us over the last three days. For me it is a first. For my fellow Commissioner, it is coming back home. It's been a wonderful experience and a very useful one for the work of the Commission. We should, also, I think, thank the staff of the Parkwood Conference Centre for having accommodated us so effectively in our work.

We should also thank in particular the individuals such as Mr Harris, who I see is still in the hearing room, for having shared with us the experiences that they have had. It's not an easy task to come up publicly and expose to, effectively, the entire world intensely personal experiences, some of which expose raw emotions. And we are very grateful that you've done that, because it's an important and vital part of the work that the Commission has been doing. Finally, we adjourn the hearing of the Commission until 11 November in Hobart at 10 am.

MATTER ADJOURNED at 3.57 pm UNTIL MONDAY, 11 NOVEMBER 2019

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