AUSCRIPT AUSTRALASIA PTY LIMITED
ACN 110 028 825

TRANSCRIPT OF PROCEEDINGS

O/N H-1157443

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

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

ADELAIDE

10.00 AM, WEDNESDAY, 4 MARCH 2020

Continued from 21.2.20

DAY 77

MR P. GRAY QC, Counsel Assisting, appears with MS B. HUTCHINS and MS E. HILL

COMMISSIONER PAGONE: We begin by acknowledging the Kaurna people, the traditional custodians of the land on which we meet today. We also pay respects to their Elders, past present and emerging ,and extend that respect to other Aboriginal and Torres Strait Islander people who are present. Mr Gray.

MR GRAY: Thank you, Commissioner. I will now make some submissions on behalf of the Counsel Assisting team and staff of the Royal Commission in relation to program redesign. Commissioners Tracey and Briggs observed in their Interim Report that it is clear that a fundamental overhaul of the design objectives, regulation and funding of aged care in Australia is required.

In these submissions, Counsel Assisting outline our current proposals for far-reaching changes in aged care program design. In doing so, we acknowledge the complexity and the dynamic nature of the aged care system, the potential for unintended consequences or reforms and the need for careful consideration of interdependencies between program design and other aspects of aged care.

Aged care is an essential human service relied upon by over 1.3 million older Australians, many of whom have complex needs and are highly vulnerable. It is imperative that continuity of services be maintained while reforms are implemented. Although the reforms are urgently needed, adequate time must be allowed for key factors in the system to be planned for and for transition to a clearly defined set of outcomes.

The proposals for change in these submissions envisage a new redesigned aged care program but those proposals cannot all be implemented overnight. A transition strategy will be needed, aspects of which may be implemented in the short-term but some of which would involve staged implementation over the medium to longer term. It is possible that some aspects of the reforms we propose would require analysis of impacts in the course of staged implementation. And if duly implemented we consider that the changes will lead to significant improvements in the way in which aged care is subsidised and provided to the older Australians who need it.

The purpose of outlining our current proposals for redesigned aged care in these submissions is to elicit responses from organisations and entities involved in the aged care system, government, experts, users of aged care services and the general public in order to build on the consultations that have already occurred in this regard. These submissions follow and have been heavily influenced by a consultation process which commenced on 6 December 2019 with the publication of Consultation Paper 1, 'Aged Care Program Redesign: services for the future'.

In response to a general invitation for submissions on the proposals in that paper, the office of the Royal Commission received 183 submissions from a range of labour and professional organisations, consumer groups, aged care sector peaks, providers and government as well as aged care experts and the public at large. Submissions

other than private submissions have now been published on the Royal Commission website.

In December 2019 and January 2020, a number of consultations took place on the subject matter of Consultation Paper 1 between staff of the Royal Commission and representatives of interested organisations, government and experts. Two days of large-scale consultations between staff and about 40 participants took place on 3 and 4 February 2020 in Canberra. The Royal Commissioners then held a hearing in the form of a workshop in Adelaide on 10 and 11 February of 2020 at which a number of such witnesses gave evidence.

During the consultation process, and at the hearing on 10 and 11 February, some aspects of Consultation Paper 1 attracted general support. However, others were critiqued on cogent and compelling grounds. In light of what staff have learned through the consultation process and the hearing, Counsel Assisting now propose a new program design for aged care in this country which builds on, but differs in several material ways, from the proposal in Consultation Paper 1.

In these submissions, Counsel Assisting are not proposing that the structure of the program be arranged into an entry level support stream, a care stream and an investment stream, or that care stream funding be agnostic of setting and capable of unbundling in a residential care context or that care plans and individualised budgets be generated through the process of independent assessment for eligibility for funding. These submissions are not our final recommendations to the Royal Commissioners about program design and we invite further public submissions in response to these submissions. Counsel Assisting intend to give careful consideration to any such submissions in formulating final submissions on recommendations to you, Commissioners, about program redesign and other aspects of reform of the aged care system.

Our current proposal for program redesign includes the following noteworthy changes, each of which is important in its own way and which in combination would achieve a fundamental overhaul of the aged care system. The first topic I want to address in this regard is needs-based entitlement to aged care. Support and care in accordance with the assessed needs of each older Australian should become an entitlement based on need. People assessed as having needs justifying higher level of care at home should not have to wait until a rationed package becomes available. People receiving care whether at home or in residential facility should have confidence that their provider is funded to provide the care that is necessary to meet their assessed needs. Such a move to a needs-based entitlement should happen in two ways.

Firstly, there should be a linking of funding levels to actual costs of providing high-quality and safe care. The first way in which care in accordance with assessed needs should become an entitlement is that for the first time funding must reflect the actual cost of providing the necessary care. Funding would be set by an independent authority on the basis of efficient standardised costs ascertained at regular intervals

by that authority. Funding would be updated regularly. There would be scope for variation in subsidies based on efficiencies in efficient standardised costs apprentice places, for example in remote locations, and taking into account the needs of people in certain recognised diverse needs groups receiving supportive care. Providers of care would be required, in our submission, to account for their expenditure on care.

The second way in which care in accordance with assessed need should become an entitlement is that subject to a careful implementation strategy, rationing of aged care funding should be removed. Rationing is the process by which a constraint is imposed on the number of people who, even if assessed as needing aged care, are eligible to receive it. An orderly transition to the removal of rationing is required for a range of reasons and the removal of rationing may have to occur at different times, depending on regional conditions.

The factors that must be considered in designing a transition strategy for uncapping supply on funding packages and places, the removal of rationing, include robust quality assurance about the entities that will be eligible to receive uncapped funding. Those quality assurance processes must be in place in advance of uncapping. Next, robust arrangements for ensuring accountability for expenditure on funding for care must be in place in advance, in our submission.

Next, a reliable understanding of demand is needed for budgeting and planning purposes. Next, based on that reliable understanding of demand, and also an understanding of supply side constraints arrangements must be made to avoid bottlenecks and ineffable access to services. Those arrangements must be made in advance. Next, uncapping should, in particular, be in line with the availability of supply site resources such as growth in the needed workforce.

The next topic I want to address in this regard with respect to fundamental change in the system is reorientation towards wellbeing and independence. In our submission, people should be entitled to care that is not only applied clinical quality but also designed to enhance their wellbeing and quality of life and also to respect their preferences within the context of the relationship between the older person themselves, or their informal carer and including their informal carer and their partner or family, and the relationship of the person receiving care and those closer with care staff and with the care provider organisation.

Comprehensive assessments establishing the eligibility for funding and care planning should be conducted in light of this objective. This, together with funding matched to assessed need and accountability for expenditure on care, would help to drive a shift in the system from its current state of rushed task-based care – I don't say that's inevitably and always the case but in many cases the evidence before you shows that that is the case – in the direction of high quality relationship-based care supported by funding, for high levels of skilled staff.

The redesigned aged care program should have an increased focus on preventative and early interventions with the aims of maintaining and restoring function,

sustaining independence and enhancing wellbeing in the best interests of each person receiving support and care. Care planning should reflect a person's choices, goals and strengths, not just their traditionally defined objective care needs. Care planning should prioritise quality of life from the outset all the way through to palliative care. It should encompass psychosocial supports, happiness, and should integrate with existing supports in the community including from family, friends and support groups. Funding for supports to enable social connection should be available at all stages of aged care.

The next topic relating to fundamental change that I wish to address is access, care finding and case management. People should be presented with a much easier path to obtaining the information and the aged care they need. The new aged care program should make it easier for people to understand their options in order for them to make informed choices about and to gain access to services they require. This could be achieved by presenting people with many pathways to aged care via referral from their existing contact points, such as their general practitioner. And it should provide a seamless process involving care finding and assessment under a single banner to minimise confusion in addition to the existing My Aged Care website and call centre.

Whether the banner for the care finding and assessment function should be called My Aged Care is an issue for further consideration. But our preliminary proposal is that it should be different. It should also be performance rating information about different services to assist users to weigh their options. The process should involve personalised health including face-to-face assistance from the outset for anyone who wants or needs it as well as ongoing case management, again for anybody who needs it.

The new structure under which this service would be provided would involve a new organisation and a new workforce. A new workforce of care-finders should be trained to perform these functions on a local basis throughout Australia and they should be able to share local knowledge with people they're assisting and to give advice about different care options. Care finders could arrange basic supports on an immediate interim basis and arrange comprehensive assessments. The institutional arrangements we propose for care finders and assessment are outlined later in the written submissions and I will address them briefly in this address as well. Those arrangements should harness existing experienced expertise and resources wherever possible.

The next topic I want to address by way of outlining reforms that will achieve fundamental change is innovative accommodation. The new aged care program should provide incentives for innovative accommodation options driven by choice, particularly directed at enabling people to remain in their own homes or in forms of accommodation less institutionalised than full-time large-scale residential care. This may involve assistive technologies and this is particular significant in the area of apparent demand for flexible and innovative supported accommodation in which more complex and intensive home support and care can be provided.

The next topic by way of fundamental change I will address is data collection and analytics. Data analytics have the potential to improve the quality and safety of care provided to each individual at the individual level. This is most obvious in areas such as in medication management and enabling preventative interventions where clinical data might raise an early warning sign that a deterioration is occurring much. The new aged care program should be underpinned by standardised data collection and evaluation. The data regime should be designed to take full advantage of available information communications technology and to minimise administrative burden in the collection of the data. It should enable evaluation over appropriate time frames for the performance of the new aged care program at the levels of the individual, the provider and the system overall, including its interfaces with the health system and with other human services. Proper evaluation at the provider and system level is critical to effective improvement in the future.

The next and final topic I want to address by way of fundamental changes is local strategies. People should have equitable access to aged care irrespective of where they live and their background. There is insufficient data about areas of unmet need across the country. The new aged care program should involve strategies to improve coverage and equity of access. And those strategies should be formed or influenced at the regional and local levels wherever possible.

This is needed because of profound regional variability in the depth of markets and other operating conditions. More must be done to take advantage of community based support methods, particularly in rural and remote areas and similar networks and organisations where diverse needs are concerned. Local government, community and diverse needs groups should be included in forming and influencing local strategies. The care finder and assessment organisation and the care finder network it manages – I will have things to say about those matters in a minute – will have an important role to play with respect to influencing and forming local strategies.

Now, moving on from the fundamental changes, at the same time we propose that a number of features of the way aged care is currently subsidised and provided can remain in place, including the following. Firstly, aged care could continue to be primarily funded by government subsidies, though individuals will also continue to make substantial contributions to the costs of their care.

Next, aged care would continue to be provided by a mix of private for profit businesses, private not for profit entities, social and charitable enterprises, religious bodies and governments. Next, aged care would continue to be provided through residential facilities and home support and care services, although there might be proportionately fewer people in residential facilities over time, and there should be growth in the proportion cared for at home or in the community or in more flexible forms of supported accommodation.

Next, residential aged care services should continue to be bundled, that is they will include a mix of health related personal care accommodation and other services, and

finally, commissioning arrangements should continue to apply, that is subsidised aged care services would only be delivered by providers which are officially approved in some way, be that through contract or some form of delegated statutory licence.

Without descending into detail in these submissions as to which institutions should perform those functions that I've just been speaking about and precisely how they should be performed, it's necessary to identify the key functions needed for the effective operation of the aged care system. Data collection, data analytics and system performance evaluation; policy development; eligibility assessment; funding; system stewardship, as the term goes, or governance; market governance, including incentivising innovation and ensuring the transparent flow of performance information; management of interfaces between Australian and State and Territory governments and their roles and responsibilities relating to aged care; workforce development and labour supply management; commissioning of providers and/or of services; establishing and sustaining institutional arrangements; supporting people receiving care and their families, including consumer feedback, complaints and advocacy support; the setting of quality and safety standards; the regulation of quality and safety, price regulation – I will be saying more about that in a moment – and the supervision of reform implementation strategies.

These are all critical functions and there are clear connections between our current program redesign proposals, which I'm outlining now and the institutional arrangements that would be necessary to implement them. We invite submissions as to how those linkages are most effectively to be developed. Now, in responding to Consultation Paper 1, numerous organisations and individuals put forward their own proposals for a future program design. Our written submissions, which will be published on the Royal Commission website, outline aspects of some of these proposals as illustrative examples. I will return to aspects of those proposals at the end of my address this morning, but I'll just mention that the illustrative examples are illustrative examples drawn from the submissions of Uniting Care Australia, the Federation of Ethnic Communities Councils of Australia, National Seniors Australia, Silver Chain, HammondCare, Catholic Health Australia and also a proposal of Professor Kathy Eagar of Wollongong University.

Designing a new aged care system requires attention to be given to a number of interdependent areas of inquiry. Program design is just one element of the design of the overall aged care system. In the context of these submissions, an aged care program refers to a group of criteria and arrangements for providing particular services to particular people supported by government subsidies. The notion of the aged care system is far broader. These submissions are confined to outlining our current proposals for program redesign.

I want to now address a number of key areas outlined in the written submissions. I won't be reading out the submissions in respect of those areas, but I'll give a brief synopsis of what's addressed and what's proposed under each heading.

I will start now with part 3, which, Commissioners, you have at page 17 of the written submissions I've provided to you.

The first area for attention in the new program that we give in our written submission at part 3 is life planning and it runs from pages 17 to 20. It's proposed in this section that there needs to be support and attention given well before somebody reaches the threshold at which they may be needing aged care services, and we address this topic under the headings of the Low Utilisation of Advanced Care Directives, the Need for Promotion of Positive Ageing – that is positive perceptions about ageing and addressing ageism – the Need to Address Health Literacy, the Need to Involve General Practitioners Wherever Possible to take advantage of their existing relationships with older Australians. They don't – an older Australian doesn't always have a general practitioner, but in the very large majority of cases they do. It also is a topic that encompasses financial planning, including planning about housing options.

And our proposal here is that the Australian Government, in cooperation with other levels of government, should fund and support education and information strategies to improve public awareness of resources to assist people to plan for ageing and potential aged care needs.

These strategies should support a continuum of planning for ageing, including consideration of the limits of healthcare preferences for care and a consideration of finances, housing and social engagement.

These strategies should support greater use of the Medicare Benefits Schedule supported annual health assessment available for people 75 and over and bring people's general practitioners to the centre of their planning for ageing and aged care.

The next topic I want to address is an area for attention which moves us closer to the threshold where a person is in need of aged care, either now or in the immediate future. This is part 4 and it runs from pages 21 to 24. Part 4 is about information and contact points, and in the submissions, the analysis of the evidence and of aspects of the responses in the consultation process on this topic are arranged under the following headings: the Need for a No Wrong Door Policy for Access to Aged Care; Information and Improving the Information that is Currently Available.

And our proposals are the people in need of aged care should no longer have to depend on using the My Aged Care website or call centre to obtain access to aged care.

In addition to people using the website and call centre, the system should accommodate referral by health practitioners, social workers, local government employees and other responsible professionals.

The Australian Government should fund and support design and implementation at the national level and at the local level of education and information strategies to improve knowledge about aged care amongst those responsible professionals with whom older Australians have frequent contact already, and to encourage discussion about, and consideration of, aged care needs.

The next area for attention addressed in part 5 of the written submissions at pages 25 to 36 is the area of care finding and case management. The analysis of the evidence – and that includes responses to Consultation Paper 1 – in respect of this area is arranged under the headings the Current System, that is relevant to the issue of trying to find care, and Manage One's Way Through the System, what are the current problems in the system as it stands.

The next heading is Support to, as the term is, Navigate the System. The next heading is Referral to Assessment. The next heading is Linking, and this refers to the linking of a person needing care with particular services that meet that need. The next heading is Immediate Interim Access to Basic Supports – this is the topic I allude today a little earlier – and the final heading is Case Management, and our proposals under this topic are lengthy, but I will read them out.

People seeking and receiving aged care should be offered personalised help at all stages including face-to-face assistance as required, as well as ongoing case management.

A new workforce of care finders should provide this help where the person wants or needs it on a local basis throughout Australia. They should be trained in understanding the expression of wishes of older people, including via techniques of supported decision-making. Care finders should also take into account the views and needs of informal carers.

Care finders should be able to share local knowledge with people they're assisting and give advice about different care options. Care finders should be able to arrange basic supports on an immediate interim basis, and arrange comprehensive assessments.

Their role should be facilitative and ought not to involve responsibility for making decisions about care planning, with the exception of the immediate interim basic supports. The care finder should have an ongoing case management role, the intensity of which should be largely driven by the preferences and needs of the people to whom they're allocated.

The proposals go on to address institutional arrangements as follows. A new organisation should be established and funded by the Australian Government to exercise central administrative responsibility for care finding and also for assessment, which I will come to in a minute.

The new organisation should be staffed by Australian public service employees. There are a number of options for recruitment of the care finders themselves. The new organisation could directly employ all the care finders. The new organisation could commission State governments, local governments or community organisations, or a blend, differing from region to region, to provide the workforce who perform the care finding role, or there could be a blend of those two models, both direct employment by the organisation and commissioning, depending on local conditions.

Care finders can work in local communities and should utilise the trusted connections with diverse needs groups which some community based organisations have established over a long course of time.

Care finders should be trained to understand the needs of diverse groups, and some care finders will have specialist expertise in this regard.

Care finders should work in close consultation with comprehensive assessment teams that are organised under the umbrella of the same organisation, and the care finders and the assessment team members should be operating under the same branding, which will assist users in understanding the system.

The next section of the submissions and the next area for attention is in part 6 at pages 37 to 45 of the written submissions, and it relates to informal carer support services and respite. This section is arranged into headings as follows. There's an introduction section, which touches upon and summarises key aspects of the evidence you've heard, Commissioners, to the effect that Australians want to stay living at home for as long as possible. The next headings into which the evidence is arranged are: Who are the Informal Carers, What Support is Currently Available to Them, then Carers and the Assessment Processes, the Role of Locally Based Community Supports, and How Can Carers be Supported in their Role, and our proposals in this area are as follows.

The Australian Government should fund and support information and local outreach to apprise informal carers of the services available to support them in caring for older Australians, including infirmed spouses and people living with dementia. The care finder network may be utilised for aspects of this work. In addition, flexible pathways for providing carers with support should be adopted, including via community based groups or hubs, as they're sometimes called. Comprehensive assessment for eligibility for aged care should give attention to the needs of informal carers for older Australians in their own right, leading to quarantined entitlements for informal carers to receive support services, such as counselling and training, and also for them to receive respite.

Respite should be overhauled by substantial increase in the scope and scale of respite and its ready availability, and the availability of different kinds of respite, and an appropriate framework of incentives for providers of respite. The Department of

Social Services carers gateway should be linked to the systems by which respite is made available in the aged care space so that informal carers are not confronted by separate systems and the task of attempting to coordinate disparate services in order to obtain the help they need.

Commissioners, the next part of the submissions at pages 46 to 51 is part 7, Assessment. This topic is arranged into the following headings. Current Processes, Our Proposal, the Care Assessment Body and Network – to which I've already referred briefly – Comprehensive Care Assessment – and there are principles proposed in relation to the approach to be taken to that – and, finally, Material Changes and Reassessment.

Our proposals in this part of the submission are as follows.

Assessments of eligibility for all aged care should be conducted by assessment teams organised as a network with coverage throughout Australia and supported and funded by a single organisation.

That organisation should be the same one which employs or commissions care finders.

Open channels of communication should be established and maintained between the care finders and the assessment teams in each area.

The assessment teams should consist of, or be able to draw upon, the full range of competencies and specialisations in aged care, and should be able to scale up the team's resources flexibly to respond to the needs of the person requiring assessment.

Assessment teams should be able to rely on current assessments by treating clinicians.

The guidance and tools for conduct of assessments should be revised in order to, firstly require assessment of the needs of informal carers in their own right and for generation from that assessment of a quarantined entitlement for carer supports and respite, as I outlined earlier.

Next, to emphasise the person's preferences – that is the person receiving care – their preferences about their quality of life.

And, finally, to emphasise preventive and reabling care objectives, and one of the aspects of the detail in the submissions in that regard, is the proposal to explore rehabilitative and reabling options before assessment of ongoing care needs is finalised.

Commissioners, the next section of the submissions at pages 52 to 57 is part 8 entitled Wellness Reablement and Rehabilitation in Aged Care. The headings in this section are quite simple in their structure. There's a section on Wellness Reablement and Rehabilitation in the Current System and then there's a section on Reform Proposals in that regard. Our proposals arising from this topic are as follows.

The Australian Government should fund and support the delivery of wellness, reablement and rehabilitation services to older Australians.

The type of services may include, but not be limited to: occupational therapy, physiotherapy, nursing support, personal care, nutritional interventions, medication reviews, provision of technologies to help with day-to-day activities, minor home modifications and measures for addressing loneliness.

The provision of such services tailored to individual needs should be explored for all older Australians irrespective of whether they're in their home or in a residential aged care facility and irrespective of their cognitive status or prognosis. This is a very important point for people who are living with dementia.

The next section of the submissions, Commissioners, is part 9 at pages 58 to 59, which is a section on diverse needs in aged care, and our proposals in this regard are as follows – I should just add that addressing these matters, I've already mentioned diverse needs a number of times. Addressing this really requires a whole of system approach and these diverse needs need to be considered at every step.

The Australian Government should fund and support the delivery of aged care services that recognises, understands, respects and responds to the diverse needs of older Australians. This should be irrespective of whether aged care services are received in a person's home, community or residential aged care setting. And there are some specific suggestions in that regard, but, as I've said, I've mentioned how the approach to formulating strategies at all levels requires consideration of these needs.

Commissioners, I will address the next three parts of the written submissions, parts 10, 11 and 12 by way of a combined overview, and then I'll go to the proposals under each. Part 10 covers pages 60 to 63 and is entitled Home Support and Care - Additional Points. Part 11 is at pages 64 to 67 and is entitled – I beg your pardon, part 11, pages 64 to 67 is entitled Innovative Accommodation Models. Part 12, pages 68 to 71, is entitled Residential Care - Additional Points.

Now, Commissioners, we've arranged these parts in this order to present what might, for many people, be the way in which they experience a continuum of progressive graduated levels of experience through the system. They might very well – this isn't always going to be the case, but they might very well experience home support first. They might receive higher levels of care in the home, involving personal care. They

might then be faced with a need that arises from their circumstances and condition to consider other accommodation options, and they might be confronted with a circumstantial need to go into residential aged care, so we've presented the parts to reflect that broad continuum.

We've called these parts additional points, because in part 2 of the submissions, which I'll actually come to at the end of my address, we've already got some proposals relating to funding in relation to these topics, home supporting care and residential care, and we have put those submissions in there because they're intimately connected with program design, and flow from, and need to be considered with program design. But also we wish to elicit responses from interested organisations and individuals ahead of a hearing to be held in a little while later in the year on the funding and financing aspects of the new aged care system that we propose and envisage.

In part 10, home support and care, the proposals we advance are as follows. The current Commonwealth Home Support programme, home care program – that's the Home Care Packages – and residential care program should transition as soon as possible to a single program based on a single eligibility assessment process where funding is demand driven based on assessed need and does not involve rationing. Eligibility for support and care in the home should be assessed holistically through that assessment process.

Basic supports that are in defined categories should be provided at the discretion of the care finder on an interim basis, pending comprehensive assessment.

Flexible funding arrangements, having regard to local conditions should be used to ensure that the spectrum of required home support and home care services are available in all areas.

Home support to care recipients, and that includes home support and home care, should either be offered on the basis of assistance by their care finders in choosing an appropriate provider who will coordinate all home support and care services for the person receiving care or, in the alternative, in respect of home support only people may choose, under our proposal, to self-manage the home support they receive where there's a sufficient market in home support and care services. There's an option there to consider whether certain kinds of personal care should be included in the self-management option, as well, and that may be appropriate.

It may be appropriate that all of the personal care available for people in their home could be self-managed. An important safeguard in that respect is that people should be given this option for self-management, provided they're assessed by the assessment process as being capable of self-managing, and that it's appropriate for them to self-manage their own care. Self-management would be a weighty thing. It'd involve the person receiving the care coordinating their own services, and that'd

have implications for the scope of regulation of quality and safety. All of these matters are addressed in detail in the written submissions.

In part [11], Innovative Accommodation Models, our proposals are as follows. The Australian Government should make available incentives to providers to encourage a range of innovative accommodation models driven by choice. Incentives should be particularly directed at measures enabling older people to live in home style accommodation where possible.

In part 12, we have a lengthy set of proposals. Part 12 is Residential Care. I'll address them now. The proposals begin with a recap of one of the proposals I read out under home care. That is for the consolidation of the main existing programs into a single program based on single eligibility assessment. They then go on to refer to the transition to that position. The transition should involve implementation of appropriate case mix based funding classification for residential care, and I'll have a little bit more to say about case mix funding classification in a minute.

The classification should be based on independent assessment. That is assessment undertaken by the comprehensive assessment team, not by the service provider, and, as I mentioned at the outset, the levels of funding corresponding to those classifications must be linked, in our submission, to actual cost data ascertained by the independent pricing authority I mentioned before. That independent pricing authority, after ascertaining costs data, would make determinations of the estimated efficient cost of providing high quality care.

Funding should include entitlements in kind or a budget to cover basic support services on the basis of assessed need, including transport and social activities. That is currently a gap in funding for residential care, and it needs to be addressed.

Responsibility for care coordination and planning should be clearly placed on the residential care provider, subject to ongoing consultation with the older person, including family and, if the recipient chooses, the care finder. That consultation will be about the person's care and, where safe and practicable, adherence to the person's choices about their care. Interventions that are independently assessed as necessary to sustain functioning or to restore functioning and reable residents should receive separate funding. That is funding not deducted from residents ongoing care budgets.

Providers should have an obligation to seek reassessment upon changes in circumstances and should have an incentive to support reablement. That could arise simply because of the extra funding that will be attracted by the reablement interventions that I've mentioned. There should be performance based loadings in light of reablement outcomes over time.

The requirement for provision of culturally and psychologically safe assessment, having regard to diverse needs, and for care planning – and for that to be involving care planning and care delivery needs to be mandated in all services.
Some diverse needs that attract loadings or supplementary funding where the needs in question reasonably require incurring of greater costs need to be identified, and there may be scope in the way loadings and supplements are granted to provide incentives for specialist accreditation for services that meet those needs.

Loadings for higher costs in rural, regional and remote areas should also apply to the extent that materially higher costs are demonstrated by reason of remoteness. In cases of very thin markets, providers may receive guaranteed base funding in return for provider of last resort obligations.

The final substantive part of the submissions is part 13 at pages 72 to 76. It's entitled Standardised Data Collection and Analysis. It's arranged under headings as follows. Data Collection and Analysis in the Current System and the Reforms that are Required.

Our proposals are as follows. The Australian Government should implement a standardised data collection program designed on the 'collect once, use many times' principle.

The program must be designed to inform longitudinal evaluation, evaluation over periods of time at the user, provider and system levels. The data to be included in the program should include, firstly, service usage data in the full range of service categories relevant to aged care, a comprehensive range – this is next – a comprehensive range of health, safety and quality outcomes data, including medication data, data about diverse needs, quality of life metrics, data about transitions and interfaces with the health system in each jurisdiction. Now, I mention those topics not to prejudge the design of the data collection program that should be undertaken, but those are obvious aspects that have to be met.

The Australian Government should fund and support the development of the information communications technology systems and links between the Pharmaceutical Benefits Schedule and the Medicare Benefits Schedule information systems, and also links with other data sets that are currently available to the Australian Institute of Health and Welfare and other government bodies in order to achieve those goals.

The Australian Government should fund and implement a program of data collection and analytics to forecast demand for aged care services in all the service categories relevant to aged care.

The Australian Government should fund and implement a program to ensure information and communications technology connection, or connectivity, between

different government bodies providing services to relevant aged care, including the Department of Veterans Affairs and the Department of Social Services.

Commissioners, I now want to return to the topic of the work that needs to be done from now on, and the fact that program design is simply one piece in a much larger body of work. At the same time as advancing the development of program redesign proposals, we are acutely conscious of the need to ensure coherence with the ongoing work of all – on and in relation to all other elements of the system. Further, at the same time as attending to program design and broader system design, it will be critical to identify what would be required to enable the design to be realised. In other words, what would be required to implement the reforms we propose.

Closely interdependent areas of inquiry include defining and measuring high quality care, public transparency of provider-related information, including performance ratings, access for groups with diverse needs, including Aboriginal and Torres Strait Islander people, quality assurance in commissioning of providers in different forms of commissioning, quality and safety regulation, the workforce, research, technology and innovation, funding and financing options.

In the written submissions we've given you, Commissioners, beginning on page 10 and running all the way through to page 16, we've expanded on interdependencies with some of those topics and, in particular, we've focused on funding elements for the reason I outlined earlier. We do want to hear from people – interested people, experts, the public at large, organisations and government – what their response is to the proposals we've outlined on funding issues at those pages of the submissions.

The headings in question begin with Workforce and, of course, you already have counsel assisting's submissions on workforce of the 21st February 2020 and the recommendations that have been made in there, which have implications for funding. Then we go into a number of related funding topics. Development and implementation of the recommendations that have already been made in relation to workforce, and also the proposals contained in the written submissions I've just summarised, will require greater levels of funding; however, merely providing greater levels of funding is not the only answer.

Great care needs to be given to designing mechanisms that provide appropriate incentives for high quality care and which impose, in our submission, appropriate accountability for the use of public funds. In a hearing to be conducted later in the year, as I said, Commissioners, you'll hear evidence on a range of potential funding reform issues, and then I – I'll just briefly refer you to the headings – the subheadings, rather, that are addressed in the written submissions on that topic.

There's particular attention given to home support funding. There's also attention given to higher levels of care in the home and the funding of that. There's attention given to carer supports and respite funding. Preventative rehabilitative and restorative interventions funding and residential care funding. There's also, in effect,

a place marker for the important topic of means testing, which is not addressed in this document, but will be an important aspect of the funding hearing, and there's reference, too, to other programs, such as the multi-purpose service program and the national Aboriginal and Torres Strait Islander flexible aged care program.

We pose a number of questions for consideration. They include, "Can a case mix model be applied outside a residential care setting and, if so, can it be applied both to basic home supports and also to higher levels of home care which involve personal care, hands-on care?" "Can, and should, a separate entitlement in kind – or a budget – be conferred for respite and for education, counselling and other support services for informal carers?" "How should preventive, rehabilitative and restorative interventions, in particular, responses to episodes of deterioration in a person's health be funded separately from the person's funding for ongoing care?" "Should a new case mix model such as the Australian National Aged Care classification, or AN-ACC, be applied in the residential care setting?" "Should the levels of case mix funding be calculated consistently with the method for imposing case mix adjusted staff ratios, which are recommended in counsel assisting's submissions on workforce?" "Should residential care case mix funding for ongoing needs be accompanied by an entitlement in kind, or a budget, for ongoing basic social supports?" "Should financial reporting of expenditure by care providers on the costs of care be required?" and, "Should adjustments to future payments apply in light of over expenditure or under expenditure?" that is the process sometimes called acquittal. "What forms of funding should be employed in home settings?" for example, for basic supports, "Should direct grants continue to be used?" and, "In thin markets should direct grants be used for both basic supports and more complex needs?" and, "Should the programs, other than the Commonwealth Home Support program and the home care packages program and the residential aged care program, continue as they are or are changes needed?"

I want to finish by returning to aspects of the submissions that were received in response to Consultation Paper 1. Some of those submissions proposed quite comprehensive designs with suggestions around the systems or model required to support the proposed new programs.

For example, Professor Eagar submitted an expanded version of her initial submission quite recently which proposes four funding streams, administered through 60 or so regional authorities with centrally allocated grants from the Commonwealth Grants Commission to each authority. The four streams Professor Eagar proposes are intended to fund services addressing a hierarchy of needs, age-friendly community services, primary aged care services – that is basic home and social support for which on Professor Eagar's model no assessment will be needed; secondary aged care services for more complex home care subject to assessment, and tertiary aged care services, which are residential care. Professor Eagar has proposed funding by direct grant, a transmission to case mix funding for secondary aged care services – that is the more complex home care services based on an AN-ACC like methodology and AN-ACC funding for tertiary aged care services.

To take another example, Catholic Health Australia endorsed aspects of the proposals in Consultation Paper 1 but with significant modifications and additions. Catholic Health Australia supported the introduction of face-to-face assistance and proposed, subject to budgetary considerations, a regional network of contact information case management and assessment centres, urging the Royal Commission to learn from the operation of shortcomings associated with the local area care accord natured, I beg your pardon, local area coordinator arrangements in the National Disability Insurance Scheme which are referred to by Mr Tune in a recent report.

The submission from Catholic Health Australia advocated assignment to a funding level or package rather than generation of individualised budgets, pointing to the subjectivity of the reasonable and necessary criterion which applies in generating individualised support plans and budgets under the NDIS. Catholic Health Australia advocated the need for separate funding mechanisms for separate residential care on the one hand and home care on the other for a range of compelling reasons and provided a detailed alternative design with their submission.

Although delivery models per se were not the focus of consultation paper 1, and we are not advancing detailed proposals yet on this topic in these submissions, the staff of the Royal Commission will be exploring with some of the people and entities who have made submissions of this kind. And we invite further submissions from the public about institutional, market structures and delivery models best suited to the new program design that I have outlined in this address and about any required modifications needed to align with optimal institutional structures and delivery models. Commissioners, these submissions that I've outlined today are reduced to written form and those written submissions will be published on the Royal Commission's website today. Submissions in reply are invited by 18 March 2020. The website will contain details of how those responding submissions can be made. Thank you.

COMMISSIONER PAGONE: Thank you, Mr Gray. Thank you for your submissions and also for having made them available to us some time before the hearing today to enable us to think about some of these matters and to digest them. That has been very helpful. I would just like to make one or two observations in support, really, of what you have said in general terms, and hope that the message is one that is brought home more broadly to those who are engaged with or ought to be engaged with the work that we and you are doing.

The Commissioners have heard and seen over many months some deeply concerning neglect, whether institutional or governmental, clinical, emotional or personal, and our focus has moved now squarely upon what to recommend to give Australians the aged care that we deserve and that will do our country proud. We have heard anecdotally that some of the participants in the sector have been reluctant to engage fully with the Commission, and we urge that any that may feel reluctant overcome their reluctance and engage fully. The process we have taken, as you have seen, both in the submissions that were made to us by Mr Rozen on 21 February and those

which you have heard today are that we are being open to the public about our thinking.

We are having those assisting us tell us iterations of their thinking and it's based, in part, upon those submissions and engagement which we have had with participants at large. Our message in Counsel's Assisting's submissions of today and also those in Mr Rozen's of 21 February is we are actively considering specific proposals. Those assisting us have read your submissions and have taken them on board to the extent that they are consistent with the views that they currently wish to put to us. They have told us where their recommendations are currently and we ask now for your detailed responses to that. We are listening to you and we will continue listening to you. We urge you, therefore, that you engage with us meaningfully so that we can continue to listen and produce the best outcome that we are able to produce.

With those observations let me thank you fully for your submissions, Mr Gray. They have been very helpful and very thoughtful. I wish also to extend that thanks to the great number of people that I know, or we know, are assisting you in that process. We are mindful that you get the glory of being up here, smartly dressed and looking as though it all comes naturally but a lot of people are behind you and we are conscious that they do a great job in making you look as easily gifted as you might otherwise not be. So please pass on that thanks to those and, of course, our thanks generally to the Commission staff who are doing all of the other things that need to be done that often don't get thanked like making sure that the lights are switched on and the doors open and the machines are all operating and all is well.

So thank you to all of those and finally to the members of the Federal Court. I assume it's the Federal Court we need to thank here. I got lost about who runs the show, whether it's the Federal Court or Federal Circuit Court or Family Court. But there's no doubt some emanation of the judiciary, so I thank them, please, too, for their accommodating of our presence.

MR GRAY: We will.

COMMISSIONER PAGONE: We will now adjourn, please.

MATTER ADJOURNED at 11.10 am UNTIL MONDAY, 16 MARCH 2020