AUSCRIPT
FAST PRECISE SECURE

AUSCRIPT AUSTRALASIA PTY LIMITED
ACN 110 028 825

T: 1800 AUSCRIPT (1800 287 274)
E: clientservices@auscript.com.au
W: www.auscript.com.au

TRANSCRIPT OF PROCEEDINGS

O/N H-1140542

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

10.10 AM, MONDAY, 10 FEBRUARY 2020

Continued from 13.12.19

DAY 74

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

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

We should begin the session, also, by making some reference to the impact of the bushfires upon the many people who are – have been involved in the aged care industry, both the vulnerable people who are residents of many aged care facilities and of those who have been very loyally supporting and looking after them.

Those in aged care facilities have not received as much of the public media attention as others have. And that's not said by way of criticism; it's just said by way of its easy to forget just how difficult it is for all peoples throughout the community, including those with which we are concerned.

We have heard many stories of many difficulties, facilities being made safe and of the staff dedicating themselves to the work with those who are particularly vulnerable. We can only imagine the considerable stress and distress that these circumstances have caused both the residents, as well as the staff and the aged care providers. We do commend their activities and thank them for their continuing work. Mr Gray.

MR GRAY: Thank you, Commissioner. Counsel assisting and solicitors assisting join the Commissioners in acknowledging and paying respect to the Kaurna people, traditional owners of the land on which we meet and their Elders, past, present and emerging. And we too express our sympathy for those who have suffered and continue to suffer from the bushfires.

Today is the first of two hearing days into system design and, specifically, program redesign. The context in which this hearing is taking place is very briefly as follows. On 6 December last year, the Commissioners issued Consultation Paper 1 in relation to program redesign. And that was published on the Royal Commission website. And in so doing, the Commissioners called for responding submissions by 24 January this year. And, in relation to Consultation Paper 1, staff of the Royal Commission have been conducting consultations and those consultations have included consultations about matters raised in responding submissions. And, most significantly, perhaps, last week in Canberra on Monday and Tuesday, there were large-scale consultations involving about 40 participants.

The purpose of the hearings today and, indeed, the previous consultation process and the continuing work which will be carried on in this space is to obtain evidence largely in the form of opinions of knowledgeable people and organisations speaking for consumer groups, providers, workforce bodies, professional bodies and the Commonwealth Department of Health on the strengths and weaknesses of the

proposals in Consultation Paper 1 and to test the proposal to work out what areas need further inquiry and development, and to improve the proposal.

The hearings that are being held today and tomorrow are being conducted here in the city rooms of the Adelaide Convention Centre and are being live streamed on the web. They're hearings in the form of workshops. We anticipate that this form of hearing will be more common from here on as the Royal Commission moves deeply into testing proposals for the future of aged care in Australia.

And all of this, of course, is intended to give the greatest assistance possible to the Commissioners in their task of framing final recommendations on that topic. The particular format we have lighted upon for the workshop, or the hearing in the form of workshop, is intended to foster a structured discussion about proposals by panels of experts holding a range of different views.

The hearings in the form of workshops are not conducted in a court-like environment. That's an indication that they're intended to be less formal than a public hearing and they're intended to foster discussion, albeit that discussion will be structured. The witnesses at these hearings will give their evidence as members of panels. And the witnesses have been selected based on a range of considerations, including, in some cases, the submissions they have made, the experience – their experience and their expertise, their past engagement with the Royal Commission and matters of that kind.

As Senior Counsel Assisting, I will be facilitating the discussion between the members of the panels. The members of the panels have been informed of the propositions which I will be raising. That's the case for all of the sessions, save for the very final session. And we will be providing the members of that session with propositions after we've heard and reflected on the evidence today.

The format of the sessions will be as follows. I will raise a particular proposition. And that proposition will, in effect, be a speaking point for the evidence that follows. The proposition might be quite developed. And that's in order to give focus to matters which we, staff of the Royal Commission, have decided need to be exposed and will benefit from ventilation in this format.

I will then nominate a member, and then I might nominate another member or two, to be the principal responders to that proposition. And, following a brief response from those people, a discussion will follow. The discussion that ensues needs to be a little structured. And I would ask for an indication by the raising of a hand if a member wants to respond. I will then do my best to moderate the discussion that follows. Time will be short. And the briefer those responses are, the better. And that will give us a better chance of getting through all of the topics that are being raised.

Witnesses at workshop hearings of this kind are not required to swear or affirm, although they may do so, if they wish. And nor are witnesses to these hearings preparing written witness statements. However, these workshops are hearings of the

Royal Commission and the provisions of the Royal Commissions Act and the Royal Commissions Regulations relevant to witnesses do apply to these hearings.

Now, hearings in the form of workshops are open to the public. And there's some space for members of the public to sit in and observe, also. And, as I said, the hearing is being livestreamed and is accessible from the Royal Commission website.

Before we commence the substantive sessions, I will say a little more about the proposals outlined in Consultation Paper 1 by way of an overview about the sessions we're going to conduct over the next two days. Consultation Paper 1 proposes that the system be designed in light of 12 principles. And they're now being – about to be displayed. They're from page 4 of the consultation paper. Those principles include emphasis on rights, choices and the dignity of people receiving care; quality and safety of the care provided; equity of access; transparency and ease of understanding and use; the need to meet individual care needs; to maximise independence, functioning and quality of life; support for a good death; support for informal care relationships and community connections; and principles addressing the workforce; interfaces with other systems; affordability and sustainability; and, also, implementation and evaluation of system reforms.

The consultation paper identifies areas requiring fundamental change and these will now be displayed, from page 5 of the paper. And, in brief terms, the paper proposes three new funding streams in place of the current programs. These streams are for the funding of services for different purposes which will be examined in some detail during our first session, which we titled Big Picture. In summary, the three streams are an entry level funding stream – and there has been some debate about whether that is the correct name for the stream. Another name for the stream might be basic services stream. This stream is intended to provide funding for basic domestic services and modifications and travel services and the arrangement of activities. These are very high volume, relatively uniform and inexpensive services.

The next stream is the investment stream. Again, there has been some debate about whether that's an appropriate name for the stream. The intention behind this stream is that it will provide flexible, prompt and scaleable funding for more complex and expensive interventions that seem likely to prevent or delay the need for higher levels of care and for longer-term care. In particular, to achieve recovery and reablement from episodes which carry the risk that the person might move on an ongoing basis to a higher level of longer-term care. And importantly, this stream is also intended to address regular and emergency respite services which are very important to sustain informal care relationships, sometimes called care dyads.

And thirdly, there's a care stream, or a care and health stream, which is intended to provide for long-term care for permanent, stable conditions of ageing, in the nature of personal nursing and allied health care and that can be provided either in the person's own home, in residential institutions or in other forms of accommodation. It's important to note that these are not mutually exclusive programs in the sense that a person can only ever be in one of the streams. That's not the case. Funding for

services from each of these streams may well be available in respect of the same person at the same time.

We've broken the two days of hearings into the following sessions. Our first session, as I just mentioned, is the big picture session. That will commence in just a minute. It will be followed by our second session, which is information assessment and navigation. And our third session will be after lunch and that's on entry level support. Beg your pardon, both of those sessions, the second and third sessions are after lunch, I believe. Tomorrow we will be continuing with looking at the funding streams proposed in Consultation Paper 1, moving to a fourth session on the investment stream and a fifth session on the care stream. We will conclude with a sixth session, transitions, which will give us the opportunity to consider what we need to do in the immediate and longer-term, ahead of any shift in how aged care services are delivered in Australia.

The designated sessions over today and tomorrow give the workshop structure which will guide our panel discussions, as well as responding to the structure of Consultation Paper 1. Now, having said that, we are very mindful that there will be overlap between the different sessions to some degree and our witnesses will have some flexibility in raising matters that may fall into another session, although we will try to keep focused on the topic of the session in hand. We are also mindful that Consultation Paper 1 necessarily can't cover everything. It doesn't cover in any detail a number of important topics that are integral to the work of the Royal Commission, including the role of older people in society and our communities and how ageing is perceived, interactions between the aged care and health care systems, system stewardship, the governance of providers, market development, funding, workforce, quality and safety regulation, technology, research and innovation.

All of these matters and others are important and there are clear linkages between each of them and system design. There will be frequent mention over the next two days of the potential implications of the system or program design proposal and these various other areas. And I didn't even mention people with diverse needs and people in rural and remote locations. There's detailed work been carried on in all of these areas and we're conscious that that work is interdependent on the progress of the work on program and system design.

We are acutely conscious that there's a need to carry forward the entire program of work in all such areas in a coherent way. That said, the focus in this hearing is on system design and we can do little more than identify the implications for those interrelated areas as we move through the topics over the next two days. There will be no time on this occasion for a deep analysis of those interdependent issues. We do ask you, our witnesses, to consider that in making your responses to propositions today. Thank you.

To commence, I will now call our first panel for the big picture session. Mr David Tune, Mr Ian Yates, Professor Mike Woods, Ms Patricia Sparrow, Dr Kirsty Nowlan, Mr Michael Lye, Mr Robert Bonner and Mr Glenn Rees are all present in their seats

and, Ms Associate, I will ask you to please swear or affirm those witnesses who have elected to take an oath or affirmation

DAVID TUNE, AFFIRMED **[10.27 am]**

GLENN REES, SWORN **[**

KIRSTY NOWLAN, SWORN

ROBERT BONNER, AFFIRMED

PATRICIA SPARROW, SWORN **[10.28 am]**

MICHAEL LYE, SWORN

MICHAEL WOODS, AFFIRMED

IAN YATES, AFFIRMED

MR GRAY: Commissioners, I will now just make some brief introductory remarks about each member of the panel. Firstly, Mr David Tune. Mr Tune has had many senior positions in the Australian public service. I won't go through them all. Mr Tune's most recent roles include independent chair of the government's Aged Care Sector Committee since early 2015, chair of the legislative review, 2017, co-chair of the independent review of Parliamentary entitlements for the Commonwealth government that reported in early 2016 and chair of the 2019 review of the NDIS Act.

I will go to Mr Ian Yates next. Mr Yates is chief executive of COTA Australia, the national peak body for the councils on the ageing in each State and Territory of Australia. Mr Yates was appointed chief executive of COTA South Australia in June 1989 and has played a national leadership role in COTA since 2002. Mr Yates also serves on a wide variety of Federal Government and aged care sector national bodies, he is a member of the Federal Government's aged care financing authority, the Aged Care Sector Committee and the Aged Care Quality Advisory Council – of the Aged Care Quality Agency – I beg your pardon – of the Aged Care Quality and Safety Commission. And he's also on the Department of Health's ACFI monitoring group. He is the COTA representative on the National Aged Care Alliance.

I go now to Professor Woods. Professor Mike Woods is Professor of Health Economics at the Centre of Health Economics, Research and Evaluation at the University of Sydney. He is also on the board of the Australian Digital Health Agency as a member of the aged care financing authority ACFA. Professor Woods has had a long career in economic policy and public finance including, 16 years as Commissioner and then deputy chair of the Productivity Commission. During his time at the Productivity Commission, Professor Woods presided over many national policy inquiries. These included the reports Australia's Health Workforce and Caring for Older Australians and, more recently, a research paper on deep and persistent disadvantage in Australia.

I will go now to Ms Patricia Sparrow. Ms Sparrow is the CEO of Aged and Community Services Australia, ACSA, a role Ms Sparrow has held since August 2016. Prior to working at ACSA, she worked for the Australian Government as an adviser and as an employee of COTA Australia, including providing support to the National Aged Care Alliance. ACSA, Aged and Community Services Australia, is the leading aged care peak body supporting church, charitable and community-based not for profit organisations. Not for profit organisations provide care and accommodation services to about one million older Australians.

Next, I will go to Dr Kirsty Nowlan. Dr Nowlan is the executive director of strategic engagement, research and advocacy at the Benevolent Society. She has previous experience working as a global policy manager and then as global director of public policy at World Vision. Dr Nowlan is co-chair of the Every Age Counts campaign.

Next I will go to Mr Michael Lye. Mr Lye joined the Department of Health in December 2019 as Deputy Secretary responsible for ageing and aged care, although not with responsibilities for the Royal Commission taskforce. Prior to joining health, Mr Lye was the Deputy Secretary responsible for disability and carers policy at the Department of Social Services, where his responsibilities included disability and carers policy and programs, the National Disability Strategy, National Disability Insurance Scheme and Disability Employment Services.

I will go now to Mr Rob Bonner. Mr Bonner is the director operations and strategy of the Australian Nursing and Midwifery Federation, South Australian branch. At the time of his submission to the Royal Commissioner September 2019, Mr Bonner was deputy chair and acting chair of the Aged Care Services Industry Reference Committee. Mr Bonner has been employed with the ANMF for over 34 years and has been a member of numerous industry-related boards. Mr Bonner also established and managed the work of a registered training organisation which has delivered aged care-specific qualifications and enrolled nursing qualifications, amongst other things.

I go to Mr Glenn Rees. Mr Rees is the chairman of Alzheimer's Disease International and an independent board member of Parkinson's Australia. Mr Rees was chair of the nursing homes and hostels review in 1986 and was involved in implementing the first wave of aged care reforms. Mr Rees was CEO of Alzheimer's Australia from the year 2000 to 2015.

That's covered everybody. Thank you. I will go now to our substantive panel discussion. And we will commence with the principles that Consultation Paper 1 outlines as the most important design principles that should inform design of aged care programs. That is a document we've already had on the screen. It's at page 4. One important additional principle that's been suggested in response submissions is the efficient use of Commonwealth subsidies. Are there other important additions to the design principles that should be made. Ms Sparrow, we will start with you.

MS SPARROW: Yes.

MR GRAY: Are there other important additions?

MS SPARROW: We think there are some things that could be added that would strengthen the principles. One of those things might be to actually a life-force lens. I appreciate that we can't go into the detail of all the things that aged care interacts with. But we think it's actually important that underpinning this is how aged care sits in the context of supporting an older person overall and that that would assist in some of those issues.

We also think that it's really important that we draw out the individual human rights, which we think the principles do quite well. But we think there's also a need to balance in the principles with the rights of those around them and the people they interact with, which doesn't come through in the current principles, and that it's important that we talk to – around community investment and building community, so that there is infrastructure in the community to support older people with which aged care services interact.

The other thing that we would say is our research highlights that respect is a key thing that people are looking for and that this needs to be strengthened in the principles, alongside talking about the concepts of compassion and relational care. And my final two points would be it's great that there's a focus on transparency and being easy to navigate for people, but we think it's also important that the principles underpin that there should also be comparability that helps people to make decisions about their care. And, finally, but certainly not last but least, is the notion of extending on the workforce to talk about having a right fit workforce to support older Australians.

MR GRAY: Thank you. Mr Rees, in Alzheimer's international submission, or in your submission, there's a call for two or three drivers to be identified, rather than principles. What do you mean by that? Why should drivers be identified and what are they?

MR REES: I would like to say two things. One is I think we need an objective. And when I read the various papers it seems to me the objective is to enable every older person to remain as independent as possible. And that form of words is actually quite different from some of the formulations over the years in terms of

staying at home or the emphasis on care. So I think it would be helpful to the wider community to have an objective to start off with.

The second thing I would say is that – I don't want to be too destructive early on, but I don't find principles helpful. They suggest consensus where there isn't consensus. And they don't recall extend to core values such as efficiency, effectiveness, equity and autonomy. For me as a consumer, the central point is how do you reconcile person-centred care with lack of empowerment? And if we can get that right in terms of the conflicting interests of government, consumer and service providers, I think we might have the makings of some good design principles which I think might turn out to be a bit different from the ones at the bottom of page 4.

MR GRAY: Thank you. I will open this up to brief panel discussion, if there are other contributions that panellists wish to make.

MR GRAY: Yes, Mr Tune - - -

MR TUNE: Thank you.

MR GRAY: - - - and Dr Nowlan.

MR TUNE: Yes. I broadly support the principles. I acknowledge the points that Mr Rees has been made. And I think there would be some advantages in rethinking them, particularly – I think the point around efficiency and effectiveness of the system is a goal in its own right. The empowering of consumer is absolutely central. And turning that into reality is a really important part of this process. So that needs some emphasis, as well.

MR GRAY: Thank you, Dr Nowlan.

DR NOWLAN: Every Age Counts, just to set the context, is Australia's national campaign against ageism. It's a broad-based coalition campaign. We applaud the level of ambition for change in the document. However, we are concerned that there is a need to recognise the normative context in which a system exists. And so we would recommend the recognition of the need to change what in the interim report is called ageist mindsets as a critical precondition for the success of the intent of the transformation.

We would broadly agree with the previous intervention in relation to the need for an objective. We note that in previous studies of what consumers of aged care want, there is a strong focus on quality of life and while quality of life is currently recognised in the principles, it is profoundly connected to a relatively limited notion of biophysical health. And we would encourage, given all the domains of wellbeing, that quality of life is elevated. The risk being that otherwise it is collapsed into kind of more of a medical definition.

Finally, we believe that kind of the principle and, indeed, to kind of respond to the previous point, there's a critical need for the governance of the system to engage a significant dimension of co-design with members of the community broadly and then older people in particular.

MR GRAY: Professor Woods.

PROF WOODS: Thank you. I think having an objective would allow those higher level concepts of ageing, wellbeing, quality of life to be brought in and provide that context for the aged care arrangements, particularly the delivery of subsidised care services. So there is merit, I think, in having that objective. In terms of the particulars, not surprisingly, I would argue, for one, on having – facilitating the efficient use of resources in the delivery of care services to older Australians. But also importantly, the concept of being consumer-directed, allowing older Australians to have choice and control over their lives. I think that has to be central. That reflects that independence that older people are seeking and wish to continue with their lives to the extent they can.

MR GRAY: Mr Yates.

MR YATES: Thank you. I will be brief because mostly people have made the points. But to underline, from the point of view of people using the system, the need for primacy of choice, of being involved in the design of services and being able to make decisions and have – and be empowered to do that. A word that we haven't used so far I think is timeliness and I think, in terms of the current system and its failures, timeliness is something that needs to be very much in the forefront of our mind. It's all very well to be assessed as having a need; if nothing happens about it for 18 months, then the system is failing.

MR GRAY: Mr Bonner.

MR BONNER: I think we would agree with the need to separate out some governing objectives or drivers for the system as it's landed, separate from the drivers for the change process. That's in – both of those are sort of grouped in the existing principles now. We would have difficulty, I think, with some of the relative questions that aren't answered within the principle, like what does affordable mean? What does an efficient system look like? Because some of those things might mean a race to the bottom in terms of cost control, rather than delivering quality outcomes for people living in the community.

MR GRAY: Thank you. I'll move to the next point. It's a brief one. There has been an important addition to the overall design principles or the need for fundamental change, contributed by a former employee of the Australian Institute of Health and Welfare, the AIHW, Mr Mark Cooper-Stanbury. Mr Cooper-Stanbury has submitted that there should be a design objective incorporated in program redesign for the better collection and analysis of data concerning the provision of

aged care services and that this would provide a much better basis for evaluation and continuous improvement.

On the screen at present is a schematic of gaps Mr Cooper-Stanbury has identified in relation to data on the topic of care provision and his submission also makes the point that there are related areas, such as workforce, that may need this sort of attention. Mr Lye, what are your views on this? Do you see merit in Mr Cooper-Stanbury's submission that there should be a focus on better data collection and analysis?

MR LYE: Yes. Yes, I would agree with that.

MR GRAY: Thank you.

MR LYE: I think if you take the consultation paper, the design proposed implicit in that, if you're going to have a continuum of care for older Australians, that you need to understand what's happening in their lives and the pathway that that will take and I think – and their movement between systems and I think that any additional data that we can collect to help inform good service delivery is well worth pursuing.

MR GRAY: Thank you. Look, I won't open that up for discussion by the panel. Time is running short. I will move to the next proposition. At the top of page 5 of Consultation Paper 1, as I mentioned in my opening remarks this morning, there's an identification of key areas the Commissioners are, in their preliminary proposals and preliminary ideas in Consultation Paper 1, identifying as needing attention in program redesign. And in the series of questions and talking points that follow, I will now move through those.

The first bullet point, on the top of page 5, under the heading Fundamental Change, relates to support needed by people to understand the system and get the services they need. The proposal in Consultation Paper 1 is for much better provision of information and, indeed, face-to-face support. In Consultation Paper 1, at page 7, there's also a schematic diagram setting out in graphic form a conception of the system as proposed in Consultation Paper 1.

Across the top of the diagram we have a reference to healthy ageing and prevention. And just below that dark blue bar, there is a schematic reference to the entry point of the aged care system. I'm going to ask the panellists now to consider what are the connections between healthy ageing and prevention and entry into the aged care system. Many older Australians are already regular users of various services such as health services. Others may have trusted relationships with organisations providing for the needs of groups who have diverse backgrounds and needs.

Is it correct to say that there should be seamless access to aged care via those sorts of existing contact points? Shouldn't eligibility to receive aged care be met perhaps by a referral from these sorts of avenues? Or is a formal assessment by a separate

functionary always needed? Could I raise that question for discussion now and we will start with Ms Sparrow. What are your thoughts on those topics?

MS SPARROW: I think it's really important that we do get this – that we do get this right and I think there is a need for referral for simple services to be able to come from a range of sources. And I'm pleased to see that we have talked about having face-to-face capacity in regions. I think the current system has actually been designed, although not recommended to be designed that way, has been designed on a call centre and a website, which are really important features but it's focused on only a small number of people needing that face-to-face support and I think we have got an opportunity now to flip that and give more people the face-to-face support and, indeed, if we design a system that is going to support more vulnerable people better, the system will actually work for everyone well.

There are two schools of thought around assessment and I think we need to work through this. I think people should be able to be referred easily and quickly, but some people will suggest that an independent assessment is important to pick up, right at the beginning, if there are a range of other things that someone needs assistance with or if in fact giving some of the investment streams services right up front is going to be better. But I think that we need to have a balance between the two. So I think in communities that people should be able to refer for simple services like transport or meals and we should have a system that goes back to check on people and allows those expert people to refer on. And it's really important in Indigenous communities and for services who are working with homeless people that trusted organisations are at the forefront of their aged care system.

MR GRAY: Thank you. Dr Nowlan.

DR NOWLAN: I would like to place this question in context of the conversation about principles and particularly the discussion around the life course. One of the reasons that people come to aged care at the point of crisis is because of internalised ageist beliefs and a desire not to engage with the aged care system and a sense that engaging with the aged care system may result in the loss of autonomy. And so we believe that it's important to start a public conversation around what support people need across the life course, such a – such that the system isn't alien at the point that one needs to start to engage with it.

We would also note that while in a broad sense the principal of no wrong door, which has underlied the previous discussion, is in some senses unimpeachable, there are two notes of concern that we would sound. The first is that we have abundant evidence that ageist mindsets are, for example, fairly endemic in sections of health care, which is not to impute the motivations of individuals, but to note that that is what the research shows at a systemic level. We would also particularly kind of draw on experience and research in other forms of social service where we note that those who most need services are those who do not currently at several levels access the system. And so we would encourage some further thinking in relation to that problem.

MR GRAY: Thank you, Mr Tune.

MR TUNE: Yes. Thanks. I don't think I would support the health services and other services being a point of assessment. I would strongly support them being, you know, simple referral points than being intimate partners in the process. But you do need an independent assessment process for eligibility in the system, particularly if you move towards an uncapped system as one of the preconditions. I would also think about – if you go to page 7 of the diagram, you have a care giver underneath the point of assessment and then you have the entry point above it. It may be that the care finder has a broader role than just finding the care. They're also a person or a group of people who can help the consumer find their way through the system.

It's one of the great difficulties of the aged care system, as it is with the NDIS, as well, of people being able to navigate the system including from go to whoa, including assessing their eligibility. So maybe there's a broader role for a navigator that can sit there and help people through the assessment process, once they're assessed as eligible, helping them find appropriate levels of care, whether that be in home or in institutional care or, indeed, the other investment stream or the basic stream. So there's a broader role there, I think, for the navigator.

MR GRAY: Thank you. I will open it up for panel discussion. I think Mr Bonner was first, then Mr Rees.

MR BONNER: I think that we need to be clear about what we are assessing for. So there are places like hospitals, GPs and others that can identify need for access and ongoing support and care. But that's a different test from testing for eligibility for subsidy and on the way through. So are we referring or assessing for care and intervention or are we assessing for some sort of means testing or funding on the way through? Completely agree with the issue of needing to provide for navigation and case management in aa much more structured and supportive way than we have.

I think that the other thing we need to recognise that if we don't improve referral and eligibility for care from hospitals and GPs and the like, then we're going to continue to trap people in inappropriate points of care that are sometimes contraindicated in terms of their care needs, but also much more expensive for the community on the way through.

MR GRAY: Thank you, Mr Rees.

MR REES: I would just like to support the points made by David Tune and say two things. One is that people often don't recognise they need help. Bureaucrats often talk as if people are slamming on the door waiting for services. It's not the truth. People with dementia don't actually want to talk about their problems. And carers are often in denial. So I think the care navigator has an important role of persuasion, as well as directing people to services. On people with dementia specifically, they're left post-diagnosis in an absolute vacuum. There is no guarantee, there is no structure. It's not like diabetes, where you get referred to a nurse or dietitian or some

other services. Nothing happens to you. So I think in the case of people with dementia you do need a structure that takes them from the point of diagnosis to a navigator who can help plan and direct the services.

MR GRAY: And is the answer there education of general practitioners?

MR REES: Well, certainly education referring, but I think you actually need a structure for GPs to refer to. They're busy. So if you have diabetics, you get referred to a nurse who takes over at that point referring you to a dietitian, exercise or whatever it you need. Nothing like that happens with dementia; you're just left in absolute limbo in terms of planning or knowing how you can help yourself in terms of technology or innovative services of any kind.

MR GRAY: Professor Woods.

PROF WOODS: Thank you. The face-to-face navigation role is absolutely fundamental and will solve a lot of problems where people just get lost in the system and, therefore, drop out; it's too hard. The idea of having basic screening versus comprehensive assessment is well placed, so that you have a soft entry for those who just require the basic service, but, nonetheless, to make sure that you understand why they need those services, because that may be an indicator of broader need. And so there still needs to be that navigator come aware of that person's circumstances, but it will also be a requirement of the provider of basic services to understand those broader issues. And yes, the assessment function does need to be separate from the provision function. But the idea of the two tier does make sense.

MR GRAY: Mr - - -

COMMISSIONER BRIGGS: If I might follow up that comment and the one by Ms Sparrow earlier on about assessment. The submissions we have received for this workshop have been quite helpful and raise, I think, a fundamental issue, which is do we bring issues about restoration, re-ablement forward in the process? And, ideally, personally, I would like to do that. But if we're to do that, then that suggests that our approach to screening with this lower level initial screening might in fact be wrong, and it might be sensible to have comprehensive screening up-front. Ms Sparrow, what's your view on that?

MS SPARROW: I think we have to balance it, because I think you're raising a really important point. And we sometimes go back and forwards on that. But I do think it's really important we pick that up early. But I don't think that should stop referral, for example. If someone instantly needs a community transport service or a meal service, I think that referral should be able to happen. And, to Professor Woods' point, that service provider then is in contact with the person and should be able to look at when does the assessment happen. You wouldn't want it to be left into the never-never; it shouldn't go for a year. But it might be that it's okay for a month or two months while the person is in a crisis to be getting something like that, as long as then there's a connection back in and that you pick up precisely what

you're saying, Commissioner, around whether or not putting in a whole range of other supports and taking a restorative approach will have benefits.

COMMISSIONER BRIGGS: Professor Woods, I interrupted you. Do you have a comment on that?

PROF WOODS: Thank you. Yes. And it is a matter of dealing with an immediate issue and not making it such a barrier that people don't want to sort of be registered with the government and, therefore, don't even receive those basic services. But there does need to be a process by which further situations for that person become discovered and appropriate supports are provided. So it is a balancing act.

MR GRAY: Mr Yates.

MR YATES: I would just want to emphasise that good assessment, comprehensive assessment that looks at restorative opportunities is a skill, set of skills, that stands alone and can be linked with navigating. So you can, if you're talking about individuals having packages of support that's designed around their needs, that needs to be put together really carefully. Yes – and we'll talk about this later – I guess we should have ways of responding quickly to things that are bleedingly obvious in terms of people's needs, but those things may be symptoms of something else that has to be uncovered and dealt with. And those things need to be separate from service providers in terms of already disincentives that would be there for that to be done objectively.

MR GRAY: In the course of that answer that you gave, you mentioned a connection between navigation and assessment. Were you suggesting that they should be performed by the same person?

MR YATES: We've suggested in our submission that, indeed, people – that when people are assessed, they are assigned someone who – we've used the term case manager – that can navigate, who knows where services are available, who can work with the person about making decisions about what's best for them and connect them up quickly. How long they will need that is something to be discussed in more detail. And some people will want to self-navigate quite quickly and one of the current problems of the system is that's not encouraged and supported. But other people might need that support for quite a while.

MR GRAY: Mr Lye.

MR LYE: I would just want to reiterate what Mr Tune said around the importance of the independence of the assessment process. I think the other thing that we would observe is that in terms of providing face-to-face services for people, if you have independent assessment, that might provide an opportunity for someone to have access to a person, so combine assessment and some of the basic navigation into the system. So that the person doesn't have to tell their story more than once. So that

would be an opportunity potentially – that function is combined in the NDIS process through the local area coordinators.

MR GRAY: The next topic for discussion was a proposition that seems to have already received broad consensus. It's a proposition that face-to-face care finding assistance should be available promptly on request. That should be proactively offered upon identification by a responsible professional that a person needs that assistance, together with decision support for people who have communication challenges or cognitive impairment. Is there consensus on the panel that such a proposal is an appropriate proposal? Not hearing any dissent. So we will move on.

Should that role extend beyond the assessment process along the lines that Mr Yates has suggested, so that it becomes a combination of care coordination or case management as well as care finding? What are the views of panellists? Dr Nowlan.

DR NOWLAN: Well, if we accept that ageing is not a kind of linear experience and, indeed, under a system that values restoration of reablement is dynamic, then, yes, we need ongoing support to enable connections to varying and different services as different needs and priorities present.

MR GRAY: Ms Sparrow.

MS SPARROW: Sorry. Yes, I think the question is where – I think we do need that but I also think it needs to connect back to service delivery. So the point is at which point does that transition, potentially. And I say that because providers see people every day, they see the changes, they know the changes and they get to know the person really well. One of the programs that I do think is overlooked often is the assistance for care and housing for the aged, which actually does quite a good balance of having a case manager who is known to the person, who is always there, that could sit quite independently, but the person can go back to them at any point in time and allow service providers to make sure too that they are doing good care coordination and they are responding to the needs of the person and working with the case management system. So I think again there's a balance and there's a point at which you need both, keeping some independence, but also making sure that those people who are dealing on a day-to-day basis and can provide valuable insights are part of that process.

MR GRAY: So you're propounding the possibility that the person who is doing case management might, once a link with a care provider is made, come from that organisation.

MS SPARROW: It could do and there should be a choice for an individual about who they feel most comfortable with, in terms of having a care manager, but I do accept the need for having some independence. But I think it's really important that there's both things happening. There's some independence for the person to go back to, that helps too, if they're unhappy with the service or if they feel that they're not getting what they need. I just want to underline that there's a really important role

that those providers and staff who see the person every day in many cases has to offer as well.

MR GRAY: I'm going to go to some economics in a minute but just on that point, can I seek views from other panellists. Is there consensus around this idea of flexibility about care coordination? Once a link with a care provider is established, is it a good idea that there should be flexibility for care coordination to be provided by that organisation? And how is this principle of maintaining some level of independence or a check and balance process to be observed? Professor Woods.

PROF WOODS: Can I speak beyond economics just for a moment?

MR GRAY: Yes.

PROF WOODS: With your permission. Thank you. The importance of relationship for the older person needs to remain central because there's a danger if we try and design it too tightly, we are going to get fragmentation and so somebody that they've built a relationship with, that they trust, who has their interests at heart and primarily is important, which is why we sort of talk about navigator and some assessment and related matters. I think the provider's responsibility is to be notifying that person, the navigator, that there is a change of circumstance, because they are close to them. But I still think it remains a separate function. But on that other side, that navigator role, I think the broader we can make it, so that it is somebody that person trusts, who knows that they're following their life course, is a very important issue.

MR GRAY: Mr Bonner.

MR BONNER: I think it's – I would agree that there's a case management function that's within the system as a whole. So how do people access services that are needed. But there's a risk if you transfer that to a particular provider. That gets captured within the case management that might be related to that episode of care or that particular environment and not taking the wider view of the person's needs or aspirations.

MS SPARROW: Could I just - - -

MR GRAY: Well, I think we better move past this topic or we will run out of time for our session. But Mr Lye, did you have a contribution on that - - -

MR LYE: Just that there's different terms here and I think case coordination - - -

MS SPARROW: It's different.

MR LYE: You imagine somebody who is receiving services under the different streams that you envisage. There could well be a role for an independent person to make sure that each of those things is happening for the individual, as distinct from

that individual providers within those streams should have a plan for the care or assistance for that person and those two are distinct things, I think. One I would see as more independent.

MS SPARROW: That was my point of clarification.

MR GRAY: Thank you, Ms Sparrow. Let's just move briefly to that point of economics. In terms of the best way to fund that role, should it be funded on a blend of block and activity-based funding? And should the program cater for funding mechanisms that ensure service coverage in rural and remote areas or in areas that can be described as thin markets in other senses, such as markets for the supply of services that meet the needs of diverse groups. Professor Woods?

PROF WOODS: I would argue that you do want some form of block funding because the important issue is the availability of that service and that availability should be made through the process of allocating care services to individuals. So it's not a matter of the individual going and choosing their navigator, unless there is not a good fit. But as a general concept, this should be funded on a competitive block grant type basis, perhaps with some variability for unexpected threshold workloads. But we also want to design it, though, so that we don't encourage over-servicing. If we are going to keep an efficiency principle, which I would argue we should, even well-meaning navigators could be prone to the concept of let's over-service because this is very good revenue stream of taxpayer money.

MR GRAY: Mr Tune.

MR TUNE: Yes, thank you. I would broadly support what Professor Woods has said. I think block funding's the preferred way to go for the bulk of the funding but there might be some provision there for some activity-based funding on top of that, if volumes become too high. The danger with block funding is that the money runs out. So you need to make sure government funding is sufficient to meet the demand, basically. So that's – whereas activity based funding is more open ended but I still favour block funding, I think.

MR GRAY: I think I will close that topic off there and we will go to the next one. Just moving down the areas of fundamental change identified by the Commissioners in their preliminary proposals, at page 5. Of course, a very important element of these areas of fundamental change is the creation of three streams. They're described as service streams in the paper. They can also be thought of as funding streams and perhaps, in some ways, it's best to think of them as funding streams, lest that confusion about whether a person can receive services funded by the three streams at once arise. A person can receive services funded by each of the three streams at the one time. An older Australian might, for example, need transportation services to maintain social connections at the same time as receiving funding under the care stream for ongoing stabilised conditions of ageing. The travel services under the conception in Consultation Paper 1 would be provided via funding from

the basic services stream, the entry level stream at the same time as the care needs would be met by the care stream.

Now, another point of note is that accommodation just gets a separate treatment altogether and there's no detail in Consultation Paper 1 on accommodation. The idea behind the three streams is that there are policy reasons such as efficiency, but also extending to the need to balance efficiency with the need for person-centred care, particularly for complex needs, and that these perhaps competing policy considerations are best accommodated by different funding approaches for services that are provided for these different purposes.

Now, I want to seek the panellists' views on this important architectural concept underlying Consultation Paper 1: is it in principle, at the level of principle, an appropriate and fit for purpose proposal to have the three streams as outlined? Professor Woods.

PROF WOODS: I think there's sufficient merit to use it as a structure for discussion.

MR GRAY: All right. Mr Yates.

MR YATES: So we have struggled a bit with this. I think the – I think in terms of what you have just said, that person-centred is something that applies to the whole of the set of services that a person gets. It's framed around their set of needs. And what mix of what this paper calls entry level or care is going to vary. I think the term "entry" is confusing for the term, because I think when you enter the system you could both need some very basic community engagement connections that you are struggling with, but you may also need quite significant medical intervention that had been undiagnosed at that point. That may actually be a cause. And, in fact, a geriatrician gave me an example of that just the other day, where that medical intervention totally changed the aged care needs of the person.

So we have struggled with that. And our suggestion was actually that you have care and support that covers basic and more complex sets of services. And you can fund those basic and other services differently, if you like, but for the consumer, for the person needing, they have to be one set of potential services. Then there's the whole – what this paper calls investment, we call capacity-building services that do require some expertise to work with the person about. And then we think the other core component is actually, as we said, the support, the guidance, the navigation of the system. The person who is in your corner is an essential part of that and a part of building your confidence.

MR GRAY: Let's start by singling out the basic services and just test the proposition as to whether there are sound reasons for having a separate funding stream in relation to those. And just to recap what I said in the opening, these are very high volume, relatively uniform and expensive services, such as gardening,

cleaning, laundry. Now, they also include travel services to maintain social connection. And they might include day centre respite-type activities.

There's, obviously, a tension here between the spectrum of the services in the stream and the very topics that have been raised by Mr Yates a minute ago around whether, well, these are really part of a continuum of care. Is there an argument based around economic efficiency for a very simplified approach – a very simple approach, a simplified screening eligibility test, for example, without the need for comprehensive assessment or high volume relatively uniform services of the basic variety? Dr Nowlan, can we start with your views on this. And then I think we'll go to Professor Woods.

DR NOWLAN: Sorry to disappoint, but I'm not going to start with the economics. I'm going to start with the question of the person-centred. And to the point that you raised earlier, the challenge here is, of course, that one of the things that we want to avoid is the ..... so that somebody comes in at a low level.

The challenge that we have is that there's a kind of conceptual model that underwrites this, that life is going okay, then something happens, either at a slow or a fast onset, and help might be needed. If we are person-centred, then there's a range of cross-cutting questions that also need to be applied to this, one of which is the question of the effect of long-term disadvantage. So the mental model in which we restore and we re-able suggests that capability was there, but that may have diminished courtesy of disadvantage over a long time. So if, for example, you couldn't access Dental Services and your social network had deteriorated, because you couldn't go out to eat and because your breath was such that you couldn't be around a large volume of other people, then are we restoring you or do we actually need to take a quite different approach?

So we are really concerned about silos. And we think from a kind of person-centred approach we would affirm COTAs perspective on the idea of thinking across a continuum. Finally and just to kind of elevate that point that was implicit in what I had said, again, we are concerned that if the objective is to support the wellbeing of older Australians, we need to come at this from a perspective that doesn't reduce that wellbeing to a biomedical model. So that takes into account the social and psychosocial needs of that community.

MR GRAY: Professor Woods.

PROF WOODS: I fully support that concept of looking at the whole needs of the person, but for the purposes of trying to create some funding streams and the like, I think there's still some value in pursuing this particular component of it. So, yes, it is about basic support services and the word "entry" was leading down the wrong pathway. It is important to define very clearly what is in it and to periodically review what services are included, to make sure that they are actually efficient and producing some benefit, both for the individual and for the tax payer.

The focus does need to be on that - both re-ablement and restorative and capacity building. And I think oral health is a very good one, because oral health is the single greatest indicator of disadvantage amongst people. And we tend to lose that. And so I'm glad that one has been brought up, a very important one.

In terms of the simply "screening", again, it has merit, because we don't want to create too high a hurdle, as long as we then do something further to assess the broader needs of the person. But there's also the important point that these services exist in the marketplace already. I mean, there is cleaning, there is gardening, there is transport, there are meals and the like. What we're talking about is providing subsidies for those services for some people for whom there is a public as well as private benefit in them being supported to access those services.

And so we've got to be very clear about that. It's not as if you can't get services because you're not in the aged care system. I mean, people continue to live throughout their lives. My mother, who is about to turn 103 in three weeks' time, doesn't want to be near the aged care system, but she has a gardener and she can hire an Uber – an Uber these days, rather than a taxi, and these sorts of things. And that's called life, that's called ageing, that's called keeping on with that sort of sense of independence and control.

So we're not talking about services; we're talking about subsidised services here; who gets access to those and why. And this – in this one we want to know why is there a public benefit in them having these. And maybe it's through a pensioner discount or some really simple form. It should only be for – the subsidised services should only be provided by registered providers, because they are dealing with vulnerable consumers and they are using public funds. A competitive block funding model, picking up David Tune's point, of course, that block funding can run out and we need to be very conscious of monitoring that.

MR GRAY: Thank you, Professor. I want to now focus on the next stream.

PROF WOODS: Okay.

MR GRAY: And the key thing about the next stream is it takes that theme of promotion of independence and re-ablement to another level because this is intended as prompt and scaleable funding for episodes that might carry the risk of the person needing to have more complex or intensive longer-term needs. It also is intended to cover respite, which doesn't really fall into that same category. It could. It could be emergency respite needed but it's also the case that the evidence suggests planned and regular respite is very important in sustaining the care dyad in the long-term, perhaps particularly for people who are caring for loved ones who are living with dementia.

Now, is the proposal for a separate stream for these sorts of services consistent with the principle of sustaining independence and focusing on re-ablement and wellness and quality of life and is it also economically sound that that be prompt and scaleable

and not subject to perhaps the more rigorous approach to budgeting for ongoing personal care needs? Can I open that topic up for discussion? The investment stream being a very important innovative feature of the model proposed in the consultation paper. Dr Nowlan.

DR NOWLAN: So we welcome the focus of the investment stream, though we encourage the application for a different name for the stream. This is, for us, the transformative attempt of the – most transformative attempt of the redesign system, alongside the separation of care and accommodation and we believe it strikes a balance between economics and rights. We are concerned about the question of two things. Firstly, siloing and how one gets into the system and when one falls out and so how those processes happen in ways that are both person-centred and also, to affirm the point that was made before, timely.

We are also concerned about the question of what is the ongoing structure of support beyond an intensive intervention? So what do you come back into? What system do you come back into after you have had an intensive period? And I would note here that I'm talking about both access to services but also, critically, the expectations of self, family, community and practitioners and their expectations about whether you have the capability and capacity to recover. That is not meant to sit separately to my other point about the kind of – the mental model about I have and then I lost being a limited one in relation to the cohort of people we're trying to serve.

MR GRAY: Mr Rees.

MR REES: I'm sorry to say the investment stream offends every principle that I have in terms of system design. I think system design should be based on two main principles and that's a continuum of care for older Australians, that supports access to a range of services, including allied health and nursing care as assessed needs change. The second principle is that re-ablement, if it's going to be transformative, needs to be across the totality of aged care and not confined as a disease that needs to be spread out from a funding point.

So I feel strongly about that. I think, if I was designing a system – and I could go on for an hour about this but I promise you I won't – there's one thing I would do. And that is I would have a low intense, high intense stream. The menu much the same across them. The intensity of care would change and the problem is for bureaucrats in terms of where the funding and assessment points actually change across that care continuum. That's the problem for bureaucrats, not for consumers, because they know what they want.

So that's how I see it. On respite, terribly complex. Terribly complex. ACFA did a good study on it, Alzheimer's Australia did two good studies on respite. My view is you need a separate funding stream for respite. Take it out of residential care. Take it out of where it is at the moment in home care. I would have one funding stream and I would ensure it gets the priority it needs, in terms of care and needs, and I would focus on respite in residential care purely on that transitional element that

helps an older person move into aged care in as graceful way as they can in terms of residential care.

MR GRAY: I will open it up to brief responses by panellists. Mr Bonner.

MR BONNER: I just want to support Glenn's view of that, the need to integrate rehabilitation and restorative care within the wider system. I think that isolating it within a particular service stream is problematic in terms of best possible life for people in all aspects of care.

MR GRAY: On that point, the consultation paper does endeavour to instil principles of re-ablement, advancing wellness and quality of life throughout all the streams.

MR BONNER: Yes. But it does, within this stream and also in the personal care and nursing health care stream, create some senses of false dichotomies between the gaps between them. So the personal care at this entry level is distinguished from nursing and allied health, for example, further up the chart, which I think are problematic too in terms of the continuum of care that has been alluded to.

MR GRAY: Mr Yates.

MR YATES: I would also underline, as we did in our submission, the need for this to be integrated and interwoven into what package of support the person is receiving. It's not something separate. The other thing that I would add in addition to what people have said and underline is the need for, as part of this, assistive technologies. They can be really important and our current system has been very disorganised and underfunded in terms of that. Assistive technologies can play a really significant capacity-building role for people and we are sure into the future that will be even more the case. We need to get that right.

MR GRAY: Mr Tune.

MR TUNE: Yes, I think one of the issues here is at the moment one of the key difficulties people have is we silo the aged care system. We talk about residential care, we talk about home care, we talk about the Commonwealth Home Support Program, which is very similar to your entry level support, and the point that has been made a number of times about wanting to move to a system that has got a continuum of care I think is a really important one. What we are doing here is in effect resetting up what we have got at the moment in a different variation of it. And it just worries me that we are going to perpetuate some of the problems we have got in the system if we don't think about it more broadly.

For example, the entry level care that we have moved on from is really – I'm really worried about the boundary between that and care itself. It's very blurred and whilst I appreciate that people could receive assistance under all three levels or all three streams, I think it's just creating boundary issues that are not necessary, in effect. If

we think about it as one big system with various components and various intensities, as Mr Rees has said, I think we might be getting somewhere.

MS SPARROW: I mean, I think it's an important point.

MR GRAY: Ms Sparrow.

MS SPARROW: I just worry that sometimes we may be mixing up what I see as the individual funding, which is important and it's built around the person, and the funding constructs that sit behind it that enable us to deliver the care individually. I just think sometimes we are mixing those things up. And I entirely agree about the high intensity and low intensity and people needing to be able to move. The fundamental thing for me is it's based on what an individual person needs and there has to be some kind of funding construct underneath that doesn't dictate what the person is receiving or when they are receiving it. So I think we should make sure that we are distinguishing those things because I think otherwise the conversation gets muddled.

MR GRAY: Thank you.

COMMISSIONER BRIGGS: If I might say, I think the key issue for me is that you have all acknowledged that re-ablement is significantly underdone in the current system and what we were trying to do was to say that was the case but I appreciate what you are saying. Now, the more radical versions of this, going to Ms Nowlan's conversations about quality of life, would take you to what's occurring in the UK at the moment through the National Health System, where the first order question is, to an older person, given the high level of depression and concern and so on, is what would make you happy? And that's quite different from any of the services that any of you have talked about or currently exist within this system. Now that's a high-risk area for an Australian Government to venture to, but does that make sense? You're nodding. Thank you.

MR GRAY: We will move now to the proposal for the funding stream for ongoing stabilised care needs called the care stream or the care and health stream. The focus here is on the ability to tailor an individual budget based on a comprehensive assessment of those needs. And there's efficiencies, it's suggested, in doing so, because these are stabilised, ongoing needs. So it's worth pursuing that objective in relation to these needs.

There is also a re-ablement focus in the way that should be done. But this is dealing with, in effect, those stable ongoing needs, as opposed to those episodic needs that are the subject of attention in investment stream. The idea of an individual budget reflecting the comprehensive care assessment of the person in question is to place in that person's hands the ability to make decisions about how that budget should be spent on the care they choose. And this is a powerful argument, it's suggested, in favour of a different funding stream for those needs. It may be that under the

investment stream that flexible, scalable funding is provided in different ways, ways that aren't dependent on the creation of an individualised budget in this way.

Now, I just want to seek the panellists views on the merits of having a separate stream for the funding of the services required to meet individualised ongoing care needs in that manner. To some extent perhaps it's implicit in the remarks you have made already in relation to the investment stream, some of you, that you have a particular view about this stream, as well. But I will open that up for discussion now. Ms Sparrow.

MS SPARROW: I think as a funding construct, you know, I understand it. I think there are a couple of issues with the care stream, particularly when you start to look at residential forms of care. And that might even be cottage residential care or respite of some sort. And the issues I would see there are about – I think it's good that the funding is individualised, but there are some things that can't be delivered in the same way in a home setting as they can be in residential care. There some things that need to be funded so that they are available and there is a capacity there to do that.

If we look at the residential care model of funding that's being trialled at the moment, it actually has a combination of acknowledging that there are some costs that are related to the place of service delivery that should be funded so the door is open, and also that there are individual funding streams that then follow the individual. And I think that's important.

I also think it's important that as we have this discussion in the community, and as people are making their choices, they understand that there are economies of scale that can be achieved in group homes or residential care type setting, and that if you're making a choice – if it's agnostic of care and you're making a choice to spend your resources at home, the level of care you receive may be different from what you would receive if you chose to have that level of care in a congregate care setting. It's a choice that people should be entitled to make. We understand that most people want to age at home. And we want to support that. But, nevertheless, with that choice there are some out-workings of that that individuals in the community need to understand and consider in making their choices.

MR GRAY: You're very right to raise the question of choice about the setting in which the person will receive care as a very important issue.

MS SPARROW: Certainly.

MR GRAY: The evidence before the Royal Commission suggests that in general the preference of people is to age in their own homes, not to move into institutionalised residential care. There's also evidence that Australia is something of an outlier in its - - -

MS SPARROW: Yes

MR GRAY: - - - use of residential care - - -

MS SPARROW: That's true.

MR GRAY: - - - as opposed to other forms of care in the community or in the home. And it seems that there's a powerful argument for untying the funding for care from any particular prescription, by a bureaucrat or by government, as to the form in which, and the setting in which, that care should be received. If the budgeting process caters for the overheads of the place in which care is to be received, would that meet the concern that you've raised about whether there are costs of providing residential forms of care that aren't going to be met this way?

MS SPARROW: I think if that's done individually, it's still difficult to ensure that you've got capacity and services in all of the communities that you want to have them in. So I think there is still something that we need to make sure that there is capacity and services available across the country that people can access. And that's why I quite like that element of the funding model. There are other elements of that funding motel that we may not agree with, but in part that notion that there are some costs and to make sure you have access across. I take the point that there are Australian – that that research study has shown that, but I think how we actually make sure that services are available, and that there is individual funding, as well. And that's why I like that split that is in that AN-ACC model, as we call it.

MR GRAY: Mr Bonner.

MR BONNER: Yes. I mean, I think the point that Ms Sparrow just raised in relation to the relationship between individualised funding and casemix is the appropriate one here. Whether or not that gets disaggregated to the individual holding level I think is a different question. And I think that there are huge workforce issues associated with individualised funding, both in the community and in residential care in the way that's sort of posited in the discussion paper that put at risk greater casualisation, greater disaggregation of work and jobs into the future that we would need to contemplate the effects of. The second thing that I would say is that the concept of this population of people having stable health conditions is a point in time concept.

MS SPARROW: That's true.

MR BONNER: And I go back to the point that has been raised previously, that this is not a linear one-way process in terms of someone entering the aged care system and staying stable, because if the person with a particular chronic disease that they're living with normally then becomes ill because of flu or something else, that changes the whole dynamic. So, again, we need to not treat this stuff too simplistically in terms of stable personal care versus someone living with a variety of dynamic health conditions that require inputs that vary according to time and location.

MR GRAY: Mr Yates. And then I think we will have to leave this topic.

COMMISSIONER PAGONE: Just before you do, Mr Gray, might I put my toe in difficult water. I think it was you, Ms Nowlan, that made some remark about the risk that we might simply be perpetuating the same problem that has underlied some of the difficulties that we've had to date. And I can't recall which in particular, but it might have been Mr Woods that talked about the concept of the funding being, essentially, that of government provision of funds.

So I wonder – this may not quite be the time or the occasion to raise this particular question, it being possibly a little bit bigger picture than the bigger picture, but let me just raise it all the same. So the basic model has been, in this country, that there be services of one kind or another funded by government. Another model that, for example, Mr Gray and I saw in Japan is that of a provision of funds by way of insurance that provides, as it were, a bucket of money to which you're entitled to draw upon as of right when you find that you wish to draw upon that bucket of money. We've got it a little bit like that with the superannuation guarantee fund. Do any of you want to say anything about that at this stage?

MR YATES: Commissioner, that's a big conversation. Yes, we think that that conversation ought to be had. And there are two venues. One is this Royal Commission. And the other, actually, is the current retirement income review that the government has underway. It is about how you effectively finance needs in later life, which is in part what our – well, is very much what other overall retirement income system is designed to do. And, as Professor Woods said earlier, to some degree what we're dealing with in a lot of the services in so-called aged care are actually things that people need, but can't in afford, and that we need to subsidise them.

So I think a discussion about social insurance is an important conversation. It has happened before in Australia and we have never moved in that direction. But there are a number of different ways of financing the level of care that we're talking about.

MR TUNE: Perhaps I could make one comment. It's a very long-term issue. It's an important issue. The whole financing of any system you come up with is critical. But if you do move to a social insurance system, in the same way as it took many years for the superannuation system and the superannuation guarantee to mature, so that people are going to accumulate enough over their lifetime to be able to meet their needs, whether they are income needs or aged care needs or health needs, is a real issue. So you are probably talking, you know, something like a 30, 40 year transition to get there. But that's not to say it should be off the table but it's worth thinking about in that context as well.

COMMISSIONER PAGONE: But it would remove some of the problems, wouldn't it, because you would have a fund of money to which you would have entitlement.

MR TUNE: That's correct, yes.

COMMISSIONER PAGONE: To draw upon that entitlement as and when you felt the need to do so.

MR BONNER: I think the issue becomes is it a social insurance system that builds a pot of money that builds for the whole community or is it a pot of money that builds individual access to services, which would be at odds of some of the posited principles about equity of access, assessment based on need and those sorts of factors, so we would argue that, yes, there is a need to explore some of these options in terms of system funding but not at the individualised level.

MR GRAY: Professor Woods.

PROF WOODS: Yes, I fully support having that conversation but we do need to distinguish between insurance and savings and savings gives you that personal entitlement, which is what the superannuation system is built on, whereas an insurance system is a pooled requirement and then people draw on it as they need, depending on their circumstances. So the idea in Japan is some hybrid of those and I think it would be worth teasing those two different concepts out and working out which one has merit in financing uncertain needs that only a limited number of people will need to only, again, uncertain but limited degree of calling upon it. So those clearly with a diagnosis of dementia and needing long-term care will have a very different circumstance to somebody who grows old and has a heart attack and has no call upon the need for subsidised care services.

MR GRAY: Mr Rees.

MR REES: Just briefly. In the 16 years that the Japanese have been developing their system, they haven't escaped financial problems. So whether you go down that track or whether you're left with the budgetary system that we have, you don't altogether escape some terrible decisions. But the thing that impresses me about the Japanese system from a consumer point of view is its flexibility. So you get services seven days, 24 hours, 365 days a year. You get dementia-specific services. So I think if you are looking at Japan, it's the flexibility of the system as well as the financing of it that might be of interest.

MR GRAY: In the brief time that is available to complete the session, I will just move to two or three other topics by way of just identifying further areas that are going to need more detailed attention. We will have to leave this very interesting topic behind now. The first topic is, as some submissions have rightly identified, a concept underlying the consultation paper is the implication that supply will become uncapped. What will be required to move to the uncapping of supply? Supply is currently capped in the form of allocated places under ACAR in the residential sphere, home care packages in the home care sphere. Now, is it appropriate for the aged care programs to be redesigned around the principle of uncapped supply and what's needed in broad terms to get there? I will open that up for any contributions from the panel. Mr Lye, you might be an appropriate person to ..... work needs to be done.

MR LYE: Thanks very much. Look, I think we would say that if you were going to move to that sort of world, that you need to have very good ways of assessing eligibility. We need to know what that demand looked like probably better than we do today and what the need looks like. So that puts a lot of emphasis in on the assessment process, making sure you've got that right. You have also got to look at your existing means testing. So you need a robust and consistently applied means test, if that's part of the system. It is currently and those two things have got to work in together, so that you know what the expenditure looks like.

I think the third thing I would say – and this probably underpins some of the work of the NDIS – that there has been some careful consideration about making sure that two people who have equivalent assessments or needs receive, you know, relatively the same level of assistance, so there's some consistency. And there's a lot of work being done in the NDIS space to make sure that reference packages and the like generate that level of uniformity. I don't mean – they are individualised packages but they are, you know, seen as fair when you look at people in like circumstances. So I think you need all of those things if you're going to have a system like that.

MR GRAY: Professor Woods.

PROF WOODS: I think you can uncap supply for residential care at the moment but primarily because it's a less attractive good than certain other goods, which are subsidised services at home. But I completely support Mr Lye's commentary that you need to have very rigorous assessment. You need to be very clear on why you are subsidising services for whom and by how much. And the assessment service does need to follow that through very closely. So I wouldn't consider that either home care packages, or even CSHP to an extent, but mainly home care packages are sufficiently mature in defining the need, the eligibility for subsidies before you can uncap demand. I don't think the assessment service supports that.

MR GRAY: Mr Yates.

MR YATES: To go to the point, firstly, to underline the – yes, there should be a principle of uncapped supply in a community of our wealth and wellbeing and not to do so is to say that people who we assess as being in need and needing that support are not going to get it. We're talking about aged care. You're talking about later life. Many times delayed care is denied care. And, you know, that's really important. But in terms of what you need, you do need really strong assessment. I agree with that, won't repeat that.

We need much more flexible regulatory environment. Part of the issue we have with Australia's residential care is there's a cookie cutter approach to it, supported by the aged care approval process. We see the same kind of unimaginative – to use the interim report's term – institutionalised approaches and we have an institutionalised approach to aged care in Australia and we have to get out of that and have much more creative approaches, which exist in other countries. So all of those things

would need to be – and simplified and equitable means testing which we also don't have at the moment.

MR GRAY: Mr Bonner.

MR BONNER: Yes, I mean, I think the question is what's the alternative to an uncapping of the system and it's a continuation of what we have got now where people waiting for aged care services or disability services are trapped either without services or in completely inappropriate settings. So that we're driving up – I think in Adelaide when we looked at it about a year ago, 150 people were in acute care hospitals across the metropolitan area, waiting for ongoing disability or aged care services. That's not only denying those people access to a descent service and life but it's also then adding cost and volume to those acute care services. It is economically inefficient and driving up costs at their worst point. So we would argue that uncapping demand in fact has the potential to be economically beneficial to the community as a whole, whilst it might uncap costs in this particular sector.

MR GRAY: Just very briefly, if the program redesign proposal in Consultation Paper 1 is implemented, involving, in the care stream in particular, the potential for individual control over the expenditure of an individualised budget and the potential for unbundling of services, if service providers are willing to provide unbundled offerings, with all of the economic benefits for potential innovation that that implies, what are the regulatory, quality and safety challenges? Do any panellists wish to just to identify what are the areas that need attention on that topic. Mr Tune.

MR TUNE: Yes, I think one of the issues – and it has arisen in the context of the NDIS as well – is when a service is registered and when it's not – or accredited is the term used in the aged care. Obviously, if you a residential aged care provider, you need to be accredited, you need to be subject to quality standards and all those regulatory standards. When you get down to your basic services, like your gardener, your person who is bringing in the Meals on Wheels or whatever, that's when the issue becomes a bit more blurry, it seems to me.

And particularly if a person has got control of their own budget and wants to use a particular gardener down the street and can't use their money for that purpose because the gardener is not registered, that's an issue. It's undermining the control that the person has over their budget. So I think you had need to think very carefully about the degree of regulation that occurs as your service intensity increases. Starting with – at least in the NDIS, a person can use unregistered providers if they so wish at their own risk and use their budget for that purpose. Not many do it, mind you, but you can do that and it's worth thinking about that.

MR GRAY: Well, that's all we have got time for. There are other topics that we could address but I will bring the session to a close, subject to any issues that the Commissioners wish to raise.

COMMISSIONER PAGONE: Thank you, Mr Gray. And thank you to each of the panellists. We are very grateful for your contribution, both in the submissions that you have made and in making yourself available today for this discussion. I think we have found it informative and helpful. I hope you feel as though you have contributed to the exercise. It has been very helpful indeed. Thank you. We will adjourn now until 1 o'clock.

ADJOURNED **[11.51 am]**

RESUMED **[12.59 pm]**

COMMISSIONER PAGONE: Mr Gray.

MR GRAY: Thank you, Commissioner. Our next session, session number 2, is on information, assessment and navigation. Our participants are Mr Ian Yates, who was already introduced in the last session and I won't introduce again. Mr Paul Versteege may be joining us later, but he's had flight difficulties. Dr Michael Fine, Dr Ricki Smith, Dr Nick Hartland, Ms Samantha Edmunds, Professor John McCallum, Mr Sean Rooney, Professor Mark Morgan and Mr Bryan Lipmann. Now, with the exception of Mr Versteege, all the participants are already in their seats at the panel and I formally call them now. Those who have elected to give an oath or take an affirmation may do so now. Ms Associate, proceed, please.

MARK MORGAN, AFFIRMED **[1.00 pm]**

RICKI SMITH, SWORN **[1.01 pm]**

JOHN McCALLUM, SWORN

MICHAEL FINE, AFFIRMED

SAMANTHA EDMONDS, AFFIRMED

NICHOLAS HARTLAND, SWORN

IAN YATES, AFFIRMED

SEAN ROONEY, AFFIRMED

BRYAN LIPMANN, AFFIRMED

MR GRAY: Thank you very much. I will now give brief introductory remarks about each of our participants, with the exception of Mr Yates, because I introduced him in the last session. Mr Yates is chief executive of COTA Australia. And Mr Versteege, I won't give him a lengthy introduction. He may be joining us. He's the policy manage of the Combined Pensioners and Superannuants Association. Starting in a little more detail with Dr Michael Fine. Should I call you Professor?

PROF FINE: You can. You can call me doctor, also.

MR GRAY: Thank you.

PROF FINE: Both good.

MR GRAY: Professor Fine is an honorary professor in the Department of Sociology at Macquarie University, Sydney. Professor Fine is associate professor and head of department - - -

PROF FINE: Was.

MR GRAY: - - - in the period - - -

PROF FINE: Was.

MR GRAY: - - - 2008 to 2012. Professor fine has researched, published and taught in the fields of social policy, ageing, care and human services for over 30 years. He is currently leading an Australian Research Council Linkage Project; is that correct? With Professor Kathy Eagar of the Australian Health Services Research Institute at the University of Wollongong on the development of Australian community care outcomes measure.

Next I will introduce Dr Ricki Smith. Dr Smith is the CEO of Access Care Network. Dr Smith has held that role since 2015. Dr Smith has more than 30 years' experience in leadership, strategic planning and business development. And Dr Smith is an advocate for sustaining independence and the concept of re-ablement. In addition to Dr Smith's professional roles, her board experience spans two decades in both government and non-government organisations.

Dr Nick Hartland is First Assistant Secretary in home aged care in the Department of Health. In that position, Dr Hartland is responsible for the Commonwealth's funding and management of aged care assessment teams, regional assessment services, the operation of My Aged Care, the Commonwealth Home Support program, the

Homecare Packages Program and, in relation to the Homecare Packages Program, the national prioritisation system.

Ms Samantha Edmonds is chair of the Aged Care Sector Committee diversity subgroup. Ms Edmonds has long experience in LGBTI-inclusive strategies and policy. Ms Edmonds has been the managing director at Ageing with Pride since October 2019. And this involves experience in assisting ageing, aged care, palliative care and health providers to develop LGBTI-inclusive services. Prior to this, Ms Edmonds was national project manager at Silver Rainbow, national LGBT health alliance and held that role for five years. And, as I said, Ms Edmonds is now chair of the Aged Care Sector Committee diversity subgroup.

Professor John McCallum is an academic of great standing, published in many peer-reviewed publications books and monographs and furthermore in National Health and Medical Research Council evidence statements, guidelines and National Seniors Reports. Professor McCallum was executive Dean of Health and Social Sciences at the University of Western Australia, Senior Deputy Vice-Chancellor and director of TAFE Victoria University, senior executive National Health and Medical Research Council, Research Translation Group, director of the NHMRC National Institute For Dementia Research, research director National Seniors Australia. He holds that role of research director National Seniors Australia and CEO and has held that role since 2018. Some of Professor McCallum's projects include the Dubbo Longitudinal Study Of Ageing and the Australia/Japan collaboration aged care, asset and health dynamics.

Mr Sean Rooney is the chief executive officer at Leading Aged Services Australia, LASA. LASA is the national association for all providers of aged care services across residential care, home care and retirement living and seniors housing.

Professor Mark Morgan completed his medical training in Cambridge and Oxford universities. Professor Morgan has worked as a GP since 1998 and now teaches medical students at Bond University. Professor Morgan is a member of the Royal Australian College of General Practitioners Quality Care Committee. And Professor Morgan has a particular interest and has particular experience in aged care elements of chronic health care.

Mr Bryan Lipmann is the chief executive officer and founder of Wintringham, an approved provider that offers residential care and home care packages to people who are experiencing homelessness. Mr Lipmann has a background in economics and social work, and also a great deal of experience working with socially and financially disadvantaged older people, in recognition of which in 1999 Mr Lipmann received the Order of Australia – Member of the Order of Australia, for his work with the elderly homeless. And he has been acknowledged as a distinguished alumni of La Trobe University.

That concludes the introductions. Members of the panel, you may be familiar with the format of the panel discussion that I'm now going to facilitate. I'm going to state

propositions and talking points and then invite one or more of you to respond to that, in a little detail. We'll only have probably around five or so minutes for each of these topics. So please be as brief as you can. There will then, in the limited time available, be a facilitated discussion by way of response to what's been said. And if you'd indicate by showing your hand, if you wish to join in that discussion, please do so.

The first question which I want to pose relates to the proposal in Consultation Paper 1 for face-to-face information and access assistance to be available to people seeking information about, and access to, the aged care system. There seems to be broad consensus already emerging from an earlier panel session about the appropriateness of some form of face-to-face services. I now wish to delve into that topic in more detail and to propose detailed elements of what that service would look like.

Firstly, there's been an emphasis already on the need for promptitude. You've got to be timely in the response that one makes to a request for access to aged care services. How is this best to be achieved so that as soon as possible after a request by a person seeking care or the raising of that topic or the identification proactively, if need, by a responsible professional this can actually occur? Professor Morgan, I will start with you.

PROF MORGAN: Thank you. I think there needs to be multiple access points to any face-to-face service. So my vision is more of a funnel way, of multiple access points, leads to the sort of provider of that service. And the sort of access point we're talking about would be the personal carer themselves experiencing an unmet need, a health provider, like a GP or hospital provider, recognising that there will be an unmet need or there is an immediate unmet need.

And if all of those potential providers of services can access a face-to-face navigation, that's going to lead to a quicker approach than having a multiple staged model where you have to go through a series of triage, assessments and meeting before getting that face-to-face help that you need to get started.

MR GRAY: Thank you. Let's just develop that a little further. So you've identified the possibility of referral by a health practitioner. Should there be any limit on who does the identification? And how would the funnel operate in practice? Would there be some sort of regional network? Would there be a hotline that any responsible professional could call to ensure that navigation services are provided face-to-face for the person in question?

PROF MORGAN: I think probably the most effective way to do this would be a reasonably succinct questionnaire online that can be used to provide some background information. There would need to be an opportunity for a telephone version of that questionnaire for people that don't have the capacity to access online. But the reason why I recommend a structured questionnaire approach is it can provide the necessary information for the next stage, which is the actual provision of face-to-face navigator. So sort of questions about where that's going to

happen, how urgent the need is and perhaps even some early information about which face-to-face navigator is going to be the most sensible.

MR GRAY: So in your proposal is it the health practitioner, say, or the other responsible professional who fills out that questionnaire?

PROF MORGAN: I think it can be a health practitioner, which would include, from a GP perspective, GPs or practice nurses. But I think there are many equivalent people that are in the right position to spot an emerging unmet need that needs to be filled quickly to prevent the wheels falling off. My observation is that people adapt to slowly changing requirements to be able to perhaps survive in their own home, for example. But it's when there's a sudden change in status or the sudden change in status of a carer that you need quick access to enhanced services.

MR GRAY: Ms Edmonds and Mr Lipmann, I want to bring you into the discussion at this point. It occurs to me that what Professor Morgan is saying might work very well for a large number of people, but are there diverse needs that we need to consider here and what are the gaps that might exist in relation to some diverse needs groups, in particular around the sort of premise that there might be already an established relationship with a GP? Perhaps if we start with you, Ms Edmonds, on some of the intricacies that are implied by diverse needs.

MS EDMONDS: Sure. Look, I think they absolutely need to be taken into consideration, but I'm still concerned that we're looking at diverse needs as an add-on or a specialist or something that needs to be tailored, rather than actually a core embedded part of the aged care system. And I don't think, until we actually look at vulnerable people and people with diversity and different needs and actually say what does the system look like for them, how will this process work for them, what will be the best for them, we're not going to actually develop any system, whether it's the information assessment or the whole system itself that's actually going to be effective to meet the needs of vulnerable people. I mean, we need, we need to take a human rights based approach. We've spoken about that. And, you know, we also need to look at the social determinants of health and how that intersects.

MR GRAY: But let's take this to a practical level.

MS EDMONDS: Yes.

MR GRAY: Would you accept that, provided the navigator or the care finder, whatever the name of the role happens to be, provided that person has an appropriate understanding of the need to deliver safe services, services that are understanding of the diverse needs of the person in question, then that would be a major gain.

MS EDMONDS: Definitely, but the person would probably also need to be from a trusted entity, so from an organisation that the person already had a developed and confident and comfortable relationship with, preferably also be from the diversity

group that the person is from, so has a lived experience of that need and can, therefore, understand some of the complexities of those needs that don't necessarily come across in a discussion or an assessment process, you know, lived experiences, past experiences, experiences of discrimination that you don't understand and don't know about until you have lived them yourself.

And if you don't have people that have that same diversity group, then you have to have a very skilled, educated workforce, the navigator or the care person, who understand cultural safety, who understand trauma-informed care, but also have the empathy and the compassion and that other understanding, as well. So it's not just the knowledge skills; it's the personal skills. And I think there needs to be a really good look at how that happens when hiring people.

MR GRAY: Just picking up on what you said about taking advantage of trusted relationships that already exist with organisations who are there to serve the group with the diverse needs in question, is that part of the solution here, that we should conceive of the pathways to referral to these care finding services as bringing in and leveraging those existing relationships with those organisations?

MS EDMONDS: Absolutely.

MR GRAY: Mr Lipmann, do you want to join into the conversation at this point. And if you could speak about, perhaps, the group of people who are homeless or at risk of homelessness in particular and the particular challenges that exist in putting them in touch with aged care services, let alone a navigator of aged care services.

MR LIPMANN: Yes. I would agree with most of what Sam said. I guess the issue for us, though is that our clients aren't – even though we're part of the diversity framework, I've never considered our clients to be part of a diversity group. They're just impoverished. It's quite a different issue. They could be from any background, but they're just impoverished. And, as a result of their impoverishment and their life they have led, they are often distrustful and wary, for very good reasons, of anybody, really.

So I hope later on this afternoon to give some examples of how we have been able to break through that, which may have relevance for this Commission. But I have always been of the view, and I've said it previously to the Commission, that what might work for the country as a whole may not necessarily work for our clients. And, rather than be arrogant enough to say you need to change the whole system to make it work for us, I'm quite happy for my good colleagues here to thrash out a system that works for the country, as long as you have a way to ensure that people who don't fit the guidelines or the policies or procedures that you have set up, that a way can be found for them to access aged care. And importantly – and I know I'm not allowed to say this, but they've got to be viable. Services aren't viable for homeless people and we have to find a way to make them viable, otherwise we will close down.

MR GRAY: Look, I want to broaden the opportunity for other panellists to join in and I noticed Dr Hartland indicated he wished to join in. Specifically, though, for you, Dr Hartland, in the course of your contribution, could you consider this proposition: that any care finding services to which people are put in touch or with which people are put in touch, that those care finding services need to be provided in the presence of informal carers, loved ones, family, and that there's an issue about impediments to the free flow of information about care needs that has been noted in evidence before the Royal Commission, centring around Privacy Act concerns in the past and that has been something that has been raised in relation to the existing information flow processes of My Aged Care. We don't want that to be carried over and duplicated in the context of navigation and care finding services either. So if you are able to give a response to that proposition, as well as making the contribution you need to make.

DR HARTLAND: Sure. Well, I think listening to the contributions and having thought about the evidence that you have had put in front of you, there's no doubt that aged care as a whole needs to have a much greater face-to-face presence and that has to take a number of forms. I wouldn't want this to be a very replacing – what can in its worst instances be a pretty mechanical process of going to a GP, getting referred to My Aged Care, getting referred to assessment, to going to a GP, getting referred to a central point and then getting referred to navigation and getting referred to other services.

I think you need to think about navigation in a slightly different way and it comes out in Sam and Brian's comments that a well-placed community group that has a relationship with people who are vulnerable to not getting a service offer is actually, as a navigator, is a way of drawing people into the system and it provides a face-to-face contact that people otherwise might not approach a formal system, wouldn't otherwise have and that's one of the things that Bryan's services do and one of the things that community-based groups have a relationship with vulnerable people do.

So I think you need to think of navigation as existing face-to-face capacity embedded in communities that people can approach, as well as a service offer that, once a vulnerable person gets into the system, will help them, guide them through the system. And in that respect, the whole thing should be geared to quickly getting people to assessment, so that you can start to think about what services that person needs and there will be other questions, I imagine, that you will comment on, that would lead you to that.

Specifically in response to your questions about informal care and information barriers, I think I would absolutely agree, so the short answer is yes. Data – I mean we have had – you have questioned me before about data and not being able to tell you as much as you needed to know about vulnerable groups. We do need to find a better way of finding out data about people that are in aged care so that we can understand their needs better and we certainly need to know .....

MR GRAY: It's all right.

DR HARTLAND: Short answer is yes.

Mr GRAY: There may be some questions about data later but if we just stick on this topic. Could the care finder go to wherever it is that the person who needs the care or - - -

DR HARTLAND: I have to admit, I'm slightly confused now about this - - -

MR GRAY: ..... should the care finder go to that person in their current care setting, be that home, a hospital, if something has happened giving rise to the need or should it just be a shopfront, face-to-face but a shopfront. What do you say?

DR HARTLAND: Well, I think you need – well, I think the answer is you need both. I'm slightly confused about the word care finder now. I thought I had it until 30 seconds ago but that's all right. You know, you need a role of trusted organisations being able to connect with people who wouldn't otherwise approach services and homelessness is a classic example of that. Homeless people are not going to go to a shopfront or ring a call centre.

You do need face-to-face contact, even once they've declared a need for services, who might need special help. I think there's a role in aged care, where we don't do enough of, which is a sort of a bit like the NDIS local area coordination. That's about actually linking people into services that are otherwise available without a funded offer. There's areas of coordination and duty of care. So I think there's actually a whole nest of roles in relation to what you have talked about in care finding that slightly need to be pulled out and could be actually residing in a number of different organisations.

MR GRAY: Let's tease that out as the session progresses. Professor Fine, are you wishing to - - -

PROF FINE: Look, I would. I might be asked the next question but I suppose I also find this question of linking the information and the care navigation a little bit confusing in the outline that's in the discussion paper. I think it's a very exciting concept in many ways but it seems to me, in the diagram, for example, and in the text, it seems that the care finder comes after a screening process or assessment and yet information probably goes before any of that. And I think we can distinguish very clearly referral and information. They belong together, even though they are also distinguishable from accessing a service, which is again separate from assessment.

And we've found how powerful it really can be to have a good assessment but I think, you know, when we have got low cost community support services, the entry level services as they are called here, although I'm going to argue that's – I think we can think of a better term. I call them primary care services because it's not entry. They may go no further than those services. It may be all you get and you don't want people to think they should be moving through a system.

But they're $55 a week. Adding on a significant high cost case management function at the beginning that could take some time – is that really valuable compared to just allowing people to access services and then, where necessary, to identify whether that service will then identify, yes, this is more complex than you just need a meal. You're going to also need someone to help clean your house, you are also going to need someone to help bring you to social activities, you are getting socially isolated and that might be a point to bring in the care finder or something. So I would distinguish them. I think each of those are very important functions but - - -

MR GRAY: Thank you. Professor McCallum.

PROF McCALLUM: Look, I'm very supportive and we'd be very supportive of face-to-face information, provided that it isn't face-to-face information only. There's a digital world we live in. It's much more efficient. We are designing a system for the future. We have to look to that and these things will be part of it and probably will get a lot better than they are. There are limits to that, of course, and face-to-face is very important. So I think let's not lose that perspective. There are people actually prefer it and would prefer to use that in the early stages for information.

MR GRAY: Can I just raise some economics? Perhaps I might pose this question to you and also adding whatever other observation you wish to make. In terms of the economics of making this work and leveraging the existing resources around community organisations that already have trusted relationships with people, how should it be funded? Should there be commissioning of trusted local organisations through block funding? Should there be some sort of combination and overlay of activity-based funding? Who should be commissioned as the people who would fulfil this important navigational role? I've been using the expression "care finder". That's an expression that is used once or twice in the consultation paper but "navigation services" is also a word that's used. Mr Yates.

MR YATES: So context, in terms of what Professor Fine just said, we have, in our submission, spelt out all those separate components. They are separable. You can do different things with information, we believe, than you can do with assessment. And we propose that you would combine assessment and what you are calling care finding, what we call case management, linking people up and indeed that the entry point, as we've said and come to, I guess, later, but provide real-time booking. We think those services are not paid for, if you like out of people's entitlement, out of people's package, they're provided by the Commonwealth and that they would be provided on whatever is assessed to be the best basis of – which would probably be, I suspect, a combination of grant funding. We don't like the term block funding. But funding related to basically providing that service in any area with some degree of capitation about what volumes you are actually going through. Because if you don't, then how do you measure your capacity to respond to the demand. And as we've said, that function needs to be independent of service providers.

The point I was going to make before you decided to give me that question was just to note that the recent – well, firstly, note two things in terms of the point that John made, which is when we originally proposed a gateway to the Productivity Commission many years ago, it was always to have a face-to-face component but also an online component. When it was established, even as an online and call centre, it was never properly resourced even to do that job – even to do that job, leaving aside that it should have. It was never – it was within a budget envelope. It was not about let's design how this system, what kind of IT platform would be needed to make this work properly. None of that. It was created out of the budget envelope that was available.

So we've always had the IT trying to catch up. It has been doing some catching up. One of the important developments that we have just seen is the capacity to self-register. So you can on now go online and register. What that means is your carer can go online with you, your GP can go – I don't think too many GPs would be going online but, you know, the trusted person you have can do that with you. That's your call. I would make the point in terms of your very early question to Dr Hartland that the presence of another person in that process has to be with the consent of the person needing the care, because sometimes those family dynamics are not in the interests of the person needing the care. I deal too much with issues of elder abuse and inheritance protection and all sorts of other issues to believe that it always is the family member acting in the best interests of the person needing the care.

MR GRAY: Should the care finder then have, within the spectrum of functions she or he can perform, the ability to apply for a guardianship order in the case of the person who doesn't appear to have cognitive competence and where the care finder is finding it difficult to obtain instructions?

MR YATES: I think that they ought to be able to facilitate that process to happen, whether the applicant – is something I would need to probably take on a bit of notice.

MR GRAY: Dr Smith, I want to bring you in on essentially the care finder function topic, not limited to the form of funding but including the form of funding that would be appropriate and who could be commissioned to do the job.

DR SMITH: Thank you. I have had the unique position of doing an implementation of two aged care assessment workforces, one in Western Australia in 2011 and then in My Aged Care in 2015. One of the features of the West Australian model was a "no wrong door". So what it meant was a service provider, a trusted advisor, a carer, a neighbour, could facilitate access to assessment and thereon. I agree with Mr Yates that the introduction of the online self-registration has given people the opportunity to have that no wrong door without necessarily the need to have somebody in-between.

I do think, though, that there are particular times when there are tough decisions to be made and that is where some independent support to do that would be important, such as when they are deciding, "Should I take up a home care package or, using

today's language, will CHSP suffice?" Whatever your financial implications of going into either an independent living or into residential care, I think at those points it's really important and would be beneficial to have some sort of navigator but unfortunately I don't agree that it's necessary now to have that care finder role between the individual and getting the assessment in the first place. I think the system has improved to the point where that's now possible.

MR GRAY: What do you say about Mr Yates' point that the care finding role can be combined with the assessment function?

DR SMITH: And that is part of our job, yes.

MR GRAY: And how would that be accommodated where there are complex needs and you might need a multiple disciplinary team?

DR SMITH: So part of our role today – so we run regional assessment services, but in the streamlined world there would have the clinical, the ACAT assessment, the clinical assessment as part of it. Our role today is to work independently with people, identify what their goals are. I will describe later how we do that. But having identified their goals and identified where the needs are, our role is to facilitate access to service, when service is required. I think the complicating factor today is that we have two assessment workforces and we have two different funding mechanisms that gets in the way of that.

So if you came to my organisation as a regional assessment service we would facilitate access online for you, if you wished, to the service provider of your choice. The package world is slightly different and some of the approaches at different assessment organisations take might give out a code instead of facilitating access. I think one of the benefits of the streamlined assessment that is being considered by the department is that we will have a more consistent approach, which will reduce the complexity enormously.

MR GRAY: What about Mr Yates' point concerning anything to do with assessment being separate from service provision? I don't think I'm misrepresenting what you said, Mr Yates.

MR YATES: No, no, and we have made that very forcefully in the paper.

DR SMITH: Yes, I agree. I think one of the reasons why Western Australia – I guess I have more knowledge of their history and why they did it. One of the reasons why Western Australia implemented a separate independent assessment organisation was to ensure that there was equity of access and that it was fair and equitable and that everyone had the same opportunity to enter the aged care system and that having an independent workforce that, to be honest, also acts somewhat as a rationing system. So people who need services get it, not the first one in, helped that. So I agree.

MR GRAY: Putting all those elements together raises a bit of a problem. If navigation is connected with assessment but it's accepted that assessment has to be separate from service providing, doesn't that jeopardise the point about making the best use of trusted relationships with existing community organisations, who may well be service providers? I want to bring you in, Mr Lipmann.

MR LIPMANN: Yes. Again, I'm not quite sure that I agree with all of those comments. I think, as a general rule, providers shouldn't be doing the assessment. I can understand that. But certain groups of people, perhaps the only person they're going to trust is the provider because the provider may well have had, in a previous iteration, quite a relationship with them before they've moved into aged care. So that relationship is important.

We have attempted to resolve that tension, because it is clearly a tension, by partnering with a local ACAS team to have one of our workers embedded in the ACAS team. So the ACAS team still makes the final decision but the assessment is, I guess, filtered or informed by the intimate knowledge of the particular client with the provider, which is us. I can see the dangers of that throughout the system but in our particular case, it's worked well and it's worth – we would like to repeat it and grow it. It seems to have been greatly informing both organisations. It has informed Wintringham of, even though we have worked with ACAS teams for an awful long time, of more of an understanding how they proceed and similarly they have much more greater knowledge of clients that they would normally struggle greatly with.

MR GRAY: Ms Edmonds.

MS EDMONDS: Yes, I would just like to agree with what Bryan said and acknowledge that for many diversity groups the trusted service provider is the provider and therefore they are the person they will trust to assess them. But there's also a very similar thing in terms of other ACAT teams around Australia, where someone being assessed feels more comfortable if a member of that team is actually from their diversity group, so there is that connection within that assessment process as well. So that separates again from the provider and there's a separate assessment team. But I think we also need to recognise that in some areas there won't be that pool of people to call on and that's where we need to look at, well, what do we do where there aren't trusted entities that people can access?

MR GRAY: I think we have got time for one more brief contribution, Professor Fine.

PROF FINE: Well, I would just say that I think experience shows us that it depends very much also on what level of service we are talking about. If we are talking about accessing residential care, we have a history in the past, going back to the 1960s and 1970s, where people would directly approach a residential care provider or a GP. Many GPs actually owned nursing homes and just admitted patients and we had the longest waiting lists in the world. The assessment teams were very effective in managing that because they were independent advice. They still gave advice when

people needed residential care to go there and, in a sense, they steered. They did do a bit of this care finding issue there. When a person was able to be supported at home, initially we didn't have aged care program and they would act as a little bit of a case manager, trying to put them into a Meals on Wheels service and home nursing service or whatnot. That's a very different sort of situation to the one of a homeless, socially-disadvantaged person, who has very few people to speak up for them.

But I think you can see how that actually does work, having somebody in an assessment team who is independent. They should not be employed by a for-profit provider. And I think that becomes very difficult when we introduce the element of marketisation and ownership and business growth into it. We just don't want good businesses being tainted by the accusation that they're over servicing or providing services where they're not needed.

MR GRAY: Did you intentionally emphasise for-profit there? Are you - - -

PROF FINE: I did, yes.

MR GRAY: - - - saying not-for–profits? .....

PROF FINE: No. For-profits. I think it makes that case very clearly. It can happen with not-for-profits, also. And it used to in the past when we had that link between what was called hostel accommodation and nursing accommodation. And what would often happen is that the church-based homes would have many of the best funded and best organised nursing homes and the only people who could get access to them were the people that were in their hostels. And it was necessary in a sense to use the assessment team to open that set of residential care facilities to a greater public. So it happens even there.

MR GRAY: I want to move to another topic. It's closely related, though. It's the topic of the very notion of entry into the aged care system. And indeed some submissions have been critical of the very notion of a system. There's also a reasonable amount of consensus in submissions received in response to the consultation paper about the need for a no wrong door approach, but perhaps some uncertainty or fluidity about what actually that means, what it would look like.

Now, Professor Kathy Eagar, in her submission, seems to be making the point that not only should there be channels of potential referral to people who can allow entry into the system, but there should be multiple entry points. She makes the case for this by posing the hypothetical: imagine the health care system if it had only one entry point. So I would ask the panellists to now turn their minds to the arguments for and against a single gateway. And I welcome Mr Versteege to the panel.

Could we have the National Seniors Australia submission at page 27 put up on the screen. It's now up on the screen. Professor McCallum, I will be asking you to speak about the schematic diagram advanced by National Seniors Australia. It's encouraging, is it not, the use of existing points of contact that already exist with

older Australians. And we've already mentioned the likelihood that there are regular visits to a general practitioner. Is it your view that the system can go further and accommodate direct referral for any of the services that are subsidised by the Commonwealth? What are your views?

PROF McCALLUM: Do you want me to comment now?

MR GRAY: Yes.

PROF McCALLUM: So this arises because we're looking at older Australians who are information poor. The information we have is not easy to get to and not getting to them, and who are very negative about the issues we're talking about. And there's a need to change the, if you like, the dialog, the discussion that's going on. It would be hard to make radical reform without a change in that mindset about the way people are thinking. So this is trying to combine the service issues with an information issue. So it's, really, only a framework. It's a sketch of what can happen. There's various points at which people would enter that.

And the idea is that information is provided on a systemic, curated or planned basis, so it's reliable information. And we were thinking that there are a number of lazy policy assets we have. One is the 75 plus medical assessment, which is really substantially undersubscribed and not well used.

MR GRAY: And that's an MBS item, isn't it?

PROF McCALLUM: And that is already an MBS item. And the life checks which were introduced last year – the end of the year before last. And, again, they didn't get a good run and get going, but - - -

MR GRAY: Is that a web-based resource?

PROF McCALLUM: It's an online resource, and you put in your request and you get an answer back. I haven't actually used it myself, so I'm not exactly an expert on it, but I know it exists and I was aware of the launch. So the issue is we, really, have to have a broader information base. And I know every aged counselling, anti-ageism campaign is looking for something that can change the debate. We're in a world which has changed dramatically. So if you talk about retirement income, it's sort of contradictory to say that somebody can work in their retirement, so that contradiction sort of is just an indicator of the way that world is changing and the way other things, particularly life expectancy and the ability to do things. So we need to have that conversation going. We need to have it with simple information.

The other really good resource we have is we have things like the longitudinal study of women's and men's health. We have a specialist centre in ageing that's funded by ARC. We have lots of resources that are publicly funded that can feed into the simple information that can be harnessed to do it.

MR GRAY: Can - - -

PROF McCALLUM: Can – probably just one - - -

MR GRAY: Yes.

PROF McCALLUM: - - - more point and then I will stop. And that is that I don't think you get an understanding of restorative care or those sort of things unless you have this conversation at the same time you're trying to fix things.

MR GRAY: Thank you. In the diagram, who does the care needs assessment in the polygon in the second row in the middle of the diagram?

PROF McCALLUM: I think we're relatively indifferent to who does it, provided it's somebody who is skilled to do it and, you know, plugged into the system so it works in that. So we do have regional aged care assessment teams that could do it. We have doctors who could be brought into that. And we have a range of other possibilities within that. So that's the multiple entry point approach to it.

MR GRAY: Is there any conception that the GP might not just be referring, but might for certain services be able to assess them, resulting in automatic eligibility, say, in urgent circumstances?

PROF McCALLUM: I mean, I think that could be a situation that's developed with proper training and approval, different people who are able to do it, yes.

MR GRAY: Professor Morgan do you have any comment?

PROF MORGAN: Yes. The current aged care assessment item that is funded annually from the age of 75 takes a biological approach and a psychological approach and a social needs approach. It covers the spectrum. Not as well standardised. So they're different from one practice to the next. But I think largely done by practice nurses working with patients and then some interaction with the GP as part of a package that's a shared approach. And what it can lead to when done well is a fairly comprehensive assessment of a person's emerging needs. And I think direct access to some services would be sensible, but it can also be a triaging role of, "This person's needs are too complex. We don't have the same skill set as an occupational therapist or a social worker." So identifying which people need additional input.

Where it gets stupid is where you have that health assessment happening for its own purposes on a cycle funded by Medicare and a completely separate assessment process as a kind of boutique process for aged care assessment for the purpose of provision of services. So I think certainly the two systems need to be married together, otherwise there's a wasteful duplication.

MR GRAY: Thank you. Dr Smith, did you have a contribution?

DR SMITH: What I'd add to that is I support early discussion, I support the annual health check-ups. Our assessment teams would love to have access to the information that general practitioners have. But can I say, with respect, no matter how good a general practitioner or a practice nurse's assessment skills, it's not the same as seeing somebody in their own home, seeing the environment they live in, seeing them walk through and live within the home. And, on that basis, I think it's really important that we continue to give people that holistic system assessment, that comprehensive assessment in the home, building on what has already been provided.

MR GRAY: Dr Hartland.

DR HARTLAND: Thank you very much.

COMMISSIONER BRIGGS: ..... that would necessarily involve provision of a health record, information in the aged care system. We've heard evidence previously that that would enhance the interaction between the health system and the medical system. Is that what you're envisaging .....

DR SMITH: I think that goes to the nth degree, but a general practitioner or any health professional can use the My Aged Care system and provide some richer information. I would say it's inconsistent. So some general practitioners will send a referral saying the person needs help. Others are really good and they provide rich information about what they've seen, why they've seen it. So some consistency even within the current framework would be helpful.

MR GRAY: Dr Hartland.

DR HARTLAND: So we think that getting better use of GP information and the stuff that they know about their patients through the normal course of their business is really valuable. And we've built a link from practice software to the systems we have to try and facilitate access to that information. But I think it's true to say that, "The department would be a very strong supporter of that" probably doesn't go as far as the actual needs assessment and that we would still prefer an integrated, unified system of assessment needs calibrated to the level of the complexity of the client to be that element of the system.

And I suspect – and I think that's what David said earlier today in the previous session you had. And I suspect it played out this way. I actually don't think GPs would really want to do that, as well. If you think about the system that you're contemplating and a more needs-based system in aged care, what you're going to find is that assessment becomes a much more pressured point in the system in terms of managing how it works, and it becomes very – it becomes much more complex than it appears to be at the moment.

So you typically find in needs-based systems that the top 10 per cent of your clients account for about 50 per cent of the costs of the scheme. And if you were to go in the way that you were thinking about in the consultation paper, I'd be pretty certain

that you would find that same structure, which means that the assessment of that top 10 per cent becomes a really, really big deal in terms of how much the scheme costs you and you have to automatically start thinking very rigorously about quality assurance and quality control in your assessment process. So you have to start doing more of what we should be doing in the current system, thinking, "Are the assessments consistent? Are they accurate? Are they comparable?" And it would be very hard imagining GPs really wanting to be a part of that system. I think they wouldn't – when you start thinking of that, well - - -

MR GRAY: Thank you. Mr Rooney.

MR ROONEY: I think the starting point would be to consider, with an aging population, the information required for growing numbers of older people would start earlier than what's described in the diagram here. I mean, a preventive health, population health, ageing well strategy for individuals from the age of 50, you're perhaps using a digital passport. Those types of ideas I think need to be considered in the context of what we're talking about well before people get to a level of need.

I think, with respect to both the assessment service and also the service finding discussion previously, you know, a person-centric, placed-based, local relationships seem to be the attributes that we're looking for. And they may well reside in existing organisations or, you know, a range of different locations, individuals or organisations specific to the context.

But when we think specifically about the assessment, it needs to be timely, accurate and consistent, because the assessment and, indeed, the reassessment will be very, very important in ensuring that they'll be delivering the outcomes that the older people need. So accuracy or time limits with regards to not just assessment, but the triggers for reassessment, accuracy, because that will inform care planning or change to that care planning, and then consistency, using standardised tools and having a skilled assessment workforce that it can actually apply those tools, these are the attributes that you would see to be contributing to – well, be fundamental to contributing to the system that's being imagined.

The one point that was raised earlier about, "Can a service finder be a care manager?" I think we need to be a little bit cautious. There may be examples where the – locations where you don't have a choice. That would make sense. But there may be other circumstances where there would be organisations that would be providing – or potentially providing those services, whether they're existing providers or not.

MR GRAY: Thank you. I want to move on from this topic, but I understand, Ms Edmonds, if you – just a brief .....

MS EDMONDS: Very briefly - - -

MR GRAY: I think Professor Morgan and Professor Fine do, too. If they're very brief.

MS EDMONDS: Okay. Firstly, I think we recognise that not everyone is going to interact with a GP or interact with the health system until it's a crisis situation, so there needs to be multiple points of entry. And, secondly, in terms of medical records and health information, I think that needs to be guided by the person themselves and what they're happy for to be passed on, because many people don't want private information passed on until they're comfortable and know they can trust the person.

MR GRAY: Yes. Professor Morgan.

PROF MORGAN: I think we're in furious agreement here that assessment is a complex process, it has to be consistent and accurate for that high needs group with complex needs. But I think if you've got a system that relies on a gold standard, home-based comprehensive assessment process as the only access point, then you're going to have waiting lists and great difficulty with access. So what I'm envisaging is a system where simpler basic needs that emerge can be managed through the already existing assessment processes that happen in primary care and general practice and almost a triaging process for the more complicated people that need that.

MR GRAY: And is that in part an argument for a different approach to basic domestic assistance? Perhaps basic home modification assistance, travel, basic services of that kind that are proposed by the consultation paper to be funded under the so-called entry or basic stream?

PROF MORGAN: I think where primary care will work well with people is to identify what their needs are. And where those needs can be met by something that's fairly easy to envisage, then make that recommendation. Where those needs require home modification, which is a specialist field, or a deep knowledge of high-end services, then that's where I think the needs would then get passed on as a set of needs to help inform a more comprehensive process.

MR GRAY: And I think Dr – well, Professor Fine, then Dr Smith, and then we'll leave the topic.

PROF FINE: Yes. Look, I just want to point out that Professor Eagar uses the term primary aged care services as one of her tiers of service. And it's a term quite independent – although we have worked together on another project. I've used the term primary care service. And I think that she's talking about no wrong doors for primary care services. In other words, where the cost is very low and where services are basic and can have a preventative function to prevent a situation deteriorating, help maintain health, etcetera, that should – we shouldn't have too many barriers between them. The nature of the assessment can be advisory and it can come after a person's first gained access. And I think – I don't think she is saying no wrong door for admission to residential care.

MR GRAY: No.

PROF FINE: Not saying – that should just revert back to anyway. I think this idea of a primary care system is something that could be very well introduced in the Australian system. We have the elements of it now, but we're not using it in that way. And that's where the large volume of clients are at the moment. That's where we can keep costs down low and we can act in a very effective way, which will help sustain – help provide sustainability. And it also makes it acceptable for the clients themselves, I think.

DR SMITH: If I can just give you a data point, if that's okay. I won't talk about re-ablement at this point. I will do that later. But when Western Australia first started the assessment process, we did a study where we looked at 3000 records. We looked at the people that we – the outcome of a telephone assessment, bearing in mind that Commonwealth HACC as it was, Home and Community Care, was the primary care or the entry level that most people are discussing in the paper.

So we looked at 3000 records and we looked at what was the outcome that would have been received by those clients or those individuals of that. And then we looked at what did they get, because we had the privilege of doing both the on the phone assessment and the in-home assessment. And what we found was that after the in-home assessment there was a much larger proportion of people who did not get ongoing services. That's because we were not able to identify that they actually had a need. But what we also identified was that there was a much higher need for many of the people that we saw. So the telephone assessment over and underestimated need.

We then looked at the economics of it. And what we determined was, even after the costs of the assessment went in, we still would have saved in 2013 dollars $264,000 per thousand people or $264 per person. So I guess what I'm saying is I'm not convinced that a basic entry is going to be – that goes straight through to the keeper is going to deliver the economic benefits that we need, as well as the consumer benefits from getting the services that they actually need, not those that a telephone screen provided.

MR GRAY: Thank you. We will go to another topic now, which is the scope of the services that would be provided at the entry point, assuming there would continue to be essentially a single entry point. If we can put up COTA's submission at page 11. COTA has, on this page, starting at the top of the page, best model of an entry point to aged care. Then there are various functions that should be performed. And then there's a summary of the essential functions under that in four points. And I want to open this up to a general response. Do the panellists see merit in COTA's spectrum of functions to be performed at the entry point? Are there any additional functions that people wish to raise, and Dr Hartland in particular, do you have any additional functions that should be raised or any comments on - - -

DR HARTLAND: I mean, I think there's a role that you see in the NDIS that we don't have strongly in aged care, about local area coordination, which is about a point of contact in the community for people, but also a point that streams people into mainstream or readily available community resources where they don't need a funded package. And I think you would want to have that in the new system and it might actually be a feed-in before you get to this point or it might be that your first point of contact, if you don't have an immediate need, is to go to local area coordination.

I think also we just need to be a bit careful about constructing a dichotomy between one gateway and a no wrong door solution because I think this description of a registration function that is a source of information about people and helps them through the system is not inconsistent with a model that has a number of community-based points of contact for the system and shepherds people into the system in quite diverse ways. So I don't think that's a dichotomous choice between one gateway and multiple points of entry.

I think you can imagine a world where we are much better at using face-to-face contacts that exist or creating new ones but still having this inter-registration function. There will be – I think the final thing to say is, you know, information about people, as was pointed out in the last session, and as I think I said before, you know, you pointed out to me when we were talking about diversity groups and we didn't have enough information to tell you about all of the diversity groups, that central hold of information about the people that are in the aged care system is going to be really vital in the world you are imagining and so you have to think about this central point function as holding that information as well.

MR GRAY: Collecting the information. I'm going to do a bit of a juggling exercise here. I want to give Mr Yates an opportunity because I have put his organisation's submission up on the screen, so that's only fair. But then I want to go to Mr Versteege because the CPSA submission proposes a different take on first point of contact and proposes, in effect, a series of – well, a local network to be, in effect, implemented, so that everybody can have access to local first contact points with particular functions that involve a broader suite of advice on financial matters and things of that kind. So if we go to Mr Yates first, then Mr Versteege and we might have then time to come back to others. Mr Yates.

MR YATES: Thank you for that. The reason I indicated I wanted to talk was not to go through this in detail and, indeed, those points are a summary of a much longer text. But to say that if you read that much longer text, there's no inconsistency between what Dr Hartland just said and what we are saying. So it's not that everything sits in some centre. Actually, it can be a network of contact points, trusted people in the community that (a) are well informed, that you are making sure are well informed, particularly with local knowledge that sits on top of, if you like, national agreed criteria.

The second point I would like to make, because it was absent from the previous conversation, is just to draw attention to determining eligibility and prioritising for assessment. As my good colleague Professor Woods would say if he were here and I am sure Dr Hartland would agree, we're not – I don't think we are seriously proposing, but it will be interesting to see if anyone is, that anybody of a certain age that feels like having their lawns mowed for them and their house cleaned can just put their hand up and it'll come. It may seem strange for a consumer organisation to be raising that but if – I do not believe that we have unlimited amounts of resources available for this, and if it is not through some screening process, then the people who really need it frequently are the ones who end up losing out and it does happen. It does happen.

MR GRAY: Thank you. Now, I don't know if we can put the CPSA submission up. Thank you. That's point 3 on page 4. Mr Versteege, just listening to what Dr Hartland said and then what Mr Yates said, there seems to be some similarities around concept of a network of local first contact point but you envisage a broader role for those contact points. Would you address in particular the connection you make between what can be done at these contact points and appropriate accommodation and age appropriate accommodation and flexible accommodation.

MR VERSTEEGE: Yes, that's right. Look, CPSA has not tried to devise a system like National Seniors has and COTA is involved in. We are simply taking this from the point of view of, for want of a better word, is the consumer and a consumer has an enormous information deficit, when they realise that they or their mother or father needs aged care. That deficit needs to be managed and, of course, part of the solution there is to provide more information and more precise information. The system is difficult to navigate because the information isn't complex, it's just obscured.

But the role of this first contact person would be to steer a person eventually in the right direction but also have a detailed knowledge of what is available in an area. That's why we use the word "local". It is – you know, on the ground knowledge is invaluable. There are also other aspects that need to be covered in that sort of first contact and I don't know whether this first contact person would be part of the My Aged Care system or would feed into it. That is not all that important. But people should be given an outline of what is actually available realistically in their area, and it may be a lot in places like Sydney and Adelaide, but it might be very little in a smaller country town out in western New South Wales. So that gives you the realism of the situation.

MR GRAY: You make a point in the submission about active encouragement, about the benefits of ageing specific housing and you make a link in the submission CPSA makes about the funding streams.

MR VERSTEEGE: Yes.

MR GRAY: You make the point, don't you that the aged care system shouldn't gear itself to keeping people in the home and encouraging independence in that sense if it means staying in their original home no matter what. There should be actually some proactive effort in encouraging people to consider alternative accommodation options.

MR VERSTEEGE: Yes, that's true. We are of the view that if you have the right housing, you are far better able to stay at home and, you know, die at home than if you continue to live in the family home, generally speaking. Family homes are, generally speaking, not designed for people as they age and their mobility reduces and other things happen to them. That's why we think it's important that, right from the start, this point is stressed with people.

We don't want to have a situation where people are forced to buy into a retirement village with independent living units or – but we want – at first contact we want them to start thinking about, "Is my house suitable for me?" That's – you know, people like to try and defend their independence by staying in the family home and it becomes a symbol of independence. If we can overcome that and encourage people to think rationally about, you know, what does the home do for you and what doesn't it do for you, that would be a big gain.

MR GRAY: Mr Lipmann.

MR LIPMANN: Thank you. I guess I would like to make a couple of comments. Firstly, what I've just heard. Wintringham always sees itself as a housing provider into which we put aged care, so we see ourselves slightly differently, and I don't really have a strong view about whether people should be encouraged to move into alternative and better housing or stay at home. The issue for me is this lack of supply. I've got 1500 people, you've heard me say this before, 1500 people on my waiting list. Now, not only is that just an outrage for such a wealthy country but in terms of economics, it's clearly that all of these people will progress towards aged care far quicker than if they were living in housing. So I really don't have a great issue about whether we encourage people to stay at home or move into other places but the real issue I've got is that we need more housing.

And in relationship to Ian's excellent submission which I read last night and thought was great, I don't have a problem with any of the points raised. The real issue for me, though, is how does the person achieve some of this knowledge to make decisions? And I mentioned before I had a couple of programs I wanted to tell you about. The first one I've already mentioned, about the linkage with ACAS teams but we now have running ACH program. So Commissioners, it is called Assistance with Care and Housing and it's running through the CHSP. It's a magnificent program. It's very small. Plenty of aged care Ministers over the years don't even know it exists, it's that small.

But it is an enormously successful program that we can track and assist people, sometimes for months, before they finally accept the need for aged care. And I

wouldn't want to say that it is all about impoverished people. Mainly it is, for our client group, but we have had people who are – and I think Ian raised the point before – sometimes the worst advocates you can ever have are family. And we really had to work with this old gentleman for many months before he and the family could accept the fact that he needed care and that was done on our money. We weren't funded to do that. Now, with the introduction of ACH it's possible to do it. I couldn't argue strongly enough that must make ACH – put it on steroids. Grow ACH. ACH can really save the community a lot of money and it's great for the consumers.

MR GRAY: Can I now go to a different topic, just in order to try to move through these topics and cover them in at least some fashion before the session closes. I want to ask some detailed questions about the shape of assessment as a trigger for eligibility for subsidy. It's a bit dependent on whether in the future system is going to be scope for separate streams for basic services on the one hand, more complex ones on the other, and indeed whether there's going to be an investment stream, which might not be dependent on a comprehensive assessment at all but might respond to more flexible and agile forms of assessment than a full comprehensive assessment.

These are questions in the background of the questions I'm going to raise with you now. The first question is, if the aged care system moves to a model which has, at least in some respects, individualised funding and investment decisions that might be based on some form of reasonably comprehensive assessment as well, how would the assessment system respond to that? Is there sufficient expertise available? Are there sufficient assessors who have the skills to perform that job? Would there be an increased need for scaleable, flexible assessment? Dr Smith, can I start with you. How would the, in effect, cohort of assessors respond to the system as envisaged by Consultation Paper 1?

DR SMITH: What I've seen over the years is a growing desire for people to enter the assessment as a workforce. So it is – we are always inundated with people who would like to participate in the assessment workforce because I think they see it as a mechanism to really make a difference in people's lives, which is fantastic. I think the agility comes down to – there's a couple of things that affect agility. One of them is the time to assess. So in Western Australia, we had three days to assess a high needs person. In My Aged Care we have 14 days. The difference isn't whether people – whether the time is right or wrong. It's the definition of "high needs". So I had to have a team of people who were available at very short notice to jump in, when you have a three day timeframe. When you have 14 days, you have longer.

We also had the challenge of we work in very remote regions in Western Australia. We have to have a way of swiftly assessing people when, as it is the case at the moment in Western Australia, you can't go out. We have three months of the year where you cannot travel because of flooding. So we have had to come up with ways, which My Aged Care also encourages, ways of putting in swift, short-term services. And I think that's the key difference. You can be agile and say I'm doing this for the

next two weeks while I get out to you is a different mindset and a different concept for an individual person than saying I can't get out to see you, I'm going to give you domestic assistance. So agility is possible, it just comes down to the, I guess, rules of engagement. But I don't feel we have the same problem with getting a workforce and clearly a clinical workforce as might be other cases in the aged care sector. It seems to be a growing industry for people.

MR GRAY: I just want to ask you further about those short-term measures. You were familiar with the basic architecture of the consultation and the presence of an investment stream scaleable, flexible responses to address the risk that somebody might suffer deconditioning and move to a more intensive or more complex need requirement if an episode isn't addressed promptly. What are your views about how the assessment process could respond to a situation?

DR SMITH: So I was really excited when I saw the investment stream because the model that we have adopted and that My Aged Care is trialling in five other organisations around Australia has the concept of reablement starting at assessment. So what we do is we go into the home and we do what's called an active assessment. We have the person – if they are referred for showering, we have them show us how they shower. If they are referred for domestic, we have them show us how they do that. What that does is a couple of things. It makes it easier for us to identify where there's a real need. It makes it easier for us to also, I guess, congratulate somebody for being able to manage something. And, importantly, have the son, daughter, niece, nephew, whoever it is that actually says Mum needs the support to see what Mum is capable of.

So we have people walk through and there's a difference between walking through and observing a bathroom and actually seeing someone shower. So, for example, we did a video for training purposes and we saw a gentleman say, "I can manage to shower quite well", but when he went into his bathroom and we asked him to show us, he came into the shower by holding on to the shower screen. He lifted himself up from the – he had a shower stool. He sat down and when he sat down it moved because his leg strength wasn't there. He pulled himself up from the showerhead. Had we just said, "Show me your bathroom", we wouldn't have seen that he actually could benefit from some short-term intervention to help him build his leg strength, as well to put rails in that suited him. They weren't there for him.

MR GRAY: Does the model also include that concept of social connection?

DR SMITH: Absolutely. Absolutely. Because we have to look at the whole person. What we identify is that, for example, it's very common to have a referral for domestic assistance, particularly for men who have lost their partner recently, because it's socially acceptable to say, "I need somebody to clean my house". But what we find when we go in and we really discuss and have that person open up in the hour, an hour and a half we are in the home, is that they are actually lonely. So they see the cleaning as someone to talk to. When what we would much rather do is

to discover what is it they used to do, what are their goals, what are the things that made
them happy before and I have got lots of stories I could tell but it would take too much time.

Importantly, though, this active assessment model has – identifies those people who need short-term intensive time to improve. Showering is an example of that. But also based on our evaluation has determined that there's significant benefits to the individual for independence but there's also significant benefits to the taxpayer. Helping somebody improve for a short period of time might mean that they don't go to ongoing services. So the assessment alone, just the assessment part, reduced the number of people going on to ongoing services from eight per cent, when we used to do tell me how you manage, to 16 per cent.

When you actually put in a short-term service as well for somebody who, say, is nervous about showering, so rails won't cut it, they're scared, that increased it almost half of those people did not go to ongoing services. And importantly, it didn't come at the cost of their own beliefs around their independence, confidence and happiness. So I was very excited to see – I do believe it should be for everyone, not just for people in Commonwealth Home Support Program. If we can have this impact on Commonwealth Home Support Program, imagine the impact we could have with the people who are going to packages where something like 80 – sorry, we see about 15 per cent of people have personal care needs, they must be in the package.

MR GRAY: Thanks, Dr Smith.

DR SMITH: Sorry.

MR GRAY: I just want to go to the topic about – back to this concept of what are the efficient and appropriate linkages of service here. Mr Rooney, LASA's submission urges the Royal Commissioners to have regard Mr Tune's recent evaluation of the NDIS and, in particular, the local area coordinator aspect of that. In brief, there has been issues of concern by reason of the fact that those LACs were undertaking both, in effect, navigation and finding services as well as assessment and that seemed to create difficulties.

On the other hand, there seems to be strong view that assessment should be conducted separately from service provision and there should be clear divisions there. Do you want to speak to that topic? Where do you come down, where does LASA come down, is there a need for separation of service provision from assessment and what do you say about the sort of linkage between navigation and assessment?

MR ROONEY: Yes, so there is a clear case to consider how we avoid perceived or real conflicts of interest between the assessment of a service and then the delivery of that service and there are examples through the NDIS but also in the existing aged care system where we, from time to time, have to deal with issues arising where we

have organisations that provide both an assessment service but also a delivery of services. I think there is some elements of the NDIS system that are really appealing and they play out in the paper that you have put forward, with individual assessment of need, tailored care plans and budgets and then how you support and access services. I think the challenges that we have seen in that space, though, is the timeliness of being able to get those assessments and have that translate into a care plan with a budget, that then translates into services being delivered.

And I guess what we are looking for here in an aged care system is coming up with an appropriate mechanism that ensures that, as I said earlier, that those assessments are done in a timely way. But then one of the current constraints in the system is even if you have that assessment completed in a timely way, is there a service then available to meet your needs and, you know, the home care wait list is a good example. Obviously, in the current system where, even if you have an assessment, the service may not be available. So we need to be able to overcome the supply constraints in order to respond to demand. And I think that's something that is playing out in the NDIS space and something that we should consider for aged care.

MR GRAY: Thank you. I do want to test further the views of the panel on the concept of different tiers of assessment and how that might be achieved. It's integral to the proposal in Consultation Paper 1 that access to the basic services, also called the entry level services, which might be a misnomer, is upon a simply screening rather than a full assessment. I think, Dr Smith, your view would be that is a lost opportunity. That seems to be a fair summary of what you were saying a minute ago.

DR SMITH: Yes.

MR GRAY: So I want to ask other panellists about their views on this difficult question. Start with you, Professor Morgan.

PROF MORGAN: I think one of the things that is potentially missing is this concept that we do an assessment and then provide some services. And without a built-in evaluation of how well those services are performing for that person, there isn't a rebalancing. If you build in that evaluation of how well those services are performing to achieve the goals for that purpose, then the system becomes self-balancing and if you discover that actually the supposedly simple situation is not performing well, that opens you up to the need for the more detailed assessment and broader range of services.

MR GRAY: Is the answer then to have simple screening, quick access to basic services, but for there also to be somebody who performance a sort of a check-in role on a regular basis to see how the person is going? Is that a reasonable compromise?

PROF MORGAN: I think if we look at the submissions that have come to the Royal Commission, that sort of personal advocacy, check-in role, face-to-face – I think you called it care finder but ongoing support person – does seem to be a missing

component of the current system. And if their role was extended to an assessment and evaluation of the provision of services, I think that would be very valuable.

MR GRAY: Professor Fine, did you want to say - - -

PROF FINE: This is very strongly supported by the literature but it doesn't always have to be an assessment person. I think it has been done very well by home nursing services under the old HACC program, who would go for a period to some – they didn't get much of the growth funding that many of the other services got and they would go to a client and after a while they would say, "Look, you are doing well, I don't need to come five times a week, it's twice a week". And then there's, "You're doing so well, I don't need to come back for a while but here is my phone number. Call me when you need me again". And you can have trust – you can trust our services. If we don't, then services quickly fill up. When they are at 100 per cent, you can't let more people in. But if we can have some turnover, then some of the turnover can be through reducing need. Some of the turnover will be people moving on to higher level services. But unless we have turnover, actually all our services become full and can't accept the new referrals and that's the situation we are in at the moment.

MR GRAY: Yes. Can we go to Mr Rooney, then Dr Hartland, then Professor McCallum.

MR ROONEY: Just a point to note on monitoring and evaluation. Going back to the Commission's discussion paper around the fundamentals, the idea of having performance information at different levels. So through a care plan, you would have outcomes that you would wanting to see realised through the provision of those services and care. So how are we monitoring and evaluating that? But then at above that level, at a care provider level, where is the performance and the benchmarking that enables them to see how they are, I guess, operating compared to other services to continuously improve and to innovate their services? And then at the system level, which we're all concerned about, is how are we ensuring that we are delivering, where do we set the benchmarks and the performance indicators, so we are delivering the best possible services we can, most efficiently and effectively? This seems to me – performance at all levels, that monitoring and evaluation is fundamental to a better system.

MR GRAY: Dr Hartland.

DR HARTLAND: So I wouldn't see quick assessment as a separate gateway to other types of assessment services. I would see it as a continuum in an integrated assessment services, calibrated to need. There's three reasons. I mean (1) for the reasons that Dr Smith outlines, it's a missed opportunity for reablement and fully understanding the person. We have talked before about it's a missed opportunity for getting data about the person that's going to be needed for the system. And somewhat cheekily, I actually think that the system you are proposing in your consultation paper mitigates against it. So you have said in your consultation paper

or in your responses to it that a person might be in all three streams at the same time. So that, I think, actually knocks off the idea that you should have a separate gateway for one aspect of those streams, that you would actually need, in the logic of what you proposed, a single type of assessment service that might be quite light touch at the lower end but because that person might go into different streams at the same time, if you did – if you had a separate gateway, you would be forcing that person to jump through two hoops rather than one. So I just don't think it's going to work.

MR GRAY: Professor McCallum.

PROF McCALLUM: I mean, the cost of the framework, there's information being imparted which is self-sustaining and able to take definitions yourself but then there's a low risk, low sort of cost assessment and service area. I mean, certainly when you get to another point where there's a higher risk and higher cost, that's where, you know, the ACAT type assessment does have to come in. But there's a more loose, if you like, an open process across the framework.

MR GRAY: Thank you. Subject to any questions the Commissioners want to raise, that should conclude the session.

COMMISSIONER BRIGGS: I've got a very challenging question for Dr Hartland. Clearly we have been discussing this morning and this afternoon, amongst other things, removing the supply barriers to access to home and community care. Do you have any sense about whether or not there's sufficient workforce supply to deliver that and over what time period that could be achieved? And if not, I'm happy for you to take it on notice.

DR HARTLAND: Look, it would be – a major expansion of the system is going to challenge the existing workforce. That's undoubtedly true. You know, the system is growing quite quickly. So if you look at the growth rates – having said that, the system is growing quite quickly at the moment and so if you look at the growth rates in home care, for example, they're very high and home support is growing, you know, five or six per cent a year. So it doesn't look like a measured expansion is an impossible task but a notch increase would have to be managed over time.

You know, it would be worth, I think, in this context, understanding the experience of the NDIS, which had a very large notch increase over a two or three year period and, you know, there is some good and bad. It seems to have managed it but there's undoubtedly some problems with the approach taken. You know, you would want to ensure that the way in which you have managed those transitions didn't add to the costs in a way that wasn't anticipated in the design of your proposal. That would be the - - -

COMMISSIONER BRIGGS: Thank you.

COMMISSIONER PAGONE: Well, thank you, panellists, for giving your time and making the submissions. It's an enormous depth of knowledge that's gathered in this

room and we are very grateful that you have made the time available and have contributed as you have in the different ways. Thank you very much. Now, I think we have another session that is due to start a bit later with a slightly reconstituted group, so we might adjourn until quarter to.

ADJOURNED **[2.32 pm]**

RESUMED **[2.47 pm]**

COMMISSIONER PAGONE: Yes, Mr Gray.

MR GRAY: Thank you, Commissioner. Our final session for today, session 3 of this hearing, is about entry level support. And there has been debate about whether that stream should be renamed something else, perhaps basic services or something of that kind. The panel are currently all in their seats. I will just announce their names and then their election: they have indicated whether they wish to take an oath or affirmation or not to do so. The Panellists are Mr Graham Aitken, Dr David Panter, Dr Michael Fine, Mr Paul Sadler, Ms Jane Mussared, Professor John McCallum and Dr Nick Hartland. Ms Associate, if you would please administer the oath or affirmation.

GRAHAM AITKEN, SWORN **[2.48 pm]**

JOHN McCALLUM, SWORN

JANE MUSSARED, AFFIRMED

DAVID PANTER, AFFIRMED **[2.49 pm]**

MICHAEL FINE, AFFIRMED

PAUL SADLER, SWORN

NICHOLAS HARTLAND, SWORN **[2.50 pm]**

MR GRAY: I will make some brief introductory remarks about those of today's – or those of this session's panellists about whom I haven't already made an introduction, starting with Mr Aitken. Mr Graham Aitken's been the CEO of Aboriginal Community Services, ACS, for eight years. Prior to his current role he worked for over 17 years with various Commonwealth and State Government departments and programs specifically designed for Aboriginal and Torres Strait Islander people. In his last position in government, Mr Aitken was responsible for the administration and funding of all Aboriginal Home and Community Care services, that is, HACC services, and programs across South Australia. Mr Aitken has a Bachelor of Commerce degree from Flinders University with majors in international business and human resource management and a minor in business economics.

Next, I will introduce Dr David Panter. Dr Panter has worked within health and social care services for almost 40 years in the UK and in Australia. Over half of that time Dr Panter has been in a chief executive level. From 2004, Dr Panter sent 10 years within the South Australian public health system leading The Central Northern Adelaide Health Service, where he was responsible for leading reforms, including the development of the new Royal Adelaide Hospital. Since 2015, Dr Panter has, I think it's fair to say, transformed ECH, an aged care provider from being – what might be regarded, perhaps, as a traditional aged care provider into one that has moved away from residential aged care to focus entirely on independent living and enabling people to exercise choice.

Professor Fine, I've already introduced you and I apologise again for calling you Dr Fine when you're a Professor. And, Dr Hartland, I've already introduced you, so I won't do so again. And, Professor McCallum, I've already introduced you.

Mr Sadler – Mr Paul Sadler has more than 30 years of experience in aged care and in related fields. Mr Sadler is a member of the Australian Government's Aged Cared Care Quality and Safety Advisory Council and was the former chair of the Aged and Community Services Australia, ACSA, board and had involvement in the National Aged Care Alliance, NACA, in particular on the paper on integration home care. Mr Sadler is currently the CEO of Presbyterian Aged Care New South Wales and ACT.

Ms Jane Mussared. Ms Mussared is the chief executive of the Council on the Ageing in South Australia, that is, COTA South Australia, one of the organisations the peak or umbrella body for which is COTA Australia. In South Australia, COTA SA is the peak body promoting the rights, needs and interests of older people. Ms Mussared moved to COTA SA in 2015 from the ACH group, where she had been part of their executive team since 2001, initially managing health and community services division, and then heading up People and Innovation. And, prior to that, Ms Mussared was the manager of the State Government Office for the Ageing. Ms Mussared chairs the NACA Home Care Committee and is also on the Federation of Ethnic Committees Council, Healthy Ageing Reference Committee.

And I think that concludes our introductions. I will now just briefly outline the format of the evidence of this panel along the lines of earlier sessions. And some of you have heard this already. There will be a structured discussion which I will facilitate. It will commence with me framing a particular proposition – some of those propositions are reasonably detailed – and then inviting a panellist or a couple of the panellists to respond for perhaps a few minutes. There will then, time permitting, be a relatively free flowing discussion. And if panellists wish to join in that discussion, respond to things that have been said, please indicate by raising your hand and I will do my best to moderate that process.

The first question I want to ask relates to the purposes for providing the basic or the so-called entry level services that are the subject of the funding stream which gives its name to this session. One objective is described in the consultation paper as enabling people to remain in their homes, to remain independent. And services mentioned in this regard include such things as gardening, meals, laundry, cleaning, also some assistive technology and even minor home modifications. That's the concept.

Another related objective is fostering continued independence through a focus on re-ablement and wellness. I want to pose this question for the consideration of the panellists: could potential inconsistency arise if, say, domestic assistance is provided in a way that encourages dependence, rather than independence, in a way might even erode dependence – no. I beg your pardon – erode independence through provision of assistance where it might actually be possible for the person in question, if they receive some restorative intervention, to do that task themselves.

Now, in this regard, the operator is displaying ACNA's submission at page 8, second-last bullet point. The question is a difficult one. I would ask the panellists to consider what might be the solution. Does it mean that, at the point at which these sorts of entry level services are being considered, there is a need for something more than a basic screening or could they be provided upon a basic screening, provided there's some sort of follow-up to see how the person is going? Could we start, please, with you Dr Panter.

DR PANTER: Thank you. I think the important thing to remember, and from our experience at ECH, is that entry into these sorts of low level services is often somebody's first step into acknowledging that they need some sort of assistance. And the amount of coaching and support potentially needed to encourage somebody to take up the offer of a service is – can be quite intense, even more so for particular groups. You know, the work that we've done with the LGBTI older community, for example, are really hesitant about admitting that they might need some sort of assistance. So in terms of the access, the eligibility of the assessment process, to my mind it has to be a fairly low bar to enable people who have built up the courage, been persuaded, to step into taking a service to actually take them.

I also think there is an issue around how we enable people to understand that restorative re-enablement-type model and approach because, again, it's not well

understood. And I will give you a little scenario, because it's one that comes across my desk fairly often, in terms of complaints about our domestic assistance service. And often the complaints are coming from the children of older parents who are receiving the service, but sometimes from the older person themselves. And it's the complaint is we're not doing a good job as a cleaner.

And we have to explain that we're not there to be a cleaner. We're there to help your mum, your dad do the task that they need to do and to support them to do what they can do and then fill in around them with perhaps tasks which are too heavy, too onerous that can't be done by them themselves. That absolutely requires a skillset in our staff. But what we're getting compared to is a cleaner. And often that complaint is, "Why are we paying your organisation $60 an hour?" or, "Why are we paying a co-payment under CHSP for this service when actually we could get a cleaner from down the road for half that?" So I think that whole notion of the restorative ..... model is one that does need to be well understood by people and to have a real benefit.

MR GRAY: This is an important insight. And it actually informs a particular view of a discussion which took place in the previous panel. Are you suggesting, Dr Panter, that there should be, at one and the same time, something like a pretty simple screening process as the touch point for eligibility for these services, by which answers are taken on faith and there isn't a comprehensive assessment done of the needs of the person, but then the workforce who performs these tasks are themselves skilled enough to know what is to be done to foster independence and not to create dependence?

DR PANTER: Absolutely, because I think we need to get the early adoption of these services, as I say, because if we don't, then we know that potentially people will decline and be in even greater need. So I think we have to have the way in which the people can get involved with the services, accept them. And again, in our experience, things like gardening, domestic assistance, help with shopping are the easier type services for people to admit that they might benefit from and therefore take up, as opposed to some of the more complex services that we might provide further down the track.

MR GRAY: How does that fit with the idea that this stream might be funded by, in effect, a voucher whereby the person requiring the assistance can choose to spend that voucher on the service provider of their choice? Are you saying there needs to be some sort of credentialing of the providers and they all need to have this skillset?

DR PANTER: Not necessarily, no. I think we need to be clear again about what the different levels are and some of the different terms that float around. I mean, I think that we need to be sure that when somebody has opted into accepting a service, that some sort of voucher-type scheme which enables them to choose between providers is entirely appropriate and it may well be that it's separate from somebody who is doing that further assessment. It may not be. And again, it depends – we have found in our practice that we can – and we have a very open approach to brokerage of

services and we work with those brokered providers, things like Jim's Mowing, and can actually provide support to those staff to be able to pick up intelligence about what is happening in the households that are they are visiting and feed that back to us to make sense of it. So I think that can be quite simple and straightforward.

MR GRAY: Professor Fine, can I bring you in here.

PROF FINE: Look, you sure can. And just thank you for a very important and intelligent question and it's profound and we could spend all afternoon on it and clearly we won't. But I'm reminded of what I learnt about 20 years ago, doing a study with the New South Wales home care service, which was then one of the, if not the largest home care service in the world, with over 40,000 staff and 50,000 clients and they decided they just couldn't cope with the waiting lists. They did an assessment at entry point and no further assessment and so people were receiving what they were assessed for at the beginning and yet clearly they were full.

So what they decided to do was to target the high-need service users and that meant it became very difficult for anyone to enter the system who needed low level services, as we call them. So that provided, in a sense, a natural experiment. We were asked to look at this question and we studied some branches where they still accepted new people and some branches where they turned them way. We knew their names. We approached them. They gave informed consent. We had 150 in each list. And what knocked me – I will never forget it. The results that were amongst the group that were turned away from one hours cleaning a week, there was a much higher death rate. Much higher. It was statistically significant. There was a higher rate of admission to hospital. So there is a value in low level services.

However it also – I agree with what David just said about a voucher can be very empowering but what's good for a service sometimes is not to just have a fee for service where they get the fee for cleaning and if they don't clean they don't get it, but to have sometimes other forms where the funding is flexible, where they can perhaps persuade instead of two hours of cleaning, let's have one hour of cleaning and one hour let's get you out of the house for that time, join a club. Or where block funding works, often what happens you can reduce a person's dependence and bring somebody else into the system instead, as you reduce the level of support they get or move them on to services that are perhaps more appropriate. It might well be gardening, it might well be art classes or attending day care services. So I think funding is a really important thing to link into this question but I think we should be indeed providing support, but not in a way which induces is dependency and wrongly provided funding absolutely does that.

MR GRAY: I will open it up to brief further responses. Ms Mussared?

MS MUSSARED: A couple of points. I mean, the first is that basic services don't always mean basic need. It is the first point at which a person says, "I need help", and that is accompanied by some energy to get information, to review decisions that people are making in their lives, indeed, you know, habits, take on new habits

whatever, and we shouldn't waste that as an opportunity. But I think – we often think that enablement is very much a – or reablement is a physical process. Taking someone's agency and decision-making away is disabling them. And so if a person chooses, having had that information – one of my favourite stories is if it takes me till lunchtime to get my trousers on, then I don't want to then – even though I can cut up my potatoes, I don't want to be the one that cuts up potatoes because then I don't do the life admin, I don't do the social stuff, I don't do the family stuff, which is also a part of life.

So it seems to me that in the pursuit of reablement, we have to make sure that we retain the choice and control, which should be the overarching principles here, and not sucker people into – you will see that in the COTA submission we suggest that this actually falls into the care stream, as part of the care stream. We acknowledge that there may be a need for a short-term intervention, a short-term – to get somebody over a hump on a more basic level. But this should be accompanied by somebody actively working with that person who is independent of the service system, to make sure that that person's agency, that person's choice and decision-making is not overridden.

MR GRAY: Well, you've gone to a question that I had next on the list. Perhaps we will put up the COTA submission at page 19, really beginning at page 18 under the heading Help at Home and going to the top of page 19. That point that you've just reiterated is that the spectrum of domestic assistance services proposed in the basic or entry level stream should be regarded as care services. This is linked to, what, Ms Mussared, a concept of holistic care, is that - - -

MS MUSSARED: Indeed that, but also, I think, the fact that we – you know, what we know is if you have an open slather on something like domestic assistance because that's a service provider convenience, that that's a system convenience, perhaps, and that's what people get. Then examining behind that to what their actual preference is or what their choice is what their need is, is a lost opportunity. And as I said, you know, a person may well get suckered into a long-term domestic assistance arrangement that's not meeting need at all or, indeed, you know, denying an opportunity perhaps to try other things or do other things. The other thing I think it's really important to say is – I mean, we reference the word "reablement" and "restoration" and obviously we need to do something about the language around that. Dr Panter's view that - - -

MR GRAY: You call it reablement and restore in the submission.

MS MUSSARED: Yes, yes, sorry.

MR GRAY: In the investment stream. The investment stream.

MS MUSSARED: It is weird language and we talk to people all over South Australia all the time. It is very weird language, it is not well understood and it is really difficult to sign onto.

MR GRAY: Thank you. Could we go to the counterargument that there might be, as you put it, system convenience or, as others might put it, economic efficiency in being able to provide, with a very low hurdle, a very low bar, a range of duplicable low cost services at high volume. Perhaps if I could bring you, Mr Sadler, into this discussion. Do you have a perspective on this?

MR SADLER: Yes, I think the evidence is quite strong that the home and community care program, which has morphed into Commonwealth Home Support, has been very successful, actually, in helping older people to stay at home. Michael Fine alluded to some of the evidence of that from, you know, 20 years ago, I think you said, and we have now got to fairly well established in Australia that that is actually true. I think the question that the paper from the Royal Commission poses is it's actually talking about those elements that have been captured in what's currently Commonwealth Home Support being broken up into different components.

However, one thing that's really important, I think, is the Royal Commission has not called those funding programs, it's talked about them being streams which you can access at any of those components. I think part of our problem with this particular group of services is describing them as entry level is a bit confusing in that context. They're really a group of services that are around social participation and help around the home and I think if you conceive them in those terms, they're absolutely worth people getting access to quickly and easily, although I thoroughly agree with Dr Panter and Jane Mussared that what we also want to do is get people into a service system where they're going to be able to get additional service, including reablement, when they need it.

MR GRAY: What about the suggestion I made just a little while ago now of low bar, services are provided, but there's follow-up.

MR SADLER: I think that's probably the preferable way to go. I think particularly the service streams are somewhat different. I was listening to Dr Ricky Smith's evidence in the last session, where she was talking about the benefit of comprehensive assessment upfront. And the difference with the stream approach that the Royal Commission paper is flagging is that the cost savings that were evidenced in the HACC program were largely around personal services, and to some extent domestic assistance, not necessarily the other things that the former HACC, now CHS Program, provided. So I think in the context of the new world that the Royal Commission paper outlines, there's absolutely benefit to a low level access point in to the system. I think Dr Hartland talked in the last session about, you know, maybe that's a lower level of the basic .....

Mr GRAY: Scaleable assessment.

MR SADLER: Yes, it's a scaleable assessment. I think that's got a lot of .....

MR GRAY: Well, let's put Dr Hartland's submission up on the screen. Commonwealth submission, page 6, second paragraph. The Commonwealth is

opposed to basic screening as the mechanism for eligibility to the basic services, whatever we're going to call them. What's the key concern there, Dr Hartland? You did raise this topic in the last session and your solution is scaleable assessment. Can you explain exactly how that would work?

DR HARTLAND: So I don't think we have to assume that every assessment that would occur in an integrated community-based assessment process is of the same level of intensity. I guess we were concerned – we covered this last time – that if you had a separate gateway, you are missing the opportunity for re-ablement that Dr Smith talked about. It didn't – you know, I made a point about how would it fit with other aspects of your design, when people could be in different services and this issue about the data. But I think we would accept all of the things that people have been saying about the value of low levels of service and having a reablement orientation, not only in assessment, but actually in the way that services are delivered.

But we would still favour an integrated assessment service but the point that you make is that could be calibrated so at the bottom end, when you got to know the person, and it was clear that actually their needs were quite simple and there weren't other processes, yes, you wouldn't put them through a three hour functional assessment test. You would make sure that the assessment was calibrated to their level of need and risk. But we would still not have two separate gateways. And I think that would be a way of bridging the economic concern you have about the cost of assessment.

MR GRAY: Thank you. I want to bring another perspective in. It's not a perspective from one of the participants here. It's Baptist Care Australia, their submission at page 6, paragraph under the heading Entry Level Support. In that submission, Baptist Care suggests that the entry level services should only be provided on an interim basis. Now, that might then be a justification for not even having to have even the low scale assessment. It might mean that you could provide it just on the screened approach but the point would be that they're only available on an interim basis. There needs to be some sort of follow-up about what's needed, are they having some sort of an effect? Mr Sadler, do you want to lead off?

MR SADLER: Certainly. The Productivity Commission really flagged this in its 2011 Caring for Older Australians Report, where it talked about a range of services it called community support services and flagged that, in their view, they should be readily accessible to older people. And they included the sorts of services that have been highlighted in this entry level process, but they also went a bit beyond that. So they actually had the wellness programs, which we have partly been talking about, in their concept of something that would be easily accessible as well. They also flagged in the Productivity Commission report the concept that you would only get interim approval or an interim start into the system for some of these sorts of services.

They highlighted Meals on Wheels in their report but I think domestic assistance would be another one, gardening would be another one that you would look at in that

kind of environment. I think it's less clear to me why you would call something like a social support group that you attend something you have only got an interim approval to go to. And, you know, I would argue and did in my witness statement to the Commission last year that there's a group of services that are actually providing a level of social capital into the system that really should probably retain being block funded and retain very easy access for people into those services and they should be continuing services.

MR GRAY: And what's an example of those? Activities?

MR SADLER: Activities is absolutely one. Potentially transport. So the Royal Commission paper talks about community transport is something that should be available, for example, to people in residential aged care, so they can maintain their participation in society and I think that would be a really good idea.

MR GRAY: Are there any other contributions? Professor Fine?

PROF FINE: I mean it's a very, very idealistic statement, in one way, in that there's no economics underlying it and if money were no object I think I would probably support them. But I cannot see how we can move 800,000 plus people on to packages without increasing the funding level up to what the levels of packages are, which would increase the budget of aged care by 40 per cent, 50 per cent, something like that. I should actually do the calculations. I've got the figures in my proposal.

MR GRAY: It's a very large .....

PROF FINE: It's a very, very costly suggestion that they are making.

MR GRAY: So you're estimating that on the basis of the current numbers in CHSP, which are up over 800,000 people.

PROF FINE: Yes. But imagine if we give them a level 2 package. You know, shift them from $55 a week to about $400 a week. That is – times 800,000, that's the calculation we are looking at to achieve this.

MR GRAY: Before we move on, are there any other - - -

DR HARTLAND: It seems to me - - -

MR GRAY: Dr Hartland.

DR HARTLAND: - - - and, sorry, I read this review in detail – that they're actually talking about investment as being the first point of entry, which is actually raised, I think, in the design that you're contemplating and I think if you saw it, that text in that respect, you would think about it in a different way.

MR GRAY: I think that's a valid point as to some of the content of what the Baptist Aged Care submission is referring to as entry level support. Some, however, is domestic assistance and so forth. So there's a blend. Yes, Ms Mussared.

MS MUSSARED: So it depends what's in and out of this, of course, whether it's a stop-start. But I think we should think about this as an opportunity – and indeed that's how we framed our submission – as an opportunity for people to continue their lives and lives don't stop and start in that sort of way. So it's really important that things that own able people to get around where they live – we have just finished a listening process across country South Australia – like transport, are ongoing, opportunities to stay in touch with other people are ongoing.

It also seems to me we need to make sure we have got a system we know is working if we are going to do things on a short-term basis and the check-in will be happening to a person. So we know for example that people get assessed to get CHSP services. We don't know enough about how long they wait. We don't know enough about the distribution of those, what the impact of waiting lists are and indeed whether people get what they actually think they need. And so, you know, it seems to me that if we do go to a short-term provision, we better make sure that we are checking in on people, so there's some certainty and some opportunity to work with them about what happens from here.

MR GRAY: Yes, thank you. We will develop this check-in idea a little further. I will just ask for the Local Government Association of South Australia submission to be put up. One can see that – this is the paragraph just below halfway down the page – about ease of access and reduction of administrative burden. There is support for simple screening on, essentially, economic efficiency grounds. And if that's to be the model and this check-in process therefore becomes an important integer in making this funding stream work, what are the key features of that form of follow-up that would ensure that the services as a whole are suitable and fit for purpose?

For example, presumably there would have to be a check-in, when, a short time after services commence and then regular check-ins after that. Who should perform it and what features need to be built into the system to make sure it happens? There's also a proposal in Consultation Paper 1 for what's variously called navigational care finding services and there's a spectrum of potential services that could be encompassed in that. Is this a task that would be appropriate for somebody fulfilling that role? Should this be added to their toolbox? Or should it be the provider of one of the basic services or all of the basic services in question who should perform that check-in? The trouble is, if there's more than one provider, which one? Can I open that up for responses from the panel? Mr Sadler, can I start with you again?

MR SADLER: Yes. Certainly. I think it would be a very good role for the care finder, should that settle into the system as described by the Royal Commission paper. We already have the navigator trials that are underway in the current system. It would be interesting to see the extent to which they're making contact with people

at this sort of stage or whether they're tending to get more questions around the Home
Care Package or residential care end of the spectrum. I think there is merit in the providers having responsibility here, but it does kind of depend, as you alluded to, on what happens with the service provision system under any new model.

Where you have a major or single provider, it's clearer who that responsibility could sit with. If you have a diverse range of Jim's Mowing-style services that have actually taken on the delivery, because that's how the person has chosen to use their voucher, I don't think you could rely on those sorts of services to have that skill base. Even some of the current CSHP services that are a volunteer based meal service or a transport service, they don't necessarily have that skill base either.

MR GRAY: Dr Panter, can I bring you in here.

DR PANTER: I mean, I think for me it does come to the sort of fundamentals of the system, really, because there has to be a part of the system that has that ongoing relationship with the individual receiving services. As their needs change, then services change accordingly. And whether that is as it is in the existing world, where providers do both tasks – so certainly, you know, we've got a very extensive CHSP program and we have a team who monitor people using those services in order to check in on them, to make sure things are going okay, if circumstances are changing, etcetera, etcetera.

MR GRAY: Can I just stop you there, not meaning to prevent you from giving the rest of your answer, but what are the incentives under which ECH does that? Are they conditions of CHSP grant agreements?

DR PANTER: Well, certainly when we have a contact assessment visit from the Quality Commission, then they want to see that there are plans there, that we have those records that people have been checked in on. So absolutely as part of that arrangement we've got to demonstrate that we have an understanding of what the situation is of any individual who's receiving a service from us. As I said in my earlier answer, we brokerage out a lot to other providers to fulfil client choice, as well as make best use of resources.

And, again, we have a straightforward induction process with any subcontractor. And that goes from the Jim's Mowing to use of individual friends and family who a person wants to actually make use of as part of delivering that service, where we expect then a certain arrangement where information is fed back to us, our person checks in with that person in order to understand what's going on for that individual.

MR GRAY: So the services in question are services provided under Home Care Packages over which the Quality and Safety Commission has supervision.
DR PANTER: And it goes for our Commonwealth Home Support Program services.

MR GRAY: And CHSP.

DR PANTER: Yes.

MR GRAY: Thank you.

DR PANTER: So I think within the system, if we're actually going to really assist people of having the benefit of early intervention, there's got to be part of the system that is not just care coordination, but is active care management of the individual and their changing needs. And whether that, in a new world, is a separate function to the provision of services, and organisations can't do both, I think is one issue. If you do them both, how you make sure, particularly, for example, where there are not a surplus of providers in some country settings, that you end up with a provider limiting the choice simply because of the services they offer. So there are a range of things that need to be put in place either way.

The other thing I wanted to raise, though, was also, in terms of that assessment process and the access points, also to try and not forget that we've got a variety of other activities going on for these people who are carrying on their lives. So, for example, we have a number of individuals who are frustrated in the CHSP program at the moment, because they cannot get the service they want from us, because of the block funding, and we are full. And if those are our wellness services, then, quite frankly, we can work with that individual to access their GP, who can prescribe many of those same services through a chronic disease management program. And so we have people using our wellness outside of CHSP for a limited period of time through using the chronic disease management program. So we've already got a system where potentially there's a variety of different assessment mechanisms being used.

MR GRAY: Mr Aitken, in your experience with Aboriginal Community Services, is this idea that the service provider might be the one who provides that follow-up and might be best placed to provide that follow-up, does that resonate with you?

MR AITKEN: Yes, certainly. For our organisation and my knowledge of other Aboriginal service providers in South Australia, the notion of a low entry and the continuum of aged care services and coordination by our own workforce is a model that has worked in the past under the HACC program. And we've lost a lot of processes in the transfer – in the transition from HACC to CHSP where some of these issues are now becoming an issue, whereas before they were already being taken care of in a service system.

MR GRAY: So has that, in a way that sort of check-in, follow-up almost approaching a care coordination role, even for the lower level services, that was a feature of HACC and it's not a feature of CHSP; is that right?

MR AITKEN: Correct. Under the old HACC system, which operated for many years, over 20 years, we did have packages. They were called something different back in those days. Jane.

MS MUSSARED: Community options.

MR AITKEN: Yes, for high level services. These days we transition people within our own service from basic Commonwealth Home Support Program services to Home Care Packages. But the entry point is still the issue where an assessment is required, even for a CHSP currently. I believe that in the past Aboriginal service providers have been that contact point and the assessment and the gateway for Aboriginal people to engage in aged care services.

MR GRAY: There was a topic addressed in the last session around what are the circumstances in which it might be appropriate – on an exceptional basis, it might be appropriate for a service provider to be involved in assessment leading to eligibility, that form of assessment which triggers eligibility. Are the Aboriginal communities an example which fits within that exception?

MR AITKEN: Definitely. Any diverse group is not really suited to the mainstream processes. People on the margins, people living in regional and remote areas, are a clear example of that. We know our community. Our community are happy to come to us, no matter which community we are talking about.

MR GRAY: Just on the – in effect, the economics along the lines of the Local Government Association submission, the economics suggesting there's merit in sort of low hurdle, low admin cost access to these sorts of services versus the opportunity to understand the person's needs and perhaps drive a better holistic plan for the restoration and re-ablement, are there any other views that the panellists wish to contribute before we move on to the next topic?

MS MUSSARED: I think our position is really clear, that this – it's really important that that person is an independent person, otherwise, you know, people do get suckered into – there's no doubt that CHSP is something of a pipeline for home care packages.

MR GRAY: Just the point - - -

MS MUSSARED: Yes.

MR GRAY: Just the point that's been made on behalf of COTA. And thank you. So we will move on.

DR HARTLAND: There is one aspect of the discussion .....

MR GRAY: Very quickly do. Sorry.

DR HARTLAND: To the extent that you're contemplating – that this contemplates a world where providers would be able to accelerate the intensity of care, I think we need to be really careful about that proposition, so - - -

MR GRAY: What about in those sorts of special need communities?

DR HARTLAND: Absolutely special needs communities need separate treatment, but in CHSP – the top 10 per cent of CHSP customers use about 50 per cent of resources. And that top 10 per cent are getting a level of support equivalent to Home Care Packages. So 10 per cent of CHSP is 80,000 people. So that subsidy is, really, quite uncontrolled at the moment. And so, you know, the government department being whipped about home care cue within CHSP there's a group getting similar levels that are completely invisible to everybody. So if you move to your world where you've, effectively, uncapped subsidies and you're contemplating a world where providers can accelerate people through the system, I think you quickly find yourself in a mess.

MR GRAY: Are you – yes. Thank you, Dr Hartland.

PROF FINE: Just very briefly, because this is a very difficult and big issue and it is worth exploring in more depth than we have an opportunity to here. But if you are to introduce a thorough screening – and I'm not opposed to that – after a period and particularly for more complex cases with CHSP, a high percentage of those clients are going to be screened as requiring packaged care services, almost without question. Now, why do I say that? I think we already know the evidence. If you look at the evidence of where they introduced the RAS, that's when we started getting waiting lists for the packages that were massive. Just looking at the statistics last night, it coincides exactly with the introduction of this screening.

I think it's not a bad thing to do. It's a very good thing to do, but we shouldn't then screen with the idea, on the one hand, we might stop people getting services they don't need. That's not really what's likely to happen. We should be aware that we're screening people telling them they need higher levels of services and then not providing them. So that's why it's a complex issue. And I think we should be prepared to spend more. I don't really want to be seen as arguing for unrealistically low spending. We are amongst the lowest spenders in the OECD. I think only Turkey and Portugal or something are lower than us. Korea spends more than we spend. We could spend a little bit more without..... I just did the calculation. 13 billion extra a year if we moved everybody off CHSP into packages. But I think that's the implication of doing thorough screenings: we will get more people who require higher levels of services.

MR GRAY: And just returning to the groups with diverse needs, is there a consensus on the panel that a simplified screening process administered by those service providers who have trusted connections with those groups is appropriate and, furthermore, that should be left in the hands – it can be safely, as an exception to the

general rule, left in the hands of those providers to conduct other forms of assessment that do, to use Dr Hartland's expression, progress the person through higher levels of response in the system. Is that a consensus?

PROF FINE: Look up and down. Have we got a consensus here?

MS MUSSARED: So, in principle, it's a really good thing to explore. One of the points I would make, certainly about CHSP, is that we've done very little testing with older people directly. We ask them very little about CHSP and their CHSP experience. We use a vehicle – a co-design vehicle called the plug in. There are lots of others around. I think we should go each of those communities and test, rather than – and pay them proper respect by testing and testing deeply and properly, rather make a consensus across a group of people.

DR PANTER: I think that that's important, because our experience at ECH with the LGBTI community, we do a lot of work engaging with that community. And the big frustration at the moment is, having got people to the point of acknowledging that they would benefit from a service at that low level, we have no CHSP capacity on most days and, therefore, they end up choosing not to take a service, because they will not go to another provider, because they don't trust whether that provider will treat them in the way in which they expect to be treated.

Now, that in part is also a basic failing of the application of the existing Quality Standards, because if every aged care provider was delivering as they should under Standard 1, around dignity and respect, then some of those issues should not be faced by that community. But, unfortunately, I have yet inform see the Commission actually hold up any provider for failing to acknowledge the LGBTI community in an appropriate way. So, anyway, so I think that that's part of the issue, that until we have a system which is genuinely embracing of diversity, then there will be groups who will feel much more comfortable working with particular providers who have demonstrated that they are appropriate and engaging with that particular community.

MR GRAY: Picking up an aspect of what you've said, Dr Panter, about your CHSP grant agreements, in effect, being full up and you're unable to provide the services that are – for which there is demand particularly in the LGBTI space, could I go to an aspect of COTA's submission that's critical about CHSP in its lack of any design feature, according the power of direction by the person receiving the services as to choice of provider. I understand that's the gist of the point that's being made.

MS MUSSARED: Yes.

MR GRAY: And, also, the criticism that is made about lack of data being collected by the Department of Health, data which would shed light on true unmet demand or true demand, rather than making assumptions about demand for these services. And perhaps those two things go hand in hand. Dr Hartland, you mentioned in the last session - - -

DR HARTLAND: I'm happy to respond, but if Jane wants to elaborate on it before I do.

MR GRAY: Well, I'll go to you directly on both points, if I may, and we might come back to you, Ms Mussared. Firstly, lack of direction by the person receiving the services. Should there be, in effect, a voucher system, to return to something I mentioned at the start? And would this perhaps address at least an aspect of what Dr Panter was talking about a minute ago. And can that actually be done – in effect, can that uncapping of supply through that means, if that's what it's involved, in assessing need and granting vouchers – can that be done with the current state of ignorance about the true state of demand?

DR HARTLAND: No. I wouldn't uncap anything unless you had a good understanding of the true state of demand. I don't think there'd be any sympathy with my colleagues and central agencies for that position. So I think COTA's – the Department agreed with COTA that the ability for a consumer to choice providers is a pretty – should be a fundamental aspect of the new system you're designing. So you wouldn't want – by dint of the way in which we funded whatever this entry level, light touch service stream was funded, you wouldn't want consumers to have no choice. Would you necessarily need to go to a voucher as such? I don't have a concluded view on that specifically, because you could have arrangements with providers whereby you funded a capacity, but there was a variable cost depending on how many people they got.

In theory, our current grant system could work a bit like that: if providers don't spend their money, they're meant to give it back. In practice, that's not a big part of what we do, although it does occur. So you could evolve grants in that respect or you could go to a voucher of some description. But I think it is true that you do need – it doesn't seem right to me that a person in your world, who has more of a notion of an entitlement, doesn't actually get to choose and have control over the provider that comes and services them or the service that they get delivered.

MR GRAY: Is there a compromise position, at least in the interim until we understand demand, by which there could be a move to a voucher type system for these sorts of services, but there's still some sort of - - -

DR HARTLAND: Let me tell you how much we don't understand that demand and then we can come back to that issue. So I think there's two ways in which you would typically go about understanding demand. One is about the waitlist approach that we've used in the national priority service. So that's actually really difficulty to do in CHSP, and I think it's because typically someone who gets assessed at the moment – and, you know, in your new world you would be contemplating different and better assessments, I think, but they would get approval for a range of services. And then they, basically, try and find a provider and – so the first service they get might not be the one that they want.

And so the idea of a waitlist doesn't work very well in CHSP, because they might get into service quite quickly, but that's just because it's the only one available; it didn't actually reflect their true demand. And I think that also makes the idea of a voucher hard to imagine in this current world, because you might give them vouchers for nine services, but now that would be a lot more service than what you're currently encompassing. So I think you would need a reformed system before you started going down that track in the way that you're proposing in your paper.

We think that there does need to be some work on the demand and supply model and that's the second way in which you typically understand demand. And this is actually really quite hard to do. So to understand demand for CHSP you actually have to understand, before you start talking about what you had assessed and what providers you were offering, you actually need to understand what the kind of need categories are in the population. So that's a bit like out of the AN-ACC work there was a recommendation to do a RUC-style study of in home arrangements. It couldn't be done exactly the same way because you can't – there's different dynamics. That work hasn't been done, so all we know about CHSP and Home Care Packages is the level of people queued for one to four levels of package, which isn't really a true sense of their need, it's, you know, an administrative process and the queueing for different service types which doesn't tell you very much.

So we think you need to do some fundamental work about what are the groups of need in the community in order to be able to understand demand. Now, I guess that's a longwinded way of we actually take COTA's criticism quite seriously but it is a really difficult and fundamental issue that you need to come to grips with. And I think the importance of this bit of work is that if you were going to go to the type of world that you envisaged where you have got a needs-based system and not, you know, a system capped in the way that we currently cap the system, you're actually going to need just to manage that system, not even to estimate how much – not only to estimate how much it costs, to actually manage that system and to understand what's happening to the clients in it, you are going to need something like that knowledge anyway.

So it's a foundational bit of work for actually making a reform system work and Mr Lye mentioned in the introductory session about how the NDIS uses reference packages. It's a similar understanding to that that you would need to develop here. So you would – to make the proposals that you have in your consultation paperwork, you actually need to understand what are the various groups and what do they need in the system, so that you can sort of judge, if you have invested in care, what's the trade-off if you invest in investment and get a reasonable approach across the system.

MR GRAY: We might have to return to that topic .....

DR HARTLAND: Sorry, I was a bit longwinded there. Got on a roll.

MR GRAY: Yes, Ms Mussared.

MS MUSSARED: I don't – it's well articulated in the paper, our submission, we just don't know enough about CHSP. And I would argue we don't know much about it in a quantitative sense. I don't think we know much about it in a qualitative sense either. And we certainly don't know – I think Dr Panter's comments about the LGBTI community. I think if we translate that across other diverse communities, certainly we do a lot of work also with the LGBTI community, we would say none of our understanding is well nuanced in terms of diverse populations.

MR GRAY: National Seniors Australia conducted a sort of a process of testing the responses of members, Professor McCallum.

PROF McCALLUM: Yes, we did, and it's sort of quantitative evidence in a way about what people are thinking about this, rather than the design aspects of it. So it's sort of reflecting back in. And generally speaking, there was no particular difference between Home Care Package and CHSP but there was – because it was under threat, I think, particularly at the time, there was a strong passionate support of CHSP as flexible, cheaper typically for what people are being told they had to pay to go into a home care package and a general support for it. I think why we're thinking it works is it works pretty well for some groups. So particularly, say, community groups like multicultural groups work really well with it and it's sort of a kind of, I guess, reablement or prevention program where people do social things together. They're typically multicultural, the groups we deal with in outer suburban areas and they make it work and they have a lot of volunteer groups within that mix as well, so you get a value for your dollar.

And so I think those sort of elements of this give it quite strong support in the people we spoke directly to for the CHSP program. Now, that – the others were talking about – clearly have to be thought through as well. I think it's not simply basic care or home help. There are so many things going on that people start with home modifications and they can have some nursing not related to hospital admission where they need some help, day care, social and community engagement, which is what we have talked about particularly with community groups, personal care and there's sort of an element for respite for carers in this as well through all that mix there. So it's kind of an interesting mix and I don't think it's one we should be throwing out.

MR GRAY: So, Dr McCallum, one of the other points mentioned was lower administrative costs and also the absence of unspent funds, the unspent funds phenomenon which really plagues the home care package program, as we understand things. Firstly, on the administrative costs, are the administrative costs actually lower or is it just that they're not perceived by the person receiving care because they don't come out of an identified budget or a package?

PROF McCALLUM: That is a word of mouth observation, we lack data on that. I think we are flying a bit blind through this area, generally speaking.

MR GRAY: Yes. And the unspent funds element is not a feature because there isn't a sort of a budget allocation to a particular person.

PROF McCALLUM: Yes, which is a pretty sensible idea.

MR GRAY: Now, Mr Aitken, could I ask you, from your experience, do you have a preference as to the funding model for these basic level services? Are there advantages of flexibility and so forth tied up in sort of direct grant model that would be lost through a voucher system?

MR AITKEN: Yes, we believe that the block funding, the community home support approach enables us the flexibility to provide services both individually and in group settings, which individualised funding probably wouldn't be able to be achieved.

MR GRAY: And is that essentially because you don't have to worry about spending a precise amount of money on a particular person, it's a sort of an organisational level? There's flexibility to use a particular allocated amount of money in a flexible manner, in effect, smoothing out the particular circumstances of the individuals and does that save time for your organisation?

MR AITKEN: Yes, it does and it also has different impacts in remote areas, where a lot of service types or purchasing of services is not an option because there is no ability to do that type of purchasing of those higher level supports and services.

MR GRAY: Thank you. Can I ask the panellists about what should be the scope of services in this stream, assuming there is a stream separately funded for basic support and assuming also that it has the sort of lower hurdles about which I've been forming propositions for discussion? Are we – on those assumptions, and I understand that not all of you agree with the assumptions?

DR PANTER: Yes.

MR GRAY: If we could have a conversation about the scope of services, are we at a level of consensus that they would include basic domestic assistance, gardening, repairs, cleaning laundry, short of personal care? Is that a consensus position on the panel?

PROF FINE: I think without question, although I'm not sure I would exclude all of personal care. What is personal care is even up for question. But I wonder whether we are not describing them in concrete terms of tasks that we are missing an approach that would provide us with the flexibility to adjust because we know what we have got in 2020 shouldn't be the same as what we had in 1985, when the program was invented, and we shouldn't be looking at that 1985 list again in 2050. So you know, for example, we are going to need something on technology. Someone's got to go in there to deal with - - -

MR GRAY: I'm going to go through the shopping list, the notes.

PROF FINE: Good.

MR GRAY: The notes with which you've been - - -

MS MUSSARED: We have suggested that that belongs with the care stream, so we - - -

MR GRAY: Yes, I understand that.

PROF FINE: But I think we talked about – sorry.

MR GRAY: I'll just – perhaps I should reel them off.

PROF FINE: Yes, do.

MR GRAY: And then we can have a discussion about all of them.

PROF FINE: Sorry.

MR GRAY: Meals, minor assistive technologies, presumably with a dollar threshold. Transport to social engagements and appointments. Day centre care and similar activities not amounting to overnight respite. Residential respite, cottage respite, those are services which the paper conceives as being funded differently. There is a proposal in submissions – we won't put them up on the screen but we have got two. Primary health network of central and eastern Sydney and also from an organisation interested in physical strengthening on essentially gym, muscle strengthening interventions.

PROF FINE: Yes.

MR GRAY: Now, noting the focus on wellbeing, wellness, reablement that is intended to underlie the philosophy of the consultation paper, is there something we are missing here? Are there more services, service types that should be included? And Professor Fine, I want to allow you to explain the point you're making about a more modern take on how to .....

PROF FINE: Well, the capacity for flexibility and innovation. I can remember a few or 20 years ago when they tried to have a dementia home visiting service introduced in one of the areas I was working in. And you know, for people living alone with dementia, that was a real issue. It was a very cheap service. Volunteers would do it, a coordinator part-time for, you know, five days a week. No, that wasn't allowable under the program. So when we get too specific under tasks we actually exclude services. It looks like we are including them and that's why I can't help but think we should have a functional description, something like we need to combine personal and domestic support with social integration and in ways which will

encourage integration of a range of different services, rather than highly specialised services.

I think initially that's the way the HACC program grew up, a service for transport, a service for meals, etcetera. And the most innovative ones, the West Australian ones, some of the South Australian ones, some of the Queensland ones, many others around Australia too I'm sure, integrate all of those services, have brought them together and you can move people seamlessly between types, providing the same functions of supporting them. And I think that would be a good way to describe it, that would give us a good flexibility into the future, as we start to tackle questions like higher IT functions at home, developing the capacity of day care as both a social intervention and as some sort of restorative care or enablement care at home, etcetera. Those things should be possible. It shouldn't have to go back to Parliament each time to get each new one improved. And yet they have got to come in some sort of descriptions. I just thought, move away from the task to a functional description.

MR GRAY: Could I just raise this. The more open-ended the description is, the more likely it seems that there will be difficulty in making decisions about whether a particular services are funded as a matter of ongoing – meeting ongoing care needs, which is the intention of the care and health stream or this basic support stream.

PROF FINE: Yes. That's a very good point and I think Jane raised the point earlier, perhaps - - -

MR GRAY: COTA's solution would sweep aside .....

PROF FINE: No, but the idea of demonstrating it, testing it in a region, so perhaps that's the right thing, you know, to actually see what a different description, whether that would facilitate innovation and enable more flexibility than we have had without indeed opening it up just to crazy exploitation.

MR GRAY: I want to go to Mr Sadler.

MR SADLER: I actually agree with Michael's point. And we did have a go at doing this in a National Aged Care Alliance working group in the department when CHSP was being created, so it might be worth some of us going back and having a look at that document. In terms of one group that is definitely missing from this description and indeed from the whole paper and it's the homeless people. So the assistance with care and housing program that Bryan Lipmann was talking about in the last session is actually funded from CHSP at the moment and we do need to make sure it's reflected in the new world.

MR GRAY: Yes. Other panellists, any contributions? Mr Panter.

DR PANTER: I would echo the issue about housing. And also, I mean, I think, again, when we look at the system today, I mean, we have to see it as a broken

system, CHSP, because, you know, as a provider, you know, we have got about $7 million worth of contracts, if you like, for CHSP in my organisation, which goes back to a set of agreements now over five years old with unit prices which haven't changed. We have got a whole load of restrictions about what we can and can't do within that and yet we see, as we've tried to respond more and more to clients' choices, that those boxes no longer fit.

And so I think we have got to have a different way of approaching this group of services which is still low level but give greater flexibility with probably a higher emphasis, from our experience, I would say, on the social as well. And we're seeing now a lot of low level – what I would describe as low level mental health issues amongst older people which are never going to get into the mental health system, and much of which goes back to their social isolation. And that's a critical factor. And we see the social element is the glue that helps people continue to living independently at home.

MR GRAY: Could I move now just – we're winding up and there are a couple of other issues we should address. One is the concept of to what extent is credential and commissioning, recognition, accreditation of the providers of these services required and to what extent should there be the opportunity for brokering into – either brokering into the open market or, indeed, just having access to the general market, perhaps through a voucher? Mr Aitken, does this raise particular issues for potentially vulnerable people in diverse needs groups? If there's enough focus on quality assurance about the providers who will be permitted to provide services that are subsidised in this way, will that do the job?

MR AITKEN: I think all the providers on this panel – we go through accreditation and accreditation processes. Under the old HACC days, it wasn't necessarily the case where – yes, there was still quality visits by various agencies, but in terms of being an approved provider, that was not necessarily a requirement. So low level services could be delivered by agencies that weren't necessarily approved providers. And I think this is where the conversation is at at the moment.

MR GRAY: And should that be the model for the future as well? So - - -

MR AITKEN: Yes. If you take South Australia as an example, there are a lot of very good Aboriginal aged care projects. They are very, very good at looking after their elders in their communities. Where some of the challenges come through are some of the administrative processes, the accountability process and, of course, compliance. So if some of the lesser low entry services were taken away and a different system used, we wouldn't have non-compliance issues with some of those Aboriginal services.

MR GRAY: Ms Mussared, you referred to brokering arrangements. What's the detail of how that should ideally work? Is that upon request by the individual or is it a matter for the provider?

MS MUSSARED: To use a debit card, as we have proposed, yes. It seems to me that it's counterproductive to talk about re-ablement and restoration and then to take away people's control and choice. So certainly a debit card and being able to be in charge of that and to make decisions about what works best makes sense to us. We think that, you know, proviso with that is the other point that we've made, which is somebody independent of a service provision to stand beside and be part of your assessment of needs and part of your decision-making about which services you go after.

MR GRAY: Do any of the panellists want to comment on the degree pf quality assurance that's needed either around that brokering arrangement or around the topic of who should be allowed to provide care that is subsidised either through a debit card or some other fashion?

MR SADLER: I think there are two interrelated sectors which we need to look at quite closely. First – and this will be particularly relevant in the care stream as proposed, but has some relationship with this stream, is what health accreditation around health professionals is actually occurring. You don't necessarily need to duplicate that with an aged care-specific overlay. Secondly is the NDIA and its approach to the marketplace there. Clearly, it doesn't make much sense for the aged care system to come up with a different solution to what happens in disability. We should be sharing any credentialing or oversight that happens for those sorts of providers.

MR GRAY: It seems to be attracting a lot of nods. I take that to be a consensus observation.

PROF FINE: Yes.

MR GRAY: I'll move on. What should be the threshold for needs based eligibility? I might just skip that and just go to means-based eligibility. Should there be means testing? Is the game worth the candle? Is it administratively so complex that you just not do it at all or philosophically is this a case where we should be saying, "No. These are the sorts of services that wealthy people have presumably have paid for if they wished to in the past. That shouldn't change just because they're 65." What are the views of the panellists?

MS MUSSARED: Some services must be universal. Certainly access to information, advocacy services, services that enable a person to get to the starting line must be universal and not means tested. I mean, that would be my .....

MR GRAY: Professor Fine.

PROF FINE: I was always amazed when I interviewed clients. And I did quite a few studies where I interviewed lots of clients. And they kept on asking that question. They kept saying, "We'd like to pay something, because it means you can then be in control. If you don't pay" – I agree with what Jane says, but I think a

means tested payment, if it's done well, doesn't prevent it being universal. It's a co-payment that's legitimate.

MR SADLER: Keep it modest. And I think for these sort of entry level, or whatever the title they end up with, services, simply testing on your aged pension, your Commonwealth health care card, something else that's very simple will be by far the easiest approach. When you get more complex care, which will come out in the care stream, then I think you're looking then at an independent means test, similar to what we've got now, though hopefully .....

MR GRAY: So, Mr Sadler, should the application of something like just a test based on do you qualify as an aged pensioner?

MR SADLER: Yes.

MR GRAY: Should that test be binary in terms of if you pass that means test, you should receive full subsidy; if you're a part pensioner, you should receive part subsidy; if you're not a pensioner, you shouldn't .....

MR SADLER: That would be the simplest, because the costs of these services, particularly if they do have some level of a kind of cost cap, even if they're uncapped in other ways, they're not necessarily going to be hugely expensive to the government. You're talking about, you know, roughly for CHSP at the moment an average of two and a-half thousand dollars per person as the cost of service. That's not a lot to put an over – a heavy means test on top of that.

COMMISSIONER BRIGGS: You know, I find these comments interesting, because I've also read the general view and submissions that says people should be paying more if they've got the means to do so. There's an argument on the health side that if you need particular health care, that should be available universally. And it seems to stop when we get to aged care, because it's seen as a social service which must be tightly restricted. I'm wondering, if we go back to Commissioner Pagone's comment around a form of insurance or whatever, whether that argument still stands, because with a form of insurance, say a disability levy or a Medicare levy, you contribute more according to your income and so you achieve an income tested purpose up front. And then when you, for example, access your superannuation, Bob's your uncle; you don't go through those complicated processes.

I've looked quite a lot at the current income testing arrangements. And they seem to me to be a complete dog's breakfast. So, whichever way it goes, you wouldn't want to keep what you've got. But have you thought about these broader issues that might enable some, in effect, means testing through the system overall, in other words the revenue collection system, rather than in terms of the provision of care which would make the care provision system simpler?

MR GRAY: Any thoughts from the panellists?

PROF FINE: Well, it would certainly give people a sense of entitlement who have paid the insurance. That's for sure. It would be interesting to have those conversations. I was very surprised when people said they wanted to pay a little bit, "only what we can afford", they stressed. You know, they weren't wealthy, the people I was interviewing. But it's a very good point you make.

MR GRAY: Dr Panter.

DR PANTER: Well, I think, again, I think to look at it from that perspective is absolutely right. I think my concerns with not having some sort of means testing for the low entry service is about creating perverse incentives throughout the rest of somebody's journey, because we know already that many people choose not to migrate from CHSP into packages, because of the level of co-payment that's required that may not – often isn't the case with CHSP. And for, you know, when people are in that interim where their needs are starting to change, then they're resistant to converting to a package, because of that impost that it has. So ..... careful that we don't have perverse incentives in the system .....

MR GRAY: Well, let's just be clear. What are the particular perverse incentives you're identifying? I think you introduced the remark by saying not having a means test for those entry level services could lead to perverse incentives. Could you just elaborate.

DR PANTER: So, I mean, my view would be that we've got to have a payment system, a funding system, which does at its broadest level – is means tested, because are we going to have to have - - -

MR GRAY: I understand.

DR PANTER: - - - people who can afford it to pay more - - -

MR GRAY: I understand.

DR PANTER: - - - whether that's through insurance or through some other sort of levy or direct payments at the time of using the service. One way or another, it seems to me, that has to be faced up to.

MR GRAY: The distortion - - -

DR PANTER: Without resolving that, you can't resolve other bits of the system.

MR GRAY: The distortion you were identifying was because the HCPs are means tested to a degree. I understand. Thank you. Any other contributions from the panellists?

MR SADLER: Just to say that I think the Commissioner makes a really valid point about the way the whole system operates, and it's not just about what happens in

aged care itself or even how we fund aged care. It's, obviously, the interaction with pension systems, superannuation systems, value of assets and housing terms. They're all going to play a part in where I hope the Commission settles on how you do this. I think the point we're making from a service provision level is there is benefit to price ..... at the point of service, considering that some of what we're talking about, particularly in the entry level, are not traditional care in a health care kind of context. They're cleaning your house, they're gardening, they're services, which in all other contexts of your life you would pay for them.

COMMISSIONER BRIGGS: I understand that, but I've listened to a lot of evidence around, particularly when you get in the package end, but to get access to the service it takes about six weeks to get through the human services finance assessment system.

PROF FINE: Doesn't it?

COMMISSIONER BRIGGS: You know, this is an incredibly complex system and do you need that? Do we need that as part of .....

PROF FINE: ..... day it takes to finish off to write the forms. I just did a set the other day. It's a day's work.

COMMISSIONER BRIGGS: Yes.

MR GRAY: Unless there are any other questions the Commissioners wish to direct to the panellists. Yes, please, Commissioner Briggs.

COMMISSIONER BRIGGS: I've got one more. I'm wondering, Dr Hartland, is the department progressing the RUCS work on home care?

DR HARTLAND: Yes. We've commissioned some people to do that thinking about that. And we have shared the description of that study with your secretariat. And, of course, we would be willing – well, of course, if you wish, we would be share as much information about it as you wish.

COMMISSIONER BRIGGS: Of course. We really appreciate that. And for the benefit of just this hearing, when would you expect that work to be completed?

DR HARTLAND: So we've done it in two stages like the original ACC work. So the first stage of designing, like, what would be the system, we want to see in April, I believe. So that would certainly fit into your timelines. Then, depending on where you get to, some of that other work about, well, what are the groups might be more difficult to coordinate, but, yes, we will keep you .....

COMMISSIONER BRIGGS: Thank you. So it's quite doable, really, to understand more about the demand drivers in the timing we've got available.

DR HARTLAND: We think so, yes.

COMMISSIONER BRIGGS: Thank you. That's terrific news.

MR GRAY: Commissioners, I have an item of housekeeping. Could I just briefly mention it. It's a summons in relation to one of the witnesses from the Commonwealth Department of Health, Mr Michael Lye, who appeared in session one. Could he formally be released from that summons. It's not intended that he be appearing in any .....

COMMISSIONER PAGONE: Yes. Of course. Yes. We'll formally release him from the summons.

MR GRAY: Thank you, Commissioner. That concludes today.

COMMISSIONER PAGONE: Thank you. I suppose that means that there are a range of people who may have received summonses to be here. No?

MR GRAY: It's only Commonwealth witnesses at this point in time, as I'm instructed.

COMMISSIONER PAGONE: I see. Well, there's one more, at least, that I need to release .....

DR HARTLAND: I'm here tomorrow.

COMMISSIONER PAGONE: All right.

DR HARTLAND: Release me then.

MR GRAY: Dr Hartland is back tomorrow.

COMMISSIONER PAGONE: We will think about releasing you tomorrow then. Well, some of you have heard this before but thank you very much for the input that you've given us. It has been very deep. We're very conscious of the importance of your contribution and depth of knowledge that we are tapping into. So thank you very much indeed. It has been very informative. Subject to that, I think it's 10 o'clock tomorrow. Adjourn until tomorrow.

MATTER ADJOURNED at 4.09 pm UNTIL TUESDAY, 11 FEBRUARY 2020

Index of Witness Events

Index of Exhibits and MFIs