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THE HONOURABLE R.R.S. TRACEY AM RFD QC, Commissioner
MS L.J. BRIGGS AO, Commissioner

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

ADELAIDE

10.18 AM, FRIDAY, 22 MARCH 2019

Continued from 21.3.19

DAY 14

MR P. GRAY QC, Counsel Assisting, appears with DR T. McEVOY QC, MR P. BOLSTER, MS E. BERGIN, MS B. HUTCHINS and MS E. HILL

COMMISSIONER TRACEY: Yes, Dr McEvoy.

DR McEVOY: Commissioner, before I call Fiona Kathryn Buffinton, I just have two statements to tender. One is by Jason Andrew Howie, who is the chief executive officer of KinCare Health Services Proprietary Limited. He has made a statement dated 7 March 2019 to the Royal Commission in response to a notice to give, and the document number is WIT.0035.0001.000. And what I propose to do, Commissioner, is to tender that statement with quite a large number of redactions. And so it's obviously only the unredacted parts of the statement that are being tendered. So if I could tender that statement.

COMMISSIONER TRACEY: What was the date of the statement?

DR McEVOY: It's 7 March 2019, Commissioner.

COMMISSIONER TRACEY: Thank you. The redacted statement of Jason Howie dated 7 March 2019 will be Exhibit 2-87.

EXHIBIT #2-87 REDACTED STATEMENT OF JASON HOWIE DATED 07/03/2019 (WIT.0035.0001.0001)

DR McEVOY: Thank you, Commissioner. There is a further statement; this is a statement of Amanda Clare Bow dated 8 March 2019. Ms Bow is the national director, home care services of Mercy Health. And the document number of that statement is WIT.0034.0001.0001. And similarly, there are a number of redactions that have been made to the statement, and so I tender the statement.

COMMISSIONER TRACEY: The redacted statement of Amanda Bow dated 8 March 2019 will be Exhibit 2-88.

EXHIBIT #2-88 REDACTED STATEMENT OF AMANDA BOW DATED 08/03/2019 (WIT.0034.0001.0001)

DR McEVOY: Thank you, Commissioner. I would now call Fiona Kathryn Buffinton.

<FIONA KATHRYN BUFFINTON, AFFIRMED [10.20 am]

<EXAMINATION-IN-CHIEF BY DR McEVOY

DR McEVOY: Thank you, operator. Ms Buffinton, can you see a document on the screen, WIT.0058.0001.0001?

MS BUFFINTON: Yes, I can.

DR McEVOY: Is that the statement that you have made to the Royal Commission?

MS BUFFINTON: It is.

DR McEVOY: And are there any changes that you would wish to make to that statement?

MS BUFFINTON: No, there's not.

DR McEVOY: And that statement is true and correct?

MS BUFFINTON: That's correct.

DR McEVOY: Commissioners, I would tender the statement of Fiona Kathryn Buffinton.

COMMISSIONER TRACEY: Yes, the statement of Fiona Kathryn Buffinton dated 11 March 2019 will be Exhibit 2-89.

EXHIBIT #2-89 STATEMENT OF FIONA KATHRYN BUFFINTON DATED 11/03/2019

DR McEVOY: Ms Buffinton, could you give the Commission your full name please.

MS BUFFINTON: Fiona Kathryn Buffinton.

DR McEVOY: What present position do you have in the Department of Health?

MS BUFFINTON: I'm the First Assistant Secretary, in Home Aged Care Division in the Department of Health.

DR McEVOY: How long have you been in that role?

MS BUFFINTON: In that particular role since December 2017.

DR McEVOY: What were you doing before that in the Department?

MS BUFFINTON: Well, I've been involved in aged care since March 2015. I looked after the access part of my current role then. I started to look after home care

from mid-2016 and I took on the additional responsibility of Commonwealth Home Support in December 2017.

DR McEVOY: And prior to that?

MS BUFFINTON: Prior to that, in fact, when I came into aged care that was from the Department of Social Services, and I looked after specialist employment services in the Department of Social Services.

DR McEVOY: Let me just ask you a couple of questions about your statement. Did you prepare your statement yourself?

MS BUFFINTON: I prepared the statement with assistance of lawyers and with staff of the Department of Health. I then reviewed the statement and I made some adjustments to that. And then I was happy to sign that as my statement.

DR McEVOY: In paragraph 6 of your statement, you say that you're responsible for a range of services to support clients to achieve greater independence at home. I would like to take you, in that connection, to a document which, operator, I will have you bring up please, it's CTH.1000.0001.2056. Are you familiar with that statement, Ms Buffinton?

MS BUFFINTON: I am. That is my division's business plan for this current year.

DR McEVOY: And when you say your business plan, you, of course, your Department is a Department oof the Commonwealth. What do you mean by your business plan?

MS BUFFINTON: So, within the Department of Health, we then break it up into a range of groupings under Deputy Secretaries and I work to the Deputy Secretary, Ageing and Aged Care. There are four First Assistant Secretaries who work to the Deputy Secretary covering issues of ageing and aged care, and this outlines my – my division's contribution to the overall operating of the role of ageing and aged care in the Department of Health. So it sets out the environment that we're in, what we hope to achieve in the year ahead. So, you know, we give ourselves objectives and outcomes for the year, and this is outlined in the – in this document.

DR McEVOY: So let me take you to that first page where you say what we do. You say there that you:

> *...provide a range of services to support greater independence and wellness for clients, including the provision of aged care information and assessment of needs.*

And you list the programs.

MS BUFFINTON: Yes.

DR McEVOY: Do you see that? And then if you turn, operator, to page 2059, which is the fourth page of that document, Ms Buffinton, can I ask you to have a look at those priorities and key deliverables, and just working through them, let me take you to the third dot point:

> *My Aged Care is an efficient and effective point of access to the Australian aged care system.*

So it would be right to say that you regard that as being, effectively, one of your key performance indicators; would that be right?

MS BUFFINTON: Yes.

DR McEVOY: And this is a responsibility that you have?

MS BUFFINTON: Clearly if we talk on, for example, My Aged Care, in the time I've been responsible, we've had increasing improvement and so - - -

DR McEVOY: We will come to that, Ms Buffinton, but my question was about your responsibility.

MS BUFFINTON: My objective is to make My Aged Care an efficient and effective point of access to the Australian aged care system, yes.

DR McEVOY: And, similarly, to ensure that there's effective program management and policy development for aged care assessments.

MS BUFFINTON: Yes.

DR McEVOY: To ensure that the Commonwealth Home Support Program is effective.

MS BUFFINTON: Yes.

DR McEVOY: And that it meets the entry level in home care needs of senior Australians. Let's just linger on that for a moment. When we say "effective" – or when you say "effective", what do you mean by the use of that adjective?

MS BUFFINTON: So, "effective" would be that we make sure that people are coming through and entering the aged care system and are getting attached to care, or where we can see through our data and through our regional offices that we have problems of high demand that when we look at doing our, for example, our growth runs, we use that data to make sure that the next round of funding focuses on those areas of high demand so that we're constantly seeking to monitor the system in order to make the program an effective program, or as effective as we can in the resources that we have.

DR McEVOY: So when you say you want to make sure that people are coming through and entering the aged care system, do you mean by that everybody that needs to enter the aged care system or do you just mean certain people?

MS BUFFINTON: Well, because I have, and I think it's the reason why it's in my division, I have the access. So that is My Aged Care, and it is the assessments and the flow through of that is the referral into service, in this case for Commonwealth Home Support. It is people. It is systems. It is providers and it is assessors.

DR McEVOY: Just going back to my question, do you mean all people? Do you mean everybody or you just mean some people?

MS BUFFINTON: The people who are assessed for Commonwealth Home Support is seeking to make sure that they get access to the – to that service.

DR McEVOY: So in the second part of that, let's call it a statement, where it's said that:

> *We have an effective CHSP system which meets the entry level in in home care needs of senior Australians.*

Are we to take that to mean that insofar as people are assessed as having in-home care needs, they will be provided – they will have those needs provided in an effective way. Is that what that means?

MS BUFFINTON: We seek to make sure that the systems of assessing them, referring them to service, that they get attached to a service, and if the wait times we're noting are too long, that we seek to try and make amends by the next – our next round of additional funding would focus in those areas.

DR McEVOY: Now, we will come to wait times, of course, but just let me take you up on that. What if the next round is six or 12 months away? What happens then?

MS BUFFINTON: Without getting into great detail, but within the Commonwealth Home Support if a provider has been approved for, for example, meals and transport and they don't have such demand for transport but they have a high demand for meals, we allow, first of all, internally that they have a 20 per cent funding flexibility where they are on the ground – because they're the ones on the ground, we are trying to run a system for 850,000 senior people, that they can make some adjustments locally in order to meet that demand. It also allows us to understand – that we get feedback from the provider that they have got that demand and that helps us to get the feedback to design the next round of funding.

DR McEVOY: Well, I was going to come to home care packages which of course are the next dot point, but what I was really asking you - - -

MS BUFFINTON: I was talking about Commonwealth Home Support.

DR McEVOY: You were, okay, I apologise. But what if they have been assessed but they haven't yet been provided with any allowance, what if there's a time period to wait?

MS BUFFINTON: So, in Commonwealth Home Support we don't have the same concept of a national wait time, a single national wait time. What we can tell from our data is a proxy, if you like, to give us an indication, which is the time that has elapsed from the assessment, the original assessment, to taking up the Commonwealth Home Support service. And the average for that is one to three months. But I should also say that in that elapsed time often that is families considering, not because they are actively seeking for those one two three months, they may be actually considering, well, how much support are the family going to be supporting. So it may well be that they make a contact with a provider earlier. But, on average, the elapsed time which is – approximates one to three months in Commonwealth Home Support.

DR McEVOY: Well, let's say the person in need doesn't have a family and let's say there's a wait time of three months. Would you say that that meant there was an effective Commonwealth Home Support system in place for that particular person or for persons in that cohort of people?

MS BUFFINTON: I think it's important to understand that we, first of all, we do have a method for getting people in high need to rapid connection to service, and that can include before even taking an assessment.

DR McEVOY: Just before you tell me about that, would the answer to my question be yes or no?

MS BUFFINTON: It depends on the circumstances with the individual and for those services that are taking one month, it tends to be those who – I think people would consider the need of things like nursing, that that would be a shorter time, and domestic assistance is in that category of a longer time, and it is unfortunate if that is taking time but that is one at three months is probably easy to understand. If it's the case of meals, we can normally, if need be, get connection to meals within – within a day. So there are systems to make sure that people for those very high need, that Commonwealth Home Support Program services can be connected without putting them in jeopardy.

DR McEVOY: So it would be your position, would it, that there is no significant problem in relation to the Commonwealth Home Support Program and that it does, effectively, to quote this document, meet the entry level in home care needs of senior Australians?

MS BUFFINTON: I think what I believe is that if we take this current year, that we could see that areas where there's three months need, and that is in areas – things like domestic assistance, home modification and home maintenance, as I outline in my statement, that that's where the growth round – we've used the understanding that

the wait is too long and that is why we have focused on the current growth round in those areas and that money started to flow in January this year. So this is us observing and constantly trying to keep an acceptable level of wait time.

DR McEVOY: Yes, we will come to deal with the wait times perhaps in a little more detail in the course of the morning. Can I take you to the next dot point. So, again, this is what the Department identifies as one of its priorities and key deliverables:

> *An effective home care packages program which meets the complex in-home care needs of senior Australians.*

What about that? Is that a fair statement of the present position?

MS BUFFINTON: In terms of my priority and my objective, is to make - - -

DR McEVOY: Ms Buffinton, can I just make it clear. I'm not suggesting that you don't have, as an objective, ensuring that there is effective – an effective home care packages program. What I am seeking to explore is whether you would say that this priority and this deliverable at the moment – this key deliverable at the moment is being achieved. And so, in particular, I'm asking you whether you would say that the home care packages program is effective in meeting the complex in-home care needs of senior Australians?

MS BUFFINTON: It is not at this present time.

DR McEVOY: Why is it not?

MS BUFFINTON: The – despite the rapid increase in the number of people going into the home care program, the fact that from in mid-2016, we had 64,000 people in home care and by June 2018, we had 92,000 people in home care. So we had unprecedented demand and we had unprecedented growth and more people than ever before in home care. I absolutely acknowledge that the unprecedented demand has led to unprecedented growth of the wait list and, therefore, wait times.

DR McEVOY: Right. When you say this, I want to explore with you this word "unprecedented". Are you suggesting that it was unexpected?

MS BUFFINTON: First of all, unprecedented, we have never had growth from 64,000 to 92,000 people in home care in a two year period.

DR McEVOY: Isn't that a feature of demographic trends of which the Department is well aware?

MS BUFFINTON: That was for the first time – let me take you back to June 19 – sorry 19 – 2016. We had 64,000 people in care, but we actually had – this was under the old system – we actually had 79,000 places sitting with home care providers. So

there was clearly a gap of people not – not – we had places but people weren't in them. In changing the system to the increasing choice system with greater consumer direction in February 2017, we have now – people now have much greater choice. We've had a rapid escalation in demand because of people being aware of this new package. We have had, as I said, extraordinary growth but we also have, for the first time understood the wait times that used to sit at individual providers, and we have now published those wait times and they've obviously been well published in the media and so forth. And by understanding that wait time, in turn the government has increased the investment in home care.

DR McEVOY: Is the increased investment that the government has made in home care adequate, in your view, as First Assistant Secretary in the home care aged care part of the Department?

MS BUFFINTON: First, I would acknowledge that over the last two years we have gone from two years ago $1.6 billion dollars, just under $1.6 billion dollars being spent on home care, to two years later, this current financial year, we have spent around $2.6 billion dollars, an additional one billion dollars in home care, and the government has announced increased investment that will take – will make more places available over the next four years. In answer to your question, will this be sufficient to get wait times to a reasonable level? It will need additional investment to that.

DR McEVOY: Have you got a sense of how much additional investment will be required?

MS BUFFINTON: That depends on what the community feel is a reasonable wait time. If I look at, say, Ian Yates in the first weeks of the Royal Commission, he felt that the wait time would be – what would be acceptable would be waiting for three months.

DR McEVOY: Well, on that basis, then, have you got a sense of how much additional investment would be required?

MS BUFFINTON: Yes.

DR McEVOY: And what would that additional investment be?

MS BUFFINTON: If we were to get all people on the waiting list and remembering that within that waiting list are people who, although they're on a waiting list, they may choose to go to residential care but for those who are on the waiting list, if we wanted to get them attached to a, for example, level 2 package, so that everybody was connected to some level of care, that would probably be in the order of – on top of the investment that is already announced, probably in the order of about $800 million.

DR McEVOY: $800 million.

MS BUFFINTON: Per annum.

DR McEVOY: So just to be clear, if we base this on a three month – roughly three-month waiting period for home care packages to come into place after an assessment, it's your evidence that the waiting list could be cleared with an additional $800 million.

MS BUFFINTON: Just to be specific, I said if people were attached to a level 2, so that's - - -

DR McEVOY: I'm sorry, yes. Okay. Well, of course, not everybody is wanting to be attached to level 2. So would you be able to answer the question on the basis of your present knowledge of the quantities of packages required in each of the levels?

MS BUFFINTON: For everybody to get a package within three months, it's probably in the order of an additional two to two and a half billion dollars per annum.

DR McEVOY: Is that on top of the $800 million or that's included - - -

MS BUFFINTON: No, I'm saying one scenario could be if we wanted to make sure people were attached to care within three months and if we made that level 2.

DR McEVOY: Yes. That would be $800 million.

MS BUFFINTON: That would be $800 million.

DR McEVOY: But if you wanted everybody to be in category 1, 2, 3 or 4, depending on their needs in the present distribution.

MS BUFFINTON: Based on their assessed level need, it would be an additional two to two and a half billion dollars per annum.

DR McEVOY: Yes. Commissioners, could I tender that document In Home and Aged Care Division vision and purpose statement, CTH.1000.0001.2056. I'm not sure that it bears a date but Ms Buffinton, you might be able to help us with that.

MS BUFFINTON: Well, that would have been – I will say it was June because we prepared that just prior to the beginning of the financial year.

DR McEVOY: June of 2018.

MS BUFFINTON: June of 2018.

COMMISSIONER TRACEY: All right. So the business plan of the In Home Care Division of the Department of Health dated June 2018 will be Exhibit 2-90.

EXHIBIT #2-90 BUSINESS PLAN OF THE IN HOME CARE DIVISION OF THE DEPARTMENT OF HEALTH DATED JUNE 2018 (CTH.1000.0001.2056)

DR McEVOY: Thank you, Commissioner. Ms Buffinton, can I turn to the general issue of the Department's knowledge of the consumer experience. You've been following the evidence being given to the Commission, of course, and you will be aware, I imagine, that there has been a good deal of evidence about the nature of the consumer experience.

MS BUFFINTON: Yes.

DR McEVOY: What knowledge does the Department have of people's experience in receiving care at home? Do you conduct market research or anything of that kind in relation to the consumer experience?

MS BUFFINTON: We do undertake research and we do a lot of consumer focus groups and, of course, we get a lot of correspondence.

DR McEVOY: What sort of numbers of people are you conducting focus group research with?

MS BUFFINTON: So, I would be happy to provide that to the Commission but we do – over the last four years, we're currently in our third wave of – of major research. We did a baseline research in 2015, a second round of research in 2017 and we're doing further research in 2019, for example, on My Aged Care and that experience. Whenever we design any part of changing a policy or any design of what we're doing, for example, to the website or program, we work with both the sector in terms of providers and consumer peaks but we also do individual – we get individuals in and showcase, for example, we're launching a new website in mid this year, where that was – the growth of that came – started off with what were people looking at, what were they seeing in our current environment. What did they want.

What they didn't like about that website, and that's how we have been building it up, and as we have built various aspects we have been testing it with older people, including in retirement villages and people who in part of our Commonwealth Home Support Program and asking their opinion. So it's very much, and for me coming into aged care in 2015, more so than most social policy areas, a co-designed experience. That said, we're responding constantly to the feedback we are getting of things that aren't working for both individuals but more broadly, themes of things that aren't working.

DR McEVOY: So are you intimately familiar with the results of this research in terms of what people are saying in response to questions about how the system is treating them?

MS BUFFINTON: Well, clearly my teams are the experts but I am – I am across that research, yes.

DR McEVOY: And are you able to say whether that research is broadly positive, broadly negative? Can you give the Commission a sense of what that research is telling you?

MS BUFFINTON: So, starting off with the website, the website - - -

DR McEVOY: That being something that has been the subject of research, you're saying?

MS BUFFINTON: Yes. But we – so we know that with the website, we have a performance indicator of that at least 65 per cent of people using the website find it useful or met their needs. That might seem low but I'm advised that websites – because people have a whole range of reasons but we have not met, on the current website, that performance, and that is part of the reason why we have looked at – so since 2013 we have had the website. We improved the website leading into 2015, and we're launching a new website in 2019 which we think will be more fit for purpose, based on the feedback we got of what people found useful or what they were looking for.

In terms of the contact centre, I think if I reflect on the feedback through the Royal Commission, is – I think there's two elements to the contact centre. One is the experience itself of people of the contract centre and the information that they've gleaned and we actually have a high level of satisfaction, except for the area, understandably, when people ring up and ask about the wait times on home care packages and they are told they will have to wait, and the operator tells them it's 12 months plus. And if they ring back again a couple of months later, it's 12 months plus, I can understand that consumers see that as an issue with the contact centre, as opposed to the quality of the information more generally from the contact extra as opposed to on that issue.

But, again, through – since 2015 when the contact centre has become – taking registrations and screening people, we have constantly sought feedback and adjusted the scripts, the training of the people in the contact centre. So it is constantly that we – every three months or so, we're constantly looking and improving, looking and improving to meet better needs.

DR McEVOY: So where – just so that I'm accurately reflecting your evidence, I think you said that the – there was a high level of satisfaction, the research was indicating, in relation to the contact centre, leaving aside the issue of wait times which is obviously a controversial matter; is that what you are saying?

MS BUFFINTON: For consumers – so interestingly, consumers have a higher level of satisfaction – and we're talking above 80 per cent satisfaction. Providers and assessors initially back in 2015 were quite negative because we also run the contact

centre not just as an outward consumer-facing contact centre, it's also for providers, it's also for assessors. And that – so internal facing, the assessors have moved from being very negative to the information they were getting from the contact centre to being quite positive about the contact centre. I think so often now, when people are talking about My Aged Care, sometimes they're talking about the contact centre. Sometimes they're talking about My Aged Care has become the whole system – and we accept that, that's great brand recognition, one way or other. But sometimes people, when they're talking about, "I rang My Aged Care", they mean the contact centre.

DR McEVOY: So do I understand you to be saying that your research into consumer experience on the contact centre, and perhaps My Aged Care more generally including the website, indicates that looking just at consumers rather than providers and others, is revealing that there's an 80 per cent satisfaction rate. Is that what you're saying?

MS BUFFINTON: I am. So we've got to remember that there is 1.4 million phone calls came in, in 2017/18 and we are heading close to probably 1.6 million this year. We have over 400,000 pieces of correspondence come into the contact centre annually. So it's a very high volume contact centre. We – in 2015, the wait times were unacceptable. The average call to wait time now is less than 30 seconds. For many people, ringing up and getting their registration in a polite manner, that information being taken, that then they're asked questions for screening, and then they're advised that they will be contacted by an assessor to arrange the face-to-face more detailed engagement and explanation of the aged care system. That, for many people, who are happy with the phone environment or family members being attached to the client record so that they can ring on their parents' behalf, by and large works well.

We know that there are issues, and Mary Patetsos from FECCA outlined for people, for example, of non-English speaking backgrounds. There would be a number of people who work through our telephone – with the assistance of our telephone interpreter service, we have about 20,000 phone calls assisted each year with the telephone interpreter service. Some would find that satisfactory, and some would find that more difficult.

DR McEVOY: I'm interested in this 80 per cent satisfaction figure. Is that the - - -

MS BUFFINTON: I would be very happy to provide the detail. We have independent – a group called AMR Research that undertakes that.

DR McEVOY: Is that, do you know, the result of just one recent survey or is that consistent - - -

MS BUFFINTON: No, we are actually – we are constantly surveying – and that's where the detail I will have to give to the Commission – so that is something that

comes up regularly research, over and above these waves of research, major research that I was describing in 2015, '17 and currently in 2019.

DR McEVOY: Well, while we're on the subject of My Aged Care, do you know what number of Australians over the age of 65 have access to the internet?

MS BUFFINTON: I don't.

DR McEVOY: If I said to you that ABS figures indicate that of people aged 65 and older only 55 per cent used the internet in 2016, '17, and that was the lowest proportion of all aged categories across Australia where usage was generally 86 per cent. Would that surprise you?

MS BUFFINTON: No, it wouldn't.

DR McEVOY: One of the criticisms that you may have heard was articulated by Mary Patetsos in evidence to the Royal Commission the other day, but it's not the first time I had heard that evidence, is that My Aged Care was designed for generation X by generation X. Does that - - -

MS BUFFINTON: I'm not generation X, by the way.

DR McEVOY: I think I am.

MS BUFFINTON: I'm not.

DR McEVOY: Does that – does that resonate, that criticism with you?

MS BUFFINTON: It doesn't and I will explain why, because I think where the inference may be going is that if our only channel of communication was the internet, I think we may have a problem. But, equally, I would turn it around and say to the 55 per cent of people over the age of 65 who do want to use the internet, and also the families who are often supporting people who are much older, they appreciate, and that's why we have three and a half million visits each year to the My Aged Care website. So if somebody doesn't want to use the internet at all, they can ring the contact centre and they do not need to use the internet. And I'm happy to go into – if we want to go into it later, or now, into the detail of how you could go through the complete system never using the internet.

DR McEVOY: Well, I was going to ask you if you do need to, if you can't use the internet or if the internet is not working for you or you don't have access to it or whatever and you do have to telephone, what sort of supports are there available for such people? How does that work?

MS BUFFINTON: Okay. So first of all, you would ring the My Aged Care number and be answered on average in less than 30 seconds. You will be asked some registration questions. So that would be name, address, Medicare number, and

explain that we're now just setting up their client record so that you don't have to keep telling us. That was one of the parts of the changes for My Aged Care is tell your story once and that will flow through. So by the time you get to an assessment and you get to service, people already have that information. Then they will be screened and asked a range of questions about their current situation, their current care situation and so forth. And then it will be explained that they will be referred to an assessor, and that an assessor will be contacting them by phone.

So then it depend on the nature of the questions, whether that person is being given a high, medium or low priority for assessment, on that basis and an assessor will contact the individual and make a time for a face-to-face assessment. If I can explain, whether that's a regional assessment or a more comprehensive aged care assessment, that would be somewhere between two to three hours in the person's home taking – using our national screening and assessment form but asking a range of consistent questions about their current status, care needs and so forth. It's also where the assessor will observe an individual in their home and just what their level of movement within the home and whether there's any ramps required or possibly some – some modifications.

But, in addition to the assessment, that is the time when – in a face-to-face environment that the assessor will sit down and explain, for example, look, really, you know, if I'm the original assessment service, the Commonwealth Home Support Program. They will leave the paper booklet which is quite a detailed booklet, I think, of about 20 pages on the Commonwealth Home Support Program. They will explain that they are going to be getting a support plan, and then they're asked would they like the assessor to refer this back to My Aged Care so that a provider can then contact the individual or, in some cases, individuals say, "No, look, I would like to do that myself" or a family member.

So the assessor can give some – will advise in the support plan the codes that just – they would then ring up a provider and say "Hello, have you got availability, I've got a code for domestic assistance." So that, I hope I've just described an environment where you actually haven't had to use the internet in order to get to a point of referral and then a provider contacting you or you contacting a provider.

DR McEVOY: That all sounds commendably plausible, with respect.

MS BUFFINTON: And in the bulk of cases that's how it works, but I would acknowledge there are times when it doesn't.

DR McEVOY: Well, the difficulty is, Ms Buffinton, that the evidence of this last week tends to demonstrate that the My Aged Care system, that is to say the website and the call centre, may not be working as perhaps it might. One of the things, for example, we've heard evidence about is that when people do call the phone centre, they speak to people who are typically reading from a script. Are you aware of that evidence?

MS BUFFINTON: I am aware of that evidence.

DR McEVOY: Do you consider that that has any basis in fact? Are scripts utilised in the call centre?

MS BUFFINTON: So, in effect scripts are because in terms of making sure that the call centre, in taking these nearly one and a half million phone calls and making sure that we have a standard method of registration, I have sat in – we have three call centre across Australia, and I've sat in all three, and I can assure you that for the most part, while people are reading from a script, they actually are both trained but they're selected for, you know, their engagement of not just being an automaton reading a script but engaging while going through a fairly standard process of registration and screening.

DR McEVOY: You may have heard this evidence, but Ms Harris – it might have been yesterday, I think – gave evidence that from her dealings with My Aged Care she was left with the impression that call centre staff just read from a screen and deliver set lines. Although her mother had been waiting for a package for over nine months she was still given the same information when she was making these inquiries that she had been given when her mother was first approved for a package, which was that it should be expected in three to six months. Now, that was in November 2017, and the same information was repeated a number of times as she tried to accelerate her access to home care packages.

Another witness gave evidence earlier in the week – this was Ms Ellis and she was the daughter of somebody needing care and her evidence – and I will quote from it, was that:

> *My Aged Care was really at most times pretty useless. I suspect they are a waste of money. Apart from referring you to other agencies they offer very little assistance in terms of actual knowledge about the aged care system.*

Another witness has given evidence – this is Mrs Dowling – that she found the My Aged Care call centre to be horrible and that she would often get the wrong information. Mrs Dowling has been legally blind for 30 years, and her evidence was that this wasn't ever the subject of any question by those on the end of the phone and that she regards it as a major flaw in the system, that a system that is targeted at older Australians has the predominance of the information online. Can I suggest to you, Ms Buffinton, that the My Aged Care system is premised on an expectation that older Australians will have someone to assist them in navigating it; what would you say to that?

MS BUFFINTON: Certainly, of the phone calls coming in at the point of registration, that somebody – it may well be a spouse sitting alongside somebody or a – some other carer, that probably around about 75 per cent of the calls coming in are where there is a call coming through from a family member either initially with – because it must be with initially the older person, but once they have the agreement

to be a representative, that they are able to ring up on their behalf. So typically then in more than 75 per cent of cases, it is involving a family member or somebody other than the older person after the initial phone call.

DR McEVOY: But that does leave those who don't have access to a family member or don't have complete access to a family member, don't have access to someone to hold their hand at a rather considerable disadvantage, wouldn't you agree?

MS BUFFINTON: I would agree and that is – was also picked up by David Tune in the legislated review, which is – while I've tried to get across that there are many people who go through the system and are satisfied. I do not want to leave the impression that there are not people who find difficulty. And that includes people who might be on their own or – or a range of other reasons and he identified that and we understand that.

DR McEVOY: Do you know - - -

MS BUFFINTON: Sorry, I was just going to say which is why he made a recommendation that in addition to – and he acknowledged in the review, that My Aged Care had improved a great deal; that for the bulk of people it was working reasonably well but there were people who didn't find the My Aged Care system as it currently is as effective, and we absolutely understand that. And that's why the government, for example, has taken up the David Tune recommendation and is currently piloting, as we heard with the evidence of Mary Patetsos from FECCA, the concept of a system navigator for those who need additional assistance.

DR McEVOY: Do you know whether My Aged Care links up to the Centrelink system in any way so as to provide notification that there are particular people with disabilities accessing it?

MS BUFFINTON: So I would have to provide to the Royal Commission the absolute detail but our system does link – so My Aged Care does link with the Department of Human Services system, and one aspect of it is for things like income assessments and for income and asset assessments for individuals. It also is our means of how we pay providers. It's actually the Department of Human Services who pay providers their subsidy.

DR McEVOY: I think last Tuesday the Department live-streamed a webinar canvassing upcoming changes to the My Aged Care website. Do you know much about that?

MS BUFFINTON: That particular webinar I'm not, but the live-streaming of a website; that would have come from my team.

DR McEVOY: Do you know much about the upcoming changes to the My Aged Care website?

MS BUFFINTON: Well, in the broader sense as the leader of that team, yes, I do.

DR McEVOY: I suppose what I'm really driving at is are you able to outline succinctly what changes you do contemplate making in the immediate term?

MS BUFFINTON: Yes. So, with the website, we have been doing work with older people, for example, the setting out and the layout of the website and where information on the home page sits; that there is much greater use of white space and that came out with Ms Dowling who – we have taken into account people who may be more vision-impaired, what is easier to be seen and what is the logic flow of information of how people think. We have created our website to match that. In terms of the service finder, which is a really important part of the website, is if you are choosing, on a consumer directed basis, let's use the example of home care, because we could have that for Commonwealth Home Support and residential care in different ways, but for home care – and you were looking for providers, how we render those service finders more easily and make it that that will be where we can have greater pricing transparency. They're going to be some of the aspects of the new website.

DR McEVOY: Do you know whether the same people who operate the website also operate the call centre?

MS BUFFINTON: The current – the current website is provided by Healthdirect Australia. We're going – we're moving to a new provider as part of the new website. The call centre is, it's operated by Stellar, under contract to Healthdirect Australia. So the current website is by Healthdirect Australia.

DR McEVOY: What level of confidence do you have that the proposed changes to the website are going to deal with at least the criticisms that have been made of the website and the system, really, in the course of the last week before the Royal Commission but more generally criticisms that you are aware of yourself from your own research?

MS BUFFINTON: So we have constantly sought to make improvement, and for us to make the decision that we would move to a new platform was for us to endeavour, because we've much been listening to concerns about the website, we began, without going into a lot of jargon but we did have design – design workshops, five different design workshops in 2017 with a whole range of people and one specifically for vulnerable people, including people of culturally and linguistic background as to what their concerns were with our current system to begin our design of our – our – our next stage of enhancements. And in this case, the decision to go to a new – a new platform. That as we've been designing each of the screens and the methodology for the home page, that has been done with older people.

We constantly, in the background, have a group called the Gateway Advisory Group which our provider peaks, consumer groups and some actual providers and actual consumers that sit on that and they've also been part of this design. So on the basis

of listening to feedback, my expectation that it will be greatly improved from where we are at the moment, and as we have already shown, that inevitably there will be aspects of that which will suit what we hope are a much broader range of people, but as we get feedback and evaluate and we need to continue to improve, we will do that as well.

DR McEVOY: I take it, Ms Buffinton, that if I were to put to you that My Aged Care is failing older Australians and their families and that the system is – the access system on the internet and over the phone is not fit for purpose, that you would not accept that characterisation?

MS BUFFINTON: I wouldn't accept that, no.

DR McEVOY: I might turn, Ms Buffinton, to something that you touched upon earlier, which was the increases in funding for home care. You deal with this at paragraphs 42 and following – 42 to 44, really, of your statement. And in paragraph 42 you set out the measures to increase the number of home care packages. And in 42(a) you say that with the MYEFO and budget announcements there are an additional 6000 higher level home care packages coming on – becoming accessible, as it were, by converting level 1 and level 2 packages into level 3 and 4 packages. Was this money applied in the Mid-Year Economic and Fiscal Outlook, new money being put into the system or was that just to bring forward?

MS BUFFINTON: So, just to complete that paragraph, which says:

> *This measure was cost neutral.*

So that was a conversion of level 1 – 17,000 level 1 and level 2 packages, which funded the 6000 level 3 and level 4 packages. If we could just recall that December 2017, David Tune in his legislated review had provided the report to government. He recommended that there was a need for a higher level of level 3, level 4 packages, and that was relative to level 1 and level 2. And that was the first round of response to that.

DR McEVOY: So it's – yes, I understand what you say about that.

MS BUFFINTON: So it was not a bring forward, it was not new money. It was within the package, it was reassigning the funding to more expensive but a smaller number of level 3, level 4, using 17,000 level 1 and level 2 packages for funding.

DR McEVOY: So that appropriation of funds is an entirely new appropriation of funds, in effect. It was an appropriation of funds drawn from funds already in the system, in the pipeline, as it were, or am I wrong about that?

MS BUFFINTON: No, so that was where – the funding for – for home care packages was the same. So budget neutral. It was an internal movement from a higher volume of lower cost, that 17,000 of level 1 and level 2. And that funding

was then used for 6000 level 3 and level 4. So just to remind, a level 1 package of $8000, level 2, a subsidy of around $15,000, a level 3 around $33,000, and a level 4 of around $50,000. So that was budget neutral. It was within the same level of appropriation but it was moving the number of level 3 and level 4s which were in much higher demand.

DR McEVOY: So if it's budget neutral and in the same level of appropriation, it would be right to say, wouldn't it, that it's not, in fact, new money?

MS BUFFINTON: It – it wasn't – it wasn't new money. It was utilising money already set for the home care package program.

DR McEVOY: So what's the decision-making or what has been the decision-making behind deciding to release more level 3 and 4 packages?

MS BUFFINTON: So that was David Tune, in his legislated review, was looking at where was demand coming from, was particularly where we had a high level of pressure, therefore a high level of demand for level 3 and level 4. He noted that in his legislated review. It's why the government has responded so that between June 2017, so mid-2017, and September 2018, there has been a 74 per cent increase in level 3 and level 4 home care packages.

DR McEVOY: This would be consistent with recommendation 7 of David Tune?

MS BUFFINTON: I will take the number on advice but, yes, that recommendation.

DR McEVOY: On what basis are package levels set in the amount that they are set?

MS BUFFINTON: So we have our quarterly data report that we've provided that to the Royal Commission, and so we look at each quarter, what are the approved levels coming through, what's the demand, how long are people waiting? And we then – we've got to make sure, of course, that there is a flow constantly of people getting into level 1, 2, 3 and 4 packages. And we knew that we had much higher demand for level 3 and 4 packages than was available, which is what was identified by Mr Tune.

DR McEVOY: Does the Department know what the true cost of providing a home care package at each level is for providers?

MS BUFFINTON: It really – it really does depend on the individual circumstance. So if I can give you some examples. That if, for example – well, the one that is most commonly discussed is the level 4 home care package of $50,000 of subsidy. So let's call that as nearly $1000 a week. If what actually is involved is two people needing to come in and do certain lifting for people, one would presume that that is, you know, a much higher cost than a single person coming in. If it's works on weekends or evenings – but I would have to say that I was greatly concerned when, in the evidence this week, for example, when one of the witnesses mentioned nine

hours of care, that – per week, for something that is, you know, around about $1000 a week, that that is very concerning.

So if I had to – we're always reticent because of all those things, you know, but what would our expectation be, it would certainly be sort of more in the sort of 12 to 14 hours. But we don't – because we can't know the circumstances, and it is appropriate if providers are doing the right thing, that they should be able to make some of those decisions, but I would have to say that nine hours a week is very concerning.

DR McEVOY: Nine hours for $1000 a week, a little less than $1000 a week is concerning. So do you monitor in any way or track in any way or consider in any way the administration costs that providers are charging?

MS BUFFINTON: So, on the current system, once somebody has an assessed – has an assessment and that they're given – they are connected to the package, the funding flows to the provider. And we haven't had sight, therefore – thereafter, it's between the provider and the individual, so we haven't had sight directly of, say, individuals and their administration fees. That's why Minister Wyatt brought in changes from mid last year which said that we needed to have greater oversight of what those administration fees were. So two things: he then said that by the end of – well, by November last year that all providers should have a PDF on their website of the details of their – of their funding policy and the funds that they charge and that by 1 July this year it will be – so that's mandatory to have had the PDF since November, and by 1 July 2019, it will be mandatory on My Aged Care that they have filled in our pricing schedule.

And that is going to be where you can, on exactly the same template, compare for example three or four providers side by side and in the standard way have to render what their pricing is so that you can genuinely compare. But it also gives the PDFs methodology which is now we're beginning to analyse and, of course, once we have the template we will be able to analyse what the level of overhead as opposed to direct cost of service. But we haven't, prior to this, been able to view that. So what we have had is the aged care funding authority do get a report each year from providers. So that was the information that I provided in my witness statement for 2017 that was in the Aged Care Funding Authority report for 2018.

DR McEVOY: Well, it's no doubt laudable that those initiatives have been taken. You might recall, though, that the secretary of the Department of Health told the Commission that back in February only 70 per cent of providers as at the end of January were compliant with the current requirement to publish their prices on My Aged Care. You recall that evidence?

MS BUFFINTON: I do.

DR McEVOY: She said also that the Department was following up the other 30 per cent. Are you able to say what has been done to follow up the other 30 per cent in the last month or so?

MS BUFFINTON: Yes, I am. So first of all, the Department wrote to that 30 per cent, that – we now have 80 per cent compliance. So of the 20 per cent, we're aware of around a quarter of those because we have gone in and looked at individual records. My Aged. We have seen they didn't actually follow the instruction, which is they did the work and they saved it but they didn't submit the – sorry.

DR McEVOY: Sorry.

MS BUFFINTON: So of the 20 per cent, a quarter have actually done the work but they didn't follow the instruction. They just saved it. They didn't submit. So of the other 15 per cent, the compliance area of the Department have written to those providers and giving them two weeks to be compliant or further compliance will follow.

DR McEVOY: So you would expect that we are not far from having a system where all of that pricing information is readily available.

MS BUFFINTON: So first up the PFD, which is less than ideal but at least we will have that and consumers will have that, but from 1 July it will be mandatory that they fill in the very comparable pricing information schedules on My Aged Care.

COMMISSIONER BRIGGS: Dr McEvoy, could I ask, in the information that is subsequently provided to consumers about possible services that they might use, is it the intention of the Department to include that information about fees as part of that information? Or will the elderly person or their family have to go to My Aged Care, the web-based system to get the information which we already understand many of them can't use?

MS BUFFINTON: I hope this is an indication that we do listen, and that schedule, in addition to being online, will need to be attached to each individual's agreement.

COMMISSIONER BRIGGS: Good. Thank you.

DR McEVOY: Yes. I mean, we have heard evidence this week, though, Ms Buffinton, that very often that information, even in the agreements themselves which providers give to their recipients, is not to be found.

MS BUFFINTON: So the – for an approved provider offering home care, they need to be giving their client a monthly itemised statement. So the fact that you have been, or, you know, through the Royal Commission we have been hearing of people who may not have had their monthly statement, that they may have waited nine months or 12 months, that is absolutely noncompliance by the provider. Certainly, we've focused on the getting the understanding of the pricing right. I do

acknowledge that I think Council of the Ageing have noted, well, that's stage 1. The next stage will be how we render – not we, how the provider renders – and maybe that might require a more standardised approach but we will look into that as the next stage of helping older people understand what their – what the agreement is and in a – that it's timely and done on a monthly basis and it's easily understood.

DR McEVOY: You will be aware that we have heard a lot of evidence from users, effectively, whether it's recipients themselves or their children, about the high level of administration or case management fees. And some of them range, you know, up to as high as 50 per cent. And this comes back to the point you were making about the nine hours for $1000. I mean, what does the Department think about all of that, and what might the Department do about all of that?

MS BUFFINTON: Clearly, we would like to see the bulk of the funding going to the consumer. Both David Tune recommended and Minister Wyatt agreed, that the consumer peaks and provider peaks would work together because it's actually not so much what the Department thinks; ultimately it's what the consumer feels comfortable – comfortable with. So when we were doing this pricing schedule that will come in on 1 July, it actually has been quite an interesting discussion with consumers, because on the one hand, was a single unit price for service the way to go. Consumers – consumer representatives said that actually they were happy for case management to be in there because you can imagine a scenario where it's largely what might be a self-managed approach. And so that overhead might be – let's call it 10 per cent but it's understood that that is where the family or somebody else, or the individual themselves needs to be very involved in the scheduling and so forth.

Or somebody who really has no other support may need a sort of, a high level of – and get the benefit of genuine case management. And so those overheads might be closer say – I'm just imagining, 25 per cent. But certainly when we're starting to hear of 50 per cent and some cases 50 per cent where there hasn't been that much case management on top of that, that is of concern. But the current approach is that – and the consumer groups including COTA and Seniors Australia, were supportive of the approach of, at this stage allowing the market to still be able to differentiate and innovate and offer different types of support. But clearly that – we have got to make sure that consumers and their family understand that they should keep an eye on those charges and if they have a complaint or they want to, they can go back to the provider.

They also have the choice of comparing with other providers, unlike prior to February 2017, they didn't have the choice to move providers. The package belongs to the individual. They can – that brings a lot of consumer power and they do have the opportunity of moving providers if they can't come to an arrangement that satisfies them with their current provider.

DR McEVOY: Commissioners, I note the time. That might be a convenient moment to pause for the morning recess.

COMMISSIONER TRACEY: Yes. Before we adjourn, Commissioner Briggs has some questions she wanted to raise.

COMMISSIONER BRIGGS: Ms Buffinton, in the information you collect on the call centre, do you also collect information on the internet or the web-based system about user satisfaction with it?

MS BUFFINTON: We do, and that's where I mentioned just quickly at the beginning that the satisfaction – websites are always lower than speaking to people. So our performance indicator is 65 per cent. And we have been in the mid to high 50 per cents. Clearly, that isn't where we want to be and that's part of the foundation of moving to a new - - -

COMMISSIONER BRIGGS: A new provider.

MS BUFFINTON: A new platform.

COMMISSIONER TRACEY: Okay. Do you know the proportion of people who start to try to access My Aged Care and then are forced to revert to the phone because the system is impenetrable to them or their families?

MS BUFFINTON: The two most common aspects of using the website is first of all going in and just getting general information. And over time we have adjusted that. So the current system, which is improved from our previous one is if you are just looking for information, you can just go in and a lot of families, dare I say, we get an increase in calls, interestingly but not surprisingly, in late January and February each year. And that correlates when families go home and often catch up with their families and just start discussing that maybe there might be some additional support. So that would be people going in and just having a look and going I wonder what services might be available. So that general information searching. We get a lot of positive feedback on people just finding that general information.

You do not need to go through the system and, in fact, you can't go in and screen and register at this point through the website. That's when you do need to ring the call centre. Having said that, while David Tune absolutely acknowledged that we need to look at navigators at one end – and it may be generation X, Y, Z who are supporting their elders – one of the areas that we are also building is the capacity for families on a Sunday afternoon not having to come through a website but to do online registration. So that will be a future that's going to be – become part of My Aged Care early next year. I don't want older people to think they've got to self-register but it just allows some families to work together in a different – we're trying to offer different channels. So from the navigator at one end but to those who actually might want to use an even more fulsome online experience that will be available but absolutely people do not need to use it.

DR McEVOY: How can you have online registration without using a website?

MS BUFFINTON: No, sorry. What I was saying is at the moment you can't – you can't enter aged care without going through the My Aged Care contact centre by calling. By early next year – and you don't have to use it – but there will be the capacity for, for example, families to just register or individuals, I do have a nearly 93-year-old father who is possibly the exception to the rule, because we shouldn't just assume that older people don't use the website, but they will be able to use that as an option, as another channel. Trying to allow different channels for different people.

COMMISSIONER BRIGGS: Okay. Could I follow up your evidence earlier on about access to the different packages, and did I take it from your evidence that in the absence of sufficient level 3 and level 4 packages, it's actually departmental practice to provide level 2 packages in the hope that that fills the gap in care.

MS BUFFINTON: So just to clarify, that was when I was being asked my opinion of how much additional funding and I said one example could be if you wanted to make sure that everybody was connected, and what would be a baseline connection level 2, $15,000. So that was to a different question. So you might like - - -

COMMISSIONER BRIGGS: So what I want to understand is, there are many people – and your own departmental people advises us of this – who were actually assessed as a level 3 or 4 package entitlement but received a level 2 package.

MS BUFFINTON: Yes.

COMMISSIONER BRIGGS: So is that departmental policy?

MS BUFFINTON: Well, it's not whether it's departmental policy but I think it's a very good design of the system. So if you have been assessed, say, for a level 4 I would strongly recommend that when an assessor is taking your assessment you indicate that you are prepared to take an interim package. What's really important to understand, that will not add one day to your wait for your level 4 package but it just means that the wait times for level 2 and level 3 are shorter than the level 4. And so we can connect people to care earlier rather than going through a whole period and then getting a level 4. So we strongly recommend that while people are waiting for any package, that in over 90 per cent of cases they've been assessed as also being able to access the Commonwealth Home Support system so, one, they should seek to connect to service or get My Aged Care to connect them, have a provider ring them from Commonwealth Home Support.

The next stage is one of the time-consuming aspects is people researching providers and getting income tests if they are, for example, self-funded retirees; that takes time. So if while you are getting a level 2 package on your way to level 4, the time-consuming part of researching and testing providers and getting all that work done. Once you enter service at level 2, it means that automatically when your – it all goes back to when your date of assessment and your priority but when – it comes through that you're now available for level 3, there is no – you automatically flow to a level

3. The provider is advised, you are advised in a letter but your funding just automatically rises to eventually level 4, rather than – I think there is a misunderstanding, and we hear that sometimes people are giving each other advice and they might not be – it might not be correct advice because we have heard people are concerned, "If I take a level 2, it's going to hold up my time waiting for a level 4." And I assure everybody that it doesn't hold you up for one day. It makes no difference to your wait time.

COMMISSIONER BRIGGS: What does make a difference to your wait time, then? We have heard references at I think each package level, but I stand corrected if I'm wrong, there's priority listing. So high, medium and low. If you're a high priority, what happens to secure that, and what does that mean categorically, and I'm happy if you want to provide that evidence in writing.

MS BUFFINTON: So in my statement, I provide that assessors – so the two key dates for a home care package is the date of your assessment, and then the priority that the assessor provides. I think people misunderstand that high priority must equal level 4 and, in fact, it doesn't. It could be that high priority, you could be level 2 and the situation where you've got a partner who has been very well and really been doing quite a lot of informal care for you and they may suddenly be hospitalised, take a fall or, unfortunately, pass away. So suddenly you've got very high needs but you're otherwise in yourself not as frail as somebody at level 4, you're still level 2. There is a strong - - -

COMMISSIONER BRIGGS: So fundamentally, there's a strong connection for high priority between whether or not you've got somebody at home who can manage your care needs for you?

MS BUFFINTON: No, I'm just giving that as an example. It could be that you've got a high level of frailty and need to be connected to care. So I've outlined in my statement that what an allied health professional in their professional judgment needs to make as to whether somebody is high or medium. With high, it genuinely does bring forward packages and so a lot of people may think, well, they need to be at a high priority. We have spoken with ACAT – the assessment teams to say we need relatively few – and, you know, that might be at level 4, you know, around 15 to 20 per cent, because if it's that kind of number, we can genuinely bring forward people and get them connected to care very, very quickly. And that's the nature of that high priority. The rest of the queue, rather than high, medium or low, is we call it the medium queue, it's basically the rest of the queue.

COMMISSIONER BRIGGS: Right. How does the actual allocation system work? Are there complex algorithms that determine this, or is it that the Department intervenes and manages that waiting list?

MS BUFFINTON: Well, it's a combination of two. So, yes, there are complex algorithms but, you know, that human – so we are always taking people off the high priority queue and medium constantly in a flow. But we're making sure that people

with a high priority don't have to wait too long. But at one stage, when we had assessors assessing with more than 50 per cent of people at level 4 being assessed as high priority, we said that they really did need to use their professional judgment to prioritise those who really were high priority, and they acknowledged that. In order for us to genuinely be able – otherwise it just becomes one long queue. But it works, that somebody with high priority, while it may be a number of months before they get their full level 4, it can be literally in a week or two that we can have them in a level 2, and within a matter of six or eight weeks, at a level 3.

COMMISSIONER BRIGGS: It would be helpful if you could provide the Commission with written advice as to the average length of time anyone on a high priority or assessed as a high priority against all of the levels waits in order to get a package.

COMMISSIONER TRACEY: Is there anything arising that can't wait until the resumption?

DR McEVOY: I think not, Commissioner.

COMMISSIONER TRACEY: Very well. The Commission will adjourn until five past 12.

ADJOURNED **[11.50 am]**

RESUMED **[12.16 pm]**

COMMISSIONER TRACEY: Yes, Dr McEvoy.

DR McEVOY: Thank you, Commissioner. Ms Buffinton, Commissioner Briggs asked you before the break some questions about issues of priority. I want to come to priority in a moment but just before we do, can I just ask you one final question about the My Aged Care portal and the call centre. Do you know, in approximate terms, how much it costs to provide the website and the call centre?

MS BUFFINTON: I prefer to give you the figures because the figures that I – come to mind are the ones that include the whole IT system that runs the whole aged care system plus the website plus the contact centre. So I would be very happy to give you breakdown of those individual items.

DR McEVOY: And you would say, would you, that you would have to divorce the other aspects - - -

MS BUFFINTON: So there's a very clear contract, for example that we have with Stellar for the operation of the call centre in terms of the cost of running and the staff and the overheads of the three contact centres.

DR McEVOY: Yes.

MS BUFFINTON: There's then, of course, the cost of the website, the production of the website, managing the website - - -

DR McEVOY: Just on the – sorry, just on the contract with Stellar for the operation of the call centre, do you know, approximately, what that cost is?

MS BUFFINTON: I think given the Royal Commission, I would prefer to provide it but what it does include is there is baseline costs. There are minutes of calls costs. So there's a whole range of things that make up our contract with Stellar to be the final number.

DR McEVOY: And then there's the cost of the website, which you said production of the website, management of the website, if you threw all of those things in, if you included all of those things, are you able to give an approximate cost of that part of it at the moment or - - -

MS BUFFINTON: I would prefer to give you the correct figure.

DR McEVOY: Do you know what the budget allocation is for the operation of the My Aged Care system?

MS BUFFINTON: The – the ballpark figure for the website and contact centre will be in – in the order of 40 to 50 million dollars.

DR McEVOY: Okay.

MS BUFFINTON: The underlying running of the My Aged Care IT system would be in the order of 20 to 25 million dollars. Then there would be the system enhancements that we make and the government announced over these current 18 months that there is $63 million going to the development and enhancements of the My Aged Care system.

DR McEVOY: Which would be on top of those figures that you've just - - -

MS BUFFINTON: Of the actual running of the IT system, yes.

DR McEVOY: Yes.

MS BUFFINTON: But I would prefer to give – I mean, they're recollections, and I think in a Royal Commission it's important that we give you the exact numbers.

DR McEVOY: Yes, thank you, Ms Buffinton, for that. All right. So, going back to priority, operator, could you please bring up CTH.0001.1000.4836. Now, you would be familiar with this document. Can you go, please, operator, to the second page of that document and you see there about halfway down on the right-hand side, in the right-hand column, you've got the heading High Priority. A high priority for home care services is defined is as:

> *Client is considered at urgent and immediate risk in terms of their personal safety or at immediate risk of entry to residential care.*

So what happens to people who are in that immediate risk position? Do they still have to wait in the same queue?

MS BUFFINTON: As we were just discussing, if, for example, you're on a level 4, we can connect somebody to a level 2 service within the next week or two, so effectively immediately. We can get them to a level 3, at the moment, in a matter of about eight weeks.

DR McEVOY: And is that what happens in circumstances of immediate risk, is it?

MS BUFFINTON: So if somebody has a high priority that's what would happen, and then they would eventually get their level 4.

DR McEVOY: How does the queue actually work? Is there some sort of algorithm that - - -

MS BUFFINTON: That's what we discussed before. So there is both an algorithm to make sure that both queues are moving but there is also, if you like, human intervention, like, we don't just rely purely on an algorithm, but it is to ensure that once the assessor has made a high priority assessment, that we can connect people to care quickly.

DR McEVOY: Do you know what the algorithm is?

MS BUFFINTON: No.

DR McEVOY: I should tender, Commissioner, the document up on the screen at the moment, CTH.0001.1000.4836, a communication from the Department of Health entitled Guidance on Priority for Home Care Services. I don't suppose, Ms Buffinton, you would happen to know what date that document or what approximate date that document would be?

MS BUFFINTON: No, sorry, I don't.

COMMISSIONER TRACEY: I think it's sufficient that if I identify it as the Department of Health Guidance on Priority for Home Care Services, and that will be Exhibit 2-91.

EXHIBIT #2-91 DEPARTMENT OF HEALTH GUIDANCE ON PRIORITY FOR HOME CARE SERVICES (CTH.0001.1000.4836)

DR McEVOY: Thank you, Commissioner.

Can I move to the issue of the wait list, perhaps in a bit more detail, Ms Buffinton. And, in particular, to paragraph 63 of your statement. So, you have there set out some information in relation to the mean time elapsing between eligibility and actual assignment in the '2016/17, '18/19 years. And so I think in '17/18 it's seven months for level 1, 13 months for level 2, 16 months for level 3, and 22 months for level 4. The trajectory is going up, is it not, but the total package level is going down.

MS BUFFINTON: The trajectory from what base? Sorry, you mean as you go from a level 1 it's a shorter wait time for a level 1 to a longer wait time for a level 4, is that - - -

DR McEVOY: Yes.

MS BUFFINTON: Yes, because $8000 packages are sort of more easily to be made available than a $50,000 package.

DR McEVOY: Do you think it's the case that people in rural and regional areas are having to wait longer than those in the population centres?

MS BUFFINTON: One of the major changes that I want to highlight for the changes in February 2017 is, up until February 2017, we provided places to providers. Whereas, since the 27 February 2017, we now provide the package to an individual. So it is the date of the assessment – so if you were provided an assessment in a rural area or in an urban area, your wait time is irrelevant to your location. It's you as an individual.

DR McEVOY: But do you – going back to my question, do you know, as a matter of fact, whether people in rural and regional areas have to wait longer for their services than people who might happen to be in the population centres?

MS BUFFINTON: Yes, to clarify, the question you asked is did they have to wait, you didn't say about services, sorry. That was where – for once they've got – once they've got their package, they don't have to wait longer to get their package from their assessment. But in order – in rural areas, what we do know is that - - -

DR McEVOY: So is the answer to that question yes or no?

MS BUFFINTON: It depends on the area, but there are more services available in urban areas than rural areas. But what we know – and we print in our quarterly report, is that in all planning regions other than – all our planning regions other than in remote that we have at least two active providers who actually have consumers on

their books in each location, but we acknowledge that there is – there can be regional variation.

DR McEVOY: Do you consider that you have a clear-sighted vision here? In other words, do you consider that you know enough about differences between waiting periods for service in rural and regional areas as compared to waiting periods for services in population centres?

MS BUFFINTON: What we can tell is once people get a package assigned, they can get connected to a provider once they have the package assignment, reasonably, you know, quickly because that's very attractive in a market environment. Now that – you've now got the package, for example, a level 4 subsidy of $50,000, and providers are keen to provide services to you. We acknowledge that as you get further into more remote areas, getting – getting the types of services that are more akin to a level 3 and level 4, can take – can take some time or in remote areas not be available.

DR McEVOY: And is that consistent with community expectations, would you say?

MS BUFFINTON: It's not – it's not. It doesn't meet community expectations that there should be equity of access to aged care. I think it goes well beyond just aged care with some of those access issues, but equally we know – and that's why we publish our quarterly report – it's not a stark contrast between regional and metropolitan Australia but it is a more stark contrast in remote Australia.

DR McEVOY: And what's the Department doing to address that mismatch, as it were?

MS BUFFINTON: So the Department has a range of additional subsidies like viability supplements, that I'm sure over the course of the Royal Commission you will hear about, across the aged care system to seek to try and support providers to be available in more remote areas.

DR McEVOY: Operator, could you bring up RCD.9999.0028.0001. Now, you are familiar with this document, Ms Buffinton?

MS BUFFINTON: Yes, I am.

DR McEVOY: So this is a report on home care packages published in March of this year, relating to the period 1 October to 31 December last year. If I could ask you to go to page 14 of that document, operator, which – yes, that's correct. So you will see there, Ms Buffinton, that that document describes the estimated wait time for approved packages as in relation to level 1, three to six months, 12 months plus for level 2, 12-plus months for level 3, and 12-plus months for level 4. So that's the publicly available data on this subject. It's apparent, though, isn't it, from paragraph

63 of your statement that you, in fact, have rather more detailed information available to you on this subject; would you agree with that?

MS BUFFINTON: I would agree.

DR McEVOY: So I suppose what I'm wondering is why the publicly available data is so vague if there is clear data known to you in the form expressed in paragraph 63.

MS BUFFINTON: So if I could first just outline that in paragraph 63, that is the known wait time because that was from people's assessment to when they were connected to service. So, if you like, that's looking backwards. What is in table 12 is the estimated wait time for those who, for example, were getting an assessment for service dated 28 February – so I'm just pointing out two are looking backwards in tables 4 and 5, and in table 12 that's looking forward, but your point do we have greater information; so looking forward there are estimates and we do have greater information than is written there. But the reason why we use bandwidths you can't just put an exact date. Looking into the future, there are so many variables and that's why bandwidths are an appropriate rendition.

DR McEVOY: I suppose to be plain about it, Ms Buffinton, what I'm wondering is whether there's sufficient transparency in the home care packages program data report series that the Department releases to the world.

MS BUFFINTON: When somebody rings the contact centre, they get their individual wait times but it's still in bandwidths. With 12 months plus. That was a decision by government to render that at 12 months plus.

DR McEVOY: So do you think there's sufficient transparency or not?

MS BUFFINTON: I – I think that when that decision was made in 2017, so for the first time we started to render for individuals that in September 2017, and then this very general one off for an individual who has just got their assessment, we started to publish that in our quarterly data report and on My Aged Care in February 2018. So at the time a decision was made 12 months plus. Your question to me now is do I think that that gives – given the sort of known wait times, is that sufficient granularity, I think that's something that we at the Department need to discuss with government how we can bring greater granularity to those wait times.

DR McEVOY: Are you aware of the effect of the delay on health outcomes, of both intended recipients and their carers?

MS BUFFINTON: I think we've heard that clearly in the evidence during the week. Certainly, we want people to connect to interim levels of care to take up the opportunity of Commonwealth Home Support. But I do understand, and I have heard the impact on individuals and their carers.

DR McEVOY: And so in practical terms, what does the Department consider that people do in the period between when they're assessed and when they get access to care? You have mentioned some initiatives but for many people and we heard, for example, from Rita Kersnovske yesterday, there are very considerable delays in being reassessed and perhaps, in her case even, at the very least a constructive refusal to reassess and establish what changes there may have been to her care needs. Having heard that evidence, are you minded to think that there may be some refinements at the very least, needed to the system?

MS BUFFINTON: You asked me whether – I think earlier I said that I believe that we do need, first of all, to have greater granularity, so understanding what it means for 12 months plus. We do have a systems for reassessment and review of people's support plans, priorities and levels, and they are actively used. But can we continue to improve the system separate from the discussion on funding, but the system that we have; we can certainly continue to improve the system.

DR McEVOY: Commissioner, I should tender the home care packages program data report for the second quarter of 2018/19 dated March of 2019.

COMMISSIONER TRACEY: Yes. The home care package program report for the period 1 October 2018 to 31 December 2018 dated March 2019 will be Exhibit 2-92.

EXHIBIT #2-92 HOME CARE PACKAGE PROGRAM REPORT FOR THE PERIOD 1 OCTOBER 2018 TO 31 DECEMBER 2018 DATED MARCH 2019 (RCD.9999.0028.0001)

DR McEVOY: So, Ms Buffinton, just going back to this issue of transparency, we heard evidence from Ms Ruth Harris that in relation to a level 3 package, she was being told that it will be three to six months every time she called, and that was for a period of more than a year. That was from about November of 2017 to December of 2018. How do you respond to evidence of that kind?

MS BUFFINTON: Well, if I can take it generally rather than specifically, as the demand for the home care package program grew, we particularly got a major influx of people who were new, who had been assessed more recently. So in 2017. We also, because we wrote out to a lot of people who had assessments prior to 2017 and outlined that the home care package was changing, a lot of those people came over the next 12 months, came into – into the queue because their aged care assessment time was earlier they actually joined the queue ahead of somebody who has been assessed more recently. So during 2017/18 we were, for the first time, trying to understand the data, the numbers of people, what was the consumer behaviour when we offer a package, do they take it up or not. So you don't make the assumption that because we offer the package that people agree: they often don't take it up initially.

And so we found that we were, in trying to be helpful – so the first time we rendered this information was in September 2017, it really was our best efforts to get that forward projection which was hard to know. Large numbers of people with older assessments came in. Therefore, we were ahead in the queue and we started to realise that we were trying to be helpful and yet we absolutely understand that people were taking our word for the fact that if it was three to six months but then after three months it was still three to six months in this situation, that that could have been the case. I've explained that we've learnt a lot. So that now, in the last – over the last six months, as we've come to understand our data better and the queue has started to stabilise with a lot of these older assessment – people with older assessments having come into the system that our predictions are much better.

And so a related issue is the letter that we were seeking to send out three months prior to be helpful, and yet we've heard through the Royal Commission people then finding that they had to wait many more months than three months. But if I look at the last six months, when we've written out those letters to say that they're likely to get their package so that they can start preparing to try and be helpful, that that almost universally has been within three months of that letter that they've actually received the offer of the package.

DR McEVOY: I don't want to make light of this, Ms Buffinton, but what happens if someone literally dies waiting? Will the Department know about that?

MS BUFFINTON: Well, we – we – we learn about people's passing in a number of ways. Some families choose to let the contact centre know. Clearly, if somebody is in service, one of the other services, like Commonwealth Home Support, we would hear that by the provider entering that – into the My Aged Care system. We are connected with the Department of Human Services, so through their pension systems and so forth, that that is where the computers do speak to each other. So they have a births and deaths register that is constantly sweeping through the computers to alert us to, if people have passed.

DR McEVOY: I'm not sure that I take that as a ringing endorsement of the proposition that if someone were to die waiting, that the Department would know. Would that be fair?

MS BUFFINTON: We – we have a number of channels to know whether somebody has passed.

DR McEVOY: Well, I can, of course, accept that. Do you think that those channels are adequate?

MS BUFFINTON: No – no, they're not because while we hear for a large number of people who have unfortunately passed, we also know and particularly if it has only been a matter of weeks or months, that we will send letters out offering packages when people have passed. And sometimes I believe it's fairly rare, but there can be even much – may take us much longer, if somebody hasn't directly rung in or they

might not have been connected to a pension, for example, that it could be quite a long time and we send out a letter in good faith offering a package and, unfortunately, that person may have passed.

DR McEVOY: Do you have plans to try to improve that processing aspect of this?

MS BUFFINTON: We work with the Department of Human Services. So unless somebody rings My Aged Care directly and advises us, our means of knowing – and they're not with a provider already for some service like an earlier service like Commonwealth Home Support, then it would be our connection with the Department of Human Services.

DR McEVOY: Is that a no? So my question was do you have plans to try to improve that processing aspect?

MS BUFFINTON: This is something that we actively discuss from time to time with the Department of Human Services about how systems can improve.

DR McEVOY: I just want to go back to a few aspects of the Commonwealth Home Support Package Program, and I might take you to paragraph 24 of your statement. Operator, if you could bring that up. You might bring up the next page as well and put them both on the screen. So you see there, Ms Buffinton, in paragraph 24, you say:

> *Funding is provided by way of grants under grants agreements. The grant is paid to the service provider as a block or lump sum amount based on the amount of previous grants made to the provider and/or funding provided through growth or expansion rounds.*

What is a growth or expansion round exactly?

MS BUFFINTON: So, in addition to the grants that we may make, for example, we had grants from 2015 to 2018, and we've had a grant from 2018 to 2020. In addition, there is funding in our forward estimates, so in the money that the government puts aside for Commonwealth Home Support, for growth, because that's the growth in the population. So we, for example, in 2016 and 2018, offered grant rounds. And so I'm happy to go into the detail of that, if you wish.

DR McEVOY: Well, yes. So you say what you say in 24(e) and then if you look at paragraph 40(a) of your statement, which is on page 14, there you describe an allocation of funds from the CHSP 2016 growth round.

MS BUFFINTON: Yes.

DR McEVOY: And that announcement. So the impression one perhaps receives is that you are describing additional – you are describing that really as additional funding for 2016/17. Is that the position?

MS BUFFINTON: So, it's funding that's in the forward estimates but hasn't been allocated to providers. So the announcement of that $115 million of funding on 10 March 2017 was additional funding out with the – with the Commonwealth Home Support providers.

DR McEVOY: So, would you say that this has led to an improvement in the quality of care received?

MS BUFFINTON: So this aspect is the fact that there are higher volumes of service available. So that is a quantity. It's not necessarily a qualitative measure. But by virtue of the fact that there are increased services available and therefore the potential for earlier intervention in supporting people in their home; does it lead to a better quality occupational for an individual. It may. But that is – increased – increased funding available for increased numbers of services available.

DR McEVOY: So when CHSP providers provide their financial reports to the department to acquit the funds they have expended and provide assurance and evidence that grants funds have been spent for their intended purpose, which is something you deal with, what types of assurance do you seek from them?

MS BUFFINTON: So, this is – there are – the Department of Health has an arrangement with the Department of Social Services. So up until September last year they were our grant managers but there has been a decision of government that all community grants are now in a hub in the Department of Social Services. So what our – you know, what the grant managers undertake is, first, each provider needs to put in, twice a year, every six months, in the Department of Social Services' data exchange a report on all the services they've offered. So whether it's number of meals or numbers of hours of service. The grant manager then looks at the grant agreement, and checks whether that is the right level of service, whether it's under-service, so maybe only 40 per cent of what was expected of the number of meals were provided.

Or it could show they are using their flexibility of funding so that they can use some of their – do a bit of flexibility within their services. So that would suggest a high level of demand. The grant manager, in around about 25 per cent of cases, is not satisfied with what the information that the provider has provided. They go back and identify whether there's concerns. If those concerns remain, there is increased monitoring. So instead of half yearly reports they may expect monthly reports to make sure that the grants are being utilised in the appropriate way. So that is – if they continue to be concerned, we may shorten the level of the agreement. So we may say that there's only six or 12 months of grant agreement. So we shorten it.

Or, if we're totally dissatisfied with the use of the grant and the arrangement, we could terminate the grant if necessary. So that's the role of the Department of Social Services as opposed to the Aged Care Quality and Safety Commission who then look at this – whether the provider is providing those services against the quality standards.

DR McEVOY: So perhaps if we just go back, operator, to paragraph 24 of Ms Buffinton's statement, 24(e). I think that's where you say that:

> *DSS may approve the carryover of unspent grant funds into the next financial year.*

Is there a consistently similar basis for the making of the decision to permit that to happen?

MS BUFFINTON: So, under usual circumstances we would expect the underspent grants to be returned each year. The exception really was in 2016/17, as you've highlighted in paragraph – my paragraph 48, that there was a grant – a growth round. The decision was taken on 10 March, by the time we got those funds flowing, because it was across two years, of those $115 million in additional funds, we knew that by the time they were flowing it was the back end of the year and the whole idea is to get these funds out to have increased care. So a decision was made to allow, on an exceptional basis, that the grants under-spends for that year could flow to the following year in order to increase the amount of care going out. Otherwise we would have got the funding out at the back end, towards the back end of the year and it would have – we would have been required to bring back that under-spend, which would have been illogical because the whole idea is we are trying to get out an increased level of care.

DR McEVOY: Did it lead to an increased level of care, would you say?

MS BUFFINTON: Yes.

DR McEVOY: And on what basis would you say that?

MS BUFFINTON: Because those funds were able to be expended over the back end of 16/17 and also be spent across 17/18. And the Department of Social Services has been monitoring that spending. So for the most part, people who have got those additional grants have spent those additional grants.

DR McEVOY: Do you know how many providers were not spending their allocated sums?

MS BUFFINTON: That's a level of detail that I'm happy to take on – to provide to the Royal Commission.

DR McEVOY: Thank you. Perhaps I might have you go, operator, back to paragraph 40(b) of Ms Buffinton's statement. That's page 14. So this is just concerned with the funding of the CHSP program and you say that:

> *Last October the government announced funding of $100 million for the 2018 growth funding.*

So what's that expression, "growth funding" talking about is that to be regarded as an extension of funding?

MS BUFFINTON: So I was describing that in the forward estimates we have, if you like, unallocated, because it's growth funding yet unallocated, so that is for allocating.

DR McEVOY: So that's what it is.

MS BUFFINTON: And, sorry, when I just read that, I realise it's a little bit unclear because the announcement was funding for $100 million for the 2018 growth funding that was going to be covering 2018/19, 19/20 because if you look at the subparagraphs of the next five dot points, that adds up to around about $50 million. It's because there's going to be $50 million going out in 18/19, and $50 million going out in 19/20.

DR McEVOY: Right. So how are the priority areas determined – or identified, perhaps, is a better word, by the Department?

MS BUFFINTON: So this was working with the Department of Social Services, and our – and the grant managers. But also going out and talking with State governments, local councils and a range of other inputs. Is – but where we've seen providers constantly using all of their funds and often using any underspend, the 20 per cent flexibility and pushing that over, we can see that that indicates demand, and we also were looking at the proxy I described earlier today of elapsed time between an assessment and going into service. So in combination, we know that there are very – that there's wait times for domestic assistance; that there is, in terms of meals, that it's not because people are waiting for meals but because the number of – that a lot of the providers are providing either right up to the level of number of meals that they're meant to be providing.

And in some cases where people have said that the costs of providing those meals are now higher so the unit cost of the meal has increased. So that's how we've – we've worked out where the demand is by doing that analysis. And that has led to domestic assistance, meals, transport, home maintenance and home modifications being the area that we flowed the growth funding for these two years.

DR McEVOY: How was the dollar amount determined?

MS BUFFINTON: So that would have been with the Department of Social Services looking at the volumes and relative demand and multiplied by the unit costs in the grant agreements to come up with those figures.

DR McEVOY: So, in other words, you don't start with an amount of money that you have in mind; you do it the other way?

MS BUFFINTON: So we know that we have, for example, $50 million for the year but first we look at where is the demand, what's the story on that demand, and build from there.

DR McEVOY: Can I move now to the issue of unspent funds and interest on those unspent funds. Now, you have a heading Unspent Funds which is above paragraph 49 and your statement deals with these issues down to about paragraph 54. You would be aware from the evidence you have heard at the Commission this week that there are many people who save their funds for a rainy day, as it were. Is that how the system or the scheme is intended to operate?

MS BUFFINTON: Certainly when we were designing the system was in order to allow a level of unspent funds to accumulate. For example, somebody who has a carer who is wanting to use some respite care because they're going to be going on holidays and somebody is going to be coming in regularly or overnight and that can be quite expensive services. So typically, when we were designing the system, we thought that if people were holding on to around about 10 to 20 per cent of their package in unspent funds for that, that would be a reasonable level of unspent funds.

DR McEVOY: There isn't a mechanism, really, is there, for the Department to control the extent to which people save or hold back their funds?

MS BUFFINTON: So, we write – have written to providers to remind them that one of their roles is to make sure if somebody has got an assessed need and therefore an assessed level package that the consumers should be encouraged to spend those – those funds for their care because we don't want wonderful older people who are trying to just accumulate for something that they're worried might happen in the future but short-change themselves on their level of care and end up having a more acute health episode. So we've certainly gone out to remind providers. We don't have a view – because we don't have a real-time view of once the subsidy goes to a provider, we don't have a real-time view of the level of unspent funds.

DR McEVOY: So I think your answer is there really isn't a mechanism for the Department to have visibility or control of what happens in that regard?

MS BUFFINTON: Not – not at the moment.

DR McEVOY: So the effect of that, I think, is that the money ends up being held by the provider; would you accept that?

MS BUFFINTON: Yes.

DR McEVOY: Yes, so in paragraph 54 of your statement, if I might just direct your attention to that, on the subject of interest, you say:

> *The Commission has asked that I address interest that may be earnt on unspent funds in the HCP. The provider is paid funds comprising subsidies and*

supplements by the Commonwealth monthly. The Commonwealth does not give guidance to providers on whether interest may be earnt and does not require interest to be paid to the Commonwealth if it has been earnt.

That's a roundabout way of saying, isn't it, that providers get to keep the interest?

MS BUFFINTON: That's correct.

DR McEVOY: So let's just look at some examples of that. Operator, if you could bring up WIT.0035.0001.0001. You might remember, Ms Buffinton, that I tendered this morning before your evidence a redacted version of Mr Howie's statement; Mr Howie being the CEO of KinCare. And, operator, if you go to paragraph 27 of that statement, you will see that KinCare is holding a little over 13 and a half million dollars of Commonwealth funds, unspent. Do you see that?

MS BUFFINTON: Yes, I do.

DR McEVOY: And then, operator, if you could bring up WIT.0034.0001.0001, and go to paragraph 7.1 on page 10. Now, this of course, I should have mentioned, this is the statement of Ms Bowe who is the national director, home care services for Mercy Health. Mercy Health is a not-for-profit. KinCare, which was holding the slightly over 13 and a half million in unspent funds, is a for-profit provider. When I talk about the funds in question, it's only Commonwealth funds but there may also be consumer contributions in there as well. But going to paragraph 7.1 of the Mercy statement. Mercy Health is holding $16,985,405, so the best part of $17 million in unspent funds. Do you accept that that's a somewhat anomalous position?

MS BUFFINTON: Anomalous meaning that they're holding the unspent funds?

DR McEVOY: From the perspective of the Commonwealth – I don't necessarily make any criticism of these organisations in this respect. They're doing nothing more than the system permits them to do. My question, really, is whether you consider that that's an appropriate state of affairs?

MS BUFFINTON: I don't see it as an appropriate state of affairs. I think we have now come to understand the level of unspent funds and that is something that the government is – is looking at.

DR McEVOY: See, I say this in circumstances where, in paragraph 42(c) of your statement, you refer to the February 2018 announcement of $282 million for 10,000 home care packages. And then in paragraph 53 of your statement, you refer to the Department's – or to an estimate, Aged Care Financing Authority estimate that home care providers are holding $329 million. So well over $300 million in unspent funds, which is a combination of both Commonwealth and client contributions but it will be largely Commonwealth money. So you've got $300 million sitting there in the system, and a lot of people who are still waiting for home care packages.

MS BUFFINTON: Yes.

DR McEVOY: And we have heard evidence this week from Ruth Harris, amongst others, of her mother moving into residential care because, after waiting for a level 3 package over months and months, she couldn't run the risk of continuing to wait. So I suppose the question that arises is whether there are policy considerations which are being taken into account at the moment about how those unspent funds can be utilised and how you can strike a balance between, on the one hand, the need to save some money, to put some money aside in the event of future needs and what might be the best use of what is predominantly Commonwealth money.

MS BUFFINTON: Yes, and the government is giving consideration to that at the moment.

DR McEVOY: And do you have any sense of how long it will be before that concern is addressed?

MS BUFFINTON: That will be a decision for the government.

DR McEVOY: But you would accept, wouldn't you, that it has to be a real priority where access to care is restricted in the way that we're seeing that it is.

MS BUFFINTON: Yes. I would agree that when we were designing the system, we didn't foresee the levels of unspent funds, and I think all of us would like to see better utility of those unspent funds.

DR McEVOY: We were speaking earlier in the context of level 4 packages of – just speaking in round terms, I think we agree that we would call that about $1000 a week. And I think you expressed some concern to the extent that that might only be resulting in about nine hours of care.

MS BUFFINTON: No, I think that – I was concerned to hear that there was only nine hours of care. I would expect that to be higher than nine hours.

DR McEVOY: Higher than that, yes. Operator, could you please bring up RCD.9999.0030.0001. Now, this chart is taken from the StewartBrown Aged Care Financial Performance Survey Home Care Report 2018. You're familiar, I take it, with the StewartBrown reports?

MS BUFFINTON: Yes, in general, yes.

DR McEVOY: At a general level, yes. Now, on the basis of data taken from a sample apparently of 21,700 packages, and the data covers a period for nine months to March of 2018 in the 2017/2018 year, what you will see is that with respect to band 4, the direct service provision appears to be only slightly over seven hours per week. So, it may be that even the nine hour figure that you have in mind is an exaggeration. Would you accept that?

MS BUFFINTON: The nine hours that I had in mind, I was referring to some evidence during the course of the week.

DR McEVOY: Yes.

MS BUFFINTON: If it's seven hours, that would absolutely increase my concern even more.

DR McEVOY: And what steps might it be possible for the Department to take to identify whether evidence of the kind that we are seeing is, on the whole, accurate?

MS BUFFINTON: So what we have described today is that we didn't have – once we get the funding out to the provider and the arrangement between the consumer and the provider, the Department has not had visibility of those arrangements of the costs of service. And when I described the work that the Minister has put in place, which was starting with getting providers and consumer groups to come together and look at how we can increase greater pricing transparency on what is a market-based system. So by getting the – by getting – for us, getting the prices put on individual PDFs, put on individual provider sites starts to give us transparency and from 1 July with the mandatory filling in of the information on My Aged Care we will get greater transparency.

What is my expectation? I think it will go a little bit like the way of exit fees. So if I could just highlight in the quarterly report, on page 16 – I will just describe it, you don't need to bring it up. But when we started, we did ask that providers publish exit fees. So when we began in February 2017 it was nearly $300 if somebody was exiting. And just because it is publicly exposed, and because it's mandatory for that to be on a website, that that has, over time, gradually declined to now it's around about $230. So what our expectation is, is that by making pricing transparent, that market forces – I'm sure media will help with people being aware as we all look to see with interest what fees are being charged, that consumers will become more informed.

We do, when we give people the three months to go for their package, we do include a small brochure. This is part of the improvement that we've made with the system, which is what is your check-list, what are the questions you need to ask of your provider. And that is aimed – and I'm happy to tender that to the Royal Commission – these are trying to help older people and their families to not just accept what may be prices advised but they should be, where possible, active consumers and, you know, pay attention to what is being charged, what's in the monthly statement, and so forth. So, with pricing transparency, I think it is a good start for that. But, absolutely we are now going to be monitoring these prices and levels of overhead as opposed to the proportion that's going to care, carefully.

DR McEVOY: You've referred to the operation of market forces in that answer, and it's an expression you've used before and, indeed, has often been used by representatives of the Department. Do you think there might be a question about

how market forces are operating in the aged care sector and, indeed, the extent to which they're properly applicable in that sector?

MS BUFFINTON: So the design of the home care package program was designed with consumer directed care and a market in mind. I think the weaknesses have been the lack of transparency and, in hindsight, why didn't we ask for that pricing transparency right from the start? It is one for us to look back and say it's something that we should have but now – and David Tune pointed out that that was something, if you are going to have a market, you absolutely need comparable prices and an oversight, particularly when it's taxpayer's money involved.

DR McEVOY: Commissioners, it has been taken down from the screen now but I should – there it is – tender the StewartBrown Aged Care Financial Performance Survey Home Care Report 2018, Figure 9, March 2018 staff hours per client per week.

COMMISSIONER TRACEY: Yes, Figure 9 of the StewartBrown report dated March 2018 will be Exhibit 2-93.

EXHIBIT #2-93 FIGURE 9 OF THE STEWARTBROWN REPORT DATED MARCH 2018 (RCD.9999.0030.0001)

DR McEVOY: Thank you, Commissioner. Just staying on the Tune report, Ms Buffinton, I think we may have mentioned recommendation 7 before. I will just read it to you to remind you. Recommendation 7 was that:

> *The government introduce a level 5 home care package to allow people with high care needs to stay at home longer with the level of assistance being no higher than the average cost of care in residential care.*

Are you able to say what the Department's position on recommendation 7 is?

MS BUFFINTON: Well, it's really the government position. So after David Tune made that recommendation, the Department did do a range of consultation with both consumer groups and provider groups. There was quite clear agreement that at this point – and we've got to remember the timing of that report was in 2017, September 2017 – when the length of the queue and the demand for home care was just coming to the fore because the first quarterly report was printed in September 2017. The provider and consumer groups felt at this time that the focus needed to be on getting sufficient level 1, 2, 3 and 4 packages. And also there was an element of concern of what actually a level 5 package might mean in terms of risk and level of frailty. So, at this point, the recommendation back to government was that a level – rather than a level 5, the focus should be on getting sufficient level 1 to 4 packages. And so at this point, there's no work being undertaken on the development of a level 5.

DR McEVOY: Recommendations 15 and 16 of Tune, I will just read, I know you are familiar with them but I will just read them to you so you know precisely what we're talking about. Recommendation 15:

> *That the government abolish the annual and lifetime caps on income-tested care fees and home care means tested care fees in residential care.*

And then recommendation 16:

> *The government introduce mandatory consumer contributions for services under the Commonwealth Home Support Program. Consumer contributions should be standardised according to individuals' financial capacity.*

In relation to recommendation 15, the abolition of annual and lifetime caps, this recommendation has been rejected by the government, I think, hasn't it?

MS BUFFINTON: That's correct.

DR McEVOY: And were you involved in that decision?

MS BUFFINTON: I was not.

DR McEVOY: Do you know who was?

MS BUFFINTON: Yes, I do.

DR McEVOY: Within the Department?

MS BUFFINTON: Yes.

DR McEVOY: Could you perhaps indicate that?

MS BUFFINTON: So, my peer, that would have been Jaye Smith – I'm just trying to remember – so the First Assistant Secretary who looks after residential care and funding for the aged care system, whether – I will exclude the individual because it's whoever was in that position at that time.

DR McEVOY: Yes, I see. So it would be fair to say, would it, that you're not aware of the factors that were considered in rejecting that recommendation.

MS BUFFINTON: No.

DR McEVOY: Commissioners, I think that I have dealt with everything that I hoped to deal with, with Ms Buffinton. So, subject to any questions any further questions you may have, she may, for the moment, be excused.

COMMISSIONER TRACEY: Yes. Thank you, Ms Buffinton, for your evidence. You are excused from further attendance.

MS BUFFINTON: Thank you.

<THE WITNESS WITHDREW [1.27 pm]

COMMISSIONER TRACEY: The Commission will adjourn until 2.30.

DR McEVOY: If the Commission pleases.

ADJOURNED [1.28 pm]

RESUMED [2.36 pm]

DR McEVOY: Commissioners, I've provided to your associate a list of documents to be tendered. They comprise a series of documents that were relevant and referred to during the examinations of Mr Josef Rack. The list also contains three documents concerning Mr Vincent. So I would seek to tender those documents and they can be given numbers.

COMMISSIONER TRACEY: Yes, those documents will be received in evidence and will a bear the exhibit numbers sequentially from Exhibit 2-94 to 2-103.

EXHIBIT #2-94 TO 2-103 DOCUMENTS

DR McEVOY: Thank you, Commissioner. Commissioners, I would make the following closing remarks. Over the last week the Royal Commission has heard evidence regarding the supply and quality of aged care services needed by Australians in their homes. This is a very important aspect of the Royal Commission's work because all the indications are that older Australians in need of aged care services wish to remain in their own homes and receive those services there rather than moving to residential care. The hearing examined key matters affecting the provision of aged care services in the home. Today I will address seven broad topics arising from the hearing. When I turn to each topic, Commissioners, I will notify noteworthy aspects of the evidence.

In respect of certain of the topics I will also foreshadow factual findings which we currently intend to ask you to make in due course. To the extent I can, I will describe the relevant implications and issues that appear to arise. In the main these are issues

to which the Royal Commission should give further attention in the coming months and over the course of the inquiry, the intention being to make recommendations for reform of the existing regulatory policy and funding framework. I recommend, Commissioners, that you permit any party with leave to appear to provide written submissions within seven days addressing the closing remarks I am making. To avoid doubt, there is no obligation on any party to make a submission.

Can I deal, first of all, Commissioners, with the subject of accessing My Aged Care. This topic concerns the experiences of older Australians attempting to use My Aged Care. The Royal Commission has heard evidence regarding the difficulties people face when using the My Aged Care systems to seek access to aged care in the home. This evidence included testimony of Ms Mary Patetsos from the Federation of Ethnic Communities' Councils of Australia, Ms Clare Hargreaves from the Municipal Association of Victoria, Mr Paul Sadler of Presbyterian Aged Care, and the personal experiences of Ms Ruth Harris, Mr Josef Rack, Ms Raelene Ellis, Mrs Marie Dowling, and Ms Rita Kersnovske.

There was a consensus between these witnesses as to the difficulties which arise when older Australians seeking home care have to navigate the My Aged Care website or to contact the call centre. This consensus is consistent with evidence you heard in our first hearing in February. It is Ms Patetsos' evidence that the modes of communication required for navigating My Aged Care are the least preferred modes for aged people from culturally and linguistically diverse backgrounds to communicate. My Aged Care is a real barrier for people who are not confident with online systems or cannot use a mobile phone, including those of diverse backgrounds. Reliance on these modes of communication means that older people are more reliant on technology-literate informed carers, often family members, to access information about their care.

This conclusion is supported by the evidence of Ms Hargreaves that South Australian councils are reporting that older residents still contact them by phone or in person seeking help and support navigating My Aged Care. That is because councils have a long history of providing home care services. Ms Hargreaves considers that South Australian councils are often the first point of contact for older members of the community who have a strong sense of trust in council services. Ms Hargreaves believes that some vulnerable clients are left without aged care supports due to the difficulty in accessing services through My Aged Care. Mrs Kersnovske, who is confident with technology, gave evidence that in her experience the online component of My Aged Care is 'almost hopeless' and instead she waits on the phone, sometimes for an hour, to speak with someone.

Mr Rack, a home care package recipient gave evidence that he cannot find his way through the My Aged Care website so he rings instead. Ms Dowling gave evidence of her experience trying to communicate with My Aged Care when her only option was to do so by telephone. Ms Dowling has been legally blind for 30 years and had to call to ask for documents with larger print to be mailed to her. She considers it a major flaw of the system that is targeted at the aged population whilst all the

information is online. Ms Dowling needed special assistance to find a provider to administer her package, a function that My Aged Care does not provide. And it was pure chance that she was put in touch with a man working at the local hospital who gave her such assistance.

Mr Sadler said that the online environment could be far more user friendly simplifying the letters sent to consumers so that they are easier to understand and highlight key information, tailoring the system to address any cultural and language issues of older people from Aboriginal and Torres Strait Islander or culturally and linguistically diverse communities. Mr Sadler supports the aged care navigator trial, the Commonwealth Government-funded program testing different types of services and activities to help people learn more about government supported aged care. There are also pressing issues concerning the quality of the information provided by My Aged Care. Ms Harris told you that from her dealings with My Aged Care she was left with the impression that call centre staff just read from a screen and deliver set lines.

Although her mother had been waiting for a package for over nine months she was given the same information that she was given when her mother was first approved for a package, namely that it should be expected in three to six months. That was in or about late November 2017. The same information was repeated a number of times as she tried to accelerate access to a home care package. Ms Ellis, who acted as a carer for her mother, said that:

> *My Aged Care were really, at most times, pretty useless. I suspect they are a waste of money. Apart from referring you to other agencies, they offer very little assistance in terms of actual knowledge about the Aged Care System.*

Ms Dowling told you that she found the My Aged Care call centre to be horrible and that she would often get the wrong information. Commissioners, you will recall from the February hearing that survey results suggested that more than 20 per cent of users considered that My Aged Care contact centre did not provide reliable information. Today you heard from Ms Buffinton. She is responsible to ensure that My Aged Care is an efficient and effective point of access to the Australian aged care system. She explained some research into the experiences of users of My Aged Care. Ms Buffinton was also able to describe some of the planned reforms and emphasised that My Aged Care is more than just the digital platform. For example, the call centre receives 1.4 million calls each year and now, apparently has an average wait time of 30 seconds. Those reforms suggest some acceptance that there is room for improvement at My Aged Care. But even faced with portions of the evidence already before the Royal Commission, Ms Buffinton did not accept My Aged Care was failing the community.

On the evidence for the above reasons, and in at least the above ways, the very people who most need to obtain access to aged care services in the home are confronted by aspects of the My Aged Care channels which inhibit their effective engagement with the system. The generation currently most in need of aged care

services is not generally computer adept. Call centre processes are challenging for many people, let alone people who are potentially living with auditory deficits. It is not respectful to expect the people who most need to use My Aged Care to deal through these channels. Over time, as more computer adept generations move into the cohort requiring aged care services web-based channels may become more the appropriate option but for the present something else needs to be done. The navigator trials may provide a useful first step. We understand that a more consumer focused My Aged Care website may be launched in 2019.

In our submission, Commissioners, three broad themes have emerged. First, My Aged Care has a single national phone number supported through a call centre network and an online portal. A broad range of older Australians experience difficulties using these channels, creating barriers to the effective use of My Aged Care. Secondly, the quality of the information provided by My Aged Care is perceived as falling short of community expectations in that the prevalence of the call centre providing information regarded by users as unreliable or unsuitable is significant, and the website does not support older people to exercise choice and control.

Thirdly, the services provided by My Aged Care are not accessible for people with hearing or visual impairments, people with communication difficulties, including those brought on through dementia or people from culturally and linguistically diverse backgrounds. Access to services that are suited to LGBTI people is also important. This is particularly important on the evidence of Lynda Henderson because, as dementia progresses, people may become who they have always wanted to be. It is likely that as the Royal Commission progresses into other themes, more attention will be brought to bear on My Aged Care. Stating that the My Aged Care system has certain general defects is one thing. To produce a solution or a set of reforms and modifications to make it fit for purpose is a very different thing.

At this stage, we can do no more than pose the need for modifications and flag that this issue requires deeper attention as the Royal Commission progresses. All parties with leave to appear will be permitted to provide written submissions addressing the following question: what improvements to the current My Aged Care system will best meet the needs of people accessing the call centre or website?

Potential improvements for accessibility to aged care services in the home already raised in the Commission's inquiries include (a) the addition of individual case managers, (b) establishing nationwide access to face-to-face assistance, and (c) making website and call centre improvements. Introducing improvements such as these raise questions of funding. In future hearings the Royal Commission will be examining the sustainability of the aged care system and financial implications of changes to the existing system.

Can I deal next, Commissioners with the waiting list for appropriate aged care services in the home, a very significant issue.

The waiting times to which older Australians have been subjected in between being assessed as needing home care packages and actually receiving funding for care are severe and unacceptable. This has caused great suffering and continues to do so. The long waiting lists are cruel, unfair, disrespectful and discriminatory against older Australians. Community expectations would be that older Australians receive the care that they need without delay. At the highest level of need, being a level 4 package, as at 30 June 2018, the waiting time was almost two years. The waiting time between assessment and the allocation of the funding *must* be reduced as closely as practicable to zero. There are also incidental aspects of the assessment and assignment process that need attention.

For a person seeking aged care services in their home, there is an immediate bifurcation depending on whether the person is likely to be assessed as only needing the entry level support of the Commonwealth Home Support Program, commonly referred to as the CHSP, or whether greater levels of support are needed under a home care package, which is commonly referred to as an HCP. This judgment is made by My Aged Care. The two assessments are conducted by different organisations. The regional assessment services, RAS, conduct assessments in the case of CHSP. Access to an HCP requires assessment by an aged care assessment team, commonly referred to as an ACAT. This is known in Victoria as an aged care assessment service.

The ACAT assessment aims to determine what level of care a person requires against the four levels. They also consider what priority the person should be given. The options are medium or high. These are both typically organised through My Aged Care which, as just detailed, has its difficulties. Thus, a person needing care might find themselves in the confusing and inconvenient position of needing successive assessments by these three different organisations. For many older Australians, this means duplication and inefficiency in the assessment process of their individual need. You should accept the criticism of this duplication by Paul Sadler of Presbyterian Aged Care as being inefficient and unnecessary.

Mr David Tune AO PSM recommended integration of the workforces who perform these assessment processes in his 2017 review. The Department of Health has released a discussion paper on this matter. The Commission will pay close attention to any developments over the coming months. We heard from Ms Kersnovske and Ms Harris about the multiple assessments people can be subjected to and we heard that often the assessment result does not align with the service that may be eventually provided. Ms Hargreaves says there is insufficient communication between My Aged Care and assessment services, leading to 'over-screening' or multiple unnecessary assessments.

This might lead us to reconsider the need for multiple levels of assessment performed by different agents. Ultimately, does assessment not have a single purpose – to determine one's needs for assistance? Are completely independent assessments required just because of where the money for a service originates? Turning now in more detail to HCPs. First of all, assessment of the person's care needs must occur,

followed by the production of an assessment letter. Secondly, before any actual funding becomes available, in a step that occurs separately and comes a considerable time after the assessment letter is issued, there must be an assignment of the entitlement to funding, which is known as the allocation of a package.

This allocation may not always be the level the older person was approved for – sometimes, they may only get access to a level 2, when they need a level 4. This second step, involves moving through a significant and unacceptable waiting list. This is due to rationing by government of aggregate numbers of home care packages. Further, significant numbers of people who have been assigned a home care package have not been on a package adequately meeting their needs because the current system, as a so-called interim measure, offers assignment for a lower and less satisfactory level than that which corresponds to the person's actual need.

You will remember that Ms Warrener gave evidence at our last hearing that she was told in February 2018 that her husband's home care package would be available in three months. It was still not available in February 2019. At this hearing, Ms Hansen, a personal care worker, told the Royal Commission about one of her clients who is receiving a level 2 home care package despite being assessed as needing a level 4 package. Ms Hansen reported that her client has basically been told that she needs to wait, literally, for a level 4 recipient to die or move into residential care before she can get a level 4 package.

Ms Buffinton told you this morning that home care packages are not effective at this time. She said that there was an unprecedented increase in demand; moving from potential 64,000 packages in June 2016 to 92,000 services in June 2018. The unprecedented increase in demand follows the reforms introduced in February 2017, and in particular the move to consumer directed care. She estimates that if home care packages were provided to all people on the waiting list at the level of their assessed need, the annual cost would be approximately $2 to $2.5 billion dollars. During the 12 month period ending 30 June 2018, a total of 212,857 people appeared in the national prioritization system for at least some part of the year.

Of these people, more than 16,000 died, waiting for a package that they never received. Long wait times first became clearly exposed to public scrutiny when numbers were reported publicly from September 2017. Mr Sadler says that the creation of the national pool of HCPs highlighted the length of the waiting list for packages. The need to address waiting times for high level home care packages was identified by Mr David Tune AO PSM in his 2017 *Legislated Review Of Aged Care*. Mr Tune made a number of recommendations associated with addressing the disproportionate wait times and demand, in particular recommending an increase in supply of high level home care packages.

The Home Care Packages Program Data report published by the Department does not specify the duration of wait times for level 2 to 4 packages beyond saying that they are 12-plus months. However, the evidence at this hearing indicates that in 2017/18, the average wait time was, for level 1 packages, seven months; for level 2

packages, 13 months; for level 3 packages, 16 months; and for level 4 packages, 22 months.

At this hearing Ms Ellis told you that despite being assessed as needing a level 4 package her mother had to wait just over 14 months to get a home care package at that level. During those 14 months her mother's health deteriorated dramatically, and they "still only received four hours of support a week".

Ms Hansen gave an example of a client receiving a level 2 package even though she was assessed as needing a level 4 package. The care recipient is basically being told that she needs literally to wait for a level 4 recipient to pass away before she can get a level 4 package. Her other option is to move into residential care. In her written statement, Ms Rosemary Dale said that, "I am aware from conversations I have had with them that most of the clients I see have accepted a lower level HCP, and are still waiting on the level 4s. These people take a lower level package because they are told their higher package is a few months away, but two years later they're still waiting". Ms Ruth Harris told you of the wait time for her mother and the decision, after waiting 13 months, to move into a residential aged care facility. She also told you of the offer of a level 3 package that was apparently sent by mail and never received.

It appears to be the reality that if an older person cannot get the care and supports they need, they may be forced into more expensive residential care. Ms Anna Hansen told you that waiting time forces people to go into residential care: they can't look after themselves without help and there's no home care packages available for them. Ms Harris spoke of her strong feelings about the wait times. As she said, 12 months is a long time to wait when you're elderly. She thought that she had said to My Aged Care at one point that they were 'waiting for them to die'. Ms Hargreaves from the Municipal Association of Victoria made the important observation that the longest wait lists are found in rural and remote council areas.

She also said that some clients with a low level of need are unnecessarily accessing home care packages contributing to the long wait of assessment and allocation of packages for people with greater support needs. Conversely, some clients of hers are refusing to move from CHSP to home care packages because of the sheer length of time waiting in the national queue and instead continue accessing their basic CHSP services. CHSP is therefore servicing some people with far more complex needs than the program is designed and funded for. This echoes the evidence of Ms Harker from the February hearings. A partial solution recommended by Ms Hargreaves is to discontinue level 1 home care pages and to role that funding into the CHSP.

On any measure, delays of this magnitude to access the care and support that is actually needed is unacceptable and raises real safety risks. There are more people waiting for care and support from a home care package at their assessed level than there are people receiving a home care package. Commissioners, you should place great weight on the following aspects of BAs evidence. BA explained that she had a client who required level 4 care, but who was only receiving level 2 funding while

waiting for the higher level package. Despite not receiving funding she said she gave him the care he needed.

BA said she was advised that she was doing the wrong thing and needed to stick to the home care guidelines and that she was over-servicing. BA says that through the additional care, her client was able to have a dignified death at home. He passed away before ever receiving his level 4 package. BA was filling a gap caused by the system at her own expense, and she should have at least been thanked for doing so. Recent announcements of additional home care packages such as in December 2018 and February 2019 are no doubt very welcome by those waiting for care. However, they do not come close to meeting current or projected demand.

In relation to the 10,000 additional packages in December, and another 10,000 in February, Mr Sadler said that there's also no question that those figures are quite small when you compare to a total waiting list of about 128,000. Mr Sadler estimates that somewhere around 40 to 50 thousand packages are needed to absorb the current waiting list of that 128,000. Evidence is building that delay in accessing care and support in your own home leads to earlier entry into residential aged care facilities and increased hospitalisation. Delay in providing services goes to the very heart of quality and safety in aged care. It pushes people into an institutional setting which is not where older Australians want to be, at significantly higher cost to the community.

I mention, again, the pressure that delays in waiting to access home care packages places on others around a care recipient. This is a very important issue. Informal carers themselves may become ill while supporting an older person to stay at home and as you have heard, the replacement value of their support is estimated at over $60 billion dollars. This is a cost not currently borne by the government. Professor Swerissen considers that aged care policy is faced with serious fiscal constraints and is struggling to balance adequate funding to provide universal access to services with user co-contributions.

Inevitably, when there is more demand than funding, people have to wait for services, service levels for individual have to be reduced, the cost of services has to be cut or some combination of these measures get put in place. He notes that as the Commonwealth has assumed centralised responsibility for aged care, the States, Territories and local governments have withdrawn from planning, funding and system coordination. He says that the Commonwealth has not instituted arrangements for localised system management to replace the role of the States etc, which has led to a weakening of local area-based service system planning, development and management.

While many people are able to access interim supports, either via the CHSP or by the offer of a lower level of HCP, that support will often need to be supplemented by private funds or by family members or both. Mr Tune recommended that a level 5 home care package be introduced to allow people with high care needs to stay at home longer. It is a recommendation which was repeated by Craig Gear of the

OPAN last month. Professor Swerissen argued for a model directed to funding individual needs that takes into account a person's "reasonable and necessary needs" as per the National Disability Insurance Scheme.

Ms Henderson and Mr Sadler also pointed to the size of packages under the National Disability Insurance Scheme as being much higher and more targeted to individual needs. Mr Sadler suggested that packaged care may benefit from a more sensitive funds allocation tool and highlighted the new Australian National Aged Care classification as a potential starting point. The Royal Commission has heard evidence at both this hearing and the February hearing that the assignment of a somewhat artificial and rigid package levels results in either much lower levels of service than required or significant levels of unspent funding. This prompts the question of whether there could be a more efficient approach to resource allocation than the four fixed levels of home care packages.

If another home care package level was introduced, more packages released or the use of levels reimagined so that the aged care system matches funding to actual access need, there is a question about whether there are sufficient providers and staff to meet that demand? The answer to this question, Commissioners, is complex and involves a range of issues, including those about workforce capacity and capability. It also involves issues about the adequacy of other systems that would be affected by the growth that would be required across the sector including the processes to approve, monitor and regulate service providers. It would also involve issues of stewardship of the sector and leadership and governance within providers. This is another example of the importance of seeing home care as part of a better integrated aged care system.

In our submission, the following key issues can be identified.

a) First of all, the existing shortfall in the availability of access to aged care services in the home needs to be addressed. The availability of aged care services in the home must meet the existing and future needs of older Australians to live with dignity, *with their needs met, in their homes*.

b) Secondly, the cost of meeting the existing needs for aged care services in the home needs to be identified. By this, we mean the actual cost of the services should be ascertained, not the arbitrary allocation of a budgeted amount at one of four levels.

c) Thirdly, ascertaining the projected cost of aged care services into the future is critical. This is particularly so in light of Australia's ageing population and the growing expectation and desire Australians have to age in their own homes rather than in residential aged care facilities.

d) Finally, each of the issues clearly raised the issue of funding. What does a sustainable funding model look like? What is the appropriate balance in funding

e) contributions from government and those receiving care that is sustainable, both for individuals and for the broader community?

Once again, these are complicated matters and they will require deeper attention as the Royal Commission progresses.

Can I turn now to the approval of providers of home care. This topic has focused on the process for approval of home care providers. This is not a topic on which we ask at this stage for particular findings to be made. For the moment we confine ourselves to a review of the evidence which appears to raise the need for improvement of departmental resourcing and processes in certain respects.

Division 8 of the *Aged Care Act* of the Commonwealth sets out the approval process for a body corporate that seeks to be a provider of home care packages. To be an approved provider an organisation must be able to demonstrate it is suitable to provide aged care services. A number of matters fall to be considered by the Department of Health in deciding whether to approve a provider. Under the Act, it appears that approved provider status continues indefinitely unless revoked. Commissioners, you heard evidence as to the workings of the Department relating to such approval from the perspectives of two employees of the Department, one of whom, Mr Graeme Barden, was assisted by the legal representatives of the Department and the other of whom was not assisted by the Department and gave evidence under the pseudonym, BE.

You also heard evidence from a person engaged in providing home care, BC, whose experience was that her organisation, BD Proprietary Limited, was granted approved provider status after satisfying a number of information requests, only to be assessed by the then Aged Care Quality Agency as not meeting the home care quality standards and subsequently being sanctioned six months later by another area of the Department for non-compliance relating to the matters about which BD Proprietary Limited had been scrutinised during the approval process. At that time, the Agency was responsible for holding approved aged care providers in receipt of Australian Government funding accountable against the applicable standards for residential aged care home services and national Australian and Aboriginal and Torres Strait Islander Flexible Care Services.

The Agency was also required to promote high quality care and service provider performance through education, training and compliance assistance. Witness BE gave evidence in response to a summons to appear that was issued under the I. She told the Royal Commission how, from her perspective, the approval process is administered by the Department of Health. In her statement, BE said that the number of applications since 2017 has been relentless. The Act – and this is section 8.5(1) – contemplates that the Department must decide an application for approved provider status within 90 days, subject to extensions of time while additional information may be sought.

At one point in 2018 there were 140 applications that were not decided within 90 days. She could not recall the number of applications presently outstanding. BE explained that there are only three permanent positions for assessors in the team. They are supplemented by contractors from recruitment agencies as appropriate. While there are good contractors, those contractors need training and the constant turnover of contract staff, she said, creates challenges. According to BE the standard of applications for approval are not always good and BE suggested there was evidence of consultants selling boilerplate applications to prospective providers.

Sometimes these boilerplate applications tick all the right boxes for approval but can still leave doubts in the minds of assessors. BE was able to discuss those doubts with others in the Department. BE put it in these terms:

> *An application only needs proposed methods. An applicant doesn't need experience … To purchase an 'off-the-shelf' application from a consultant does not prove suitability to provide care under the Act. It simply proves one company can purchase an often inferior product from another. I will be fair to applicants; if it meets the criteria it must be approved, and I can't knock them back just because I have a bad feeling.*

BE was concerned that some applicants may have slipped through and as there is no longer any second vetting for home care packages through the Aged Care Approval Rounds, there is a cluster of providers already in the system with compliance issues. There may be a connection between that concern and the increase in complaints over recent years. BE told the Commission that once approved, the process to revoke approved provider status was complicated. Graeme Barden, Assistant Secretary, Residential And Flexible Care Branch, gave evidence that there was a peak period in outstanding applications between about March 2017 and March 2018 owing to a greater than anticipated increase in applications after which the workload of outstanding applications decreased, such that there are currently about 60 applications on hand.

He accepted that the available team of assessors are not meeting the 90 day standard in all cases. The extent of the failure to meet the 90 day standard in the current 2018/19 financial year is in the order of 10 to 20 cases, according to Mr Barden's recollection. He also explained that on Friday, 15 March 2019 the Department put in place a process to obtain an additional permanent officer to assess some of the outstanding applications. Mr Barden confirmed that the Department assesses an applicant on the basis of a written application and supporting documents together, a limited degree of research. During his evidence, I referred him to a Departmental document relating to the approval process which records that in the 2017/18 year only 42 per cent of applications were approved.

It appears that there may be weaknesses in the administration of the approved provider approval process. I do not foreshadow seeking that any particular findings be made at this stage. I have, however, formed a preliminary view that the approval process may not be properly vetting applications to become an approved provider,

creating an expectation in a new provider that they are equipped to take on work that they were not ready for. The possible weakness in the approval process I've just mentioned may arise from the under-resourcing of the assessment and approval process, the lack of independent verification of information supplied, and perhaps a focus on formal matters at the expense of qualitative evaluation of the merit in the process evaluation of applications for approval as a provider. I consider that more work could be done by the Department to support and educate newly approved providers.

Can I turn next, Commissioners, to the regulation of services and ensuring quality and safety of home care. This fourth topic raised on the evidence this week related to the processes of quality and safety regulation of home care providers by the Quality Agency (the predecessor of the Aged Care Quality and Safety Commission) and by the Department. Questions are raised by the evidence concerning whether quality and safety regulation is directed to matters likely to influence the actual outcomes for people receiving home care, or whether it may be overly directed to matters of formal process and documentary systems. The evidence also raises questions about the potential for disproportionate consequences arising from sanctions in certain respects.

In evidence heard by the Royal Commission in the February hearing, the Aged Care Quality and Safety Commissioner, Ms Anderson, accepted that in her view the current oversight of quality and safety in home care is inadequate. On current information, I understand that only five approved providers delivering home care packages have ever been sanctioned. I'm not suggesting that the limited number of sanctions itself is a basis for concluding anything about the adequacy of the system of regulation. What matters more is whether the regulatory framework in process is well adapted to identifying poor care outcomes.

On that score, the evidence that emerged in the hearing raises real questions about whether quality and safety regulation of home care is fit for the purpose of identifying actual outcomes or whether it is misdirected in its focus. The current system for regulation for home care package services involves the following steps. First, approval as a provider by the Department of Health, which I've already addressed. Secondly, an initial review by the Aged Care Quality and Safety Commission, possibly in conjunction with a self-assessment against the home care standards. Thirdly, quality reviews conducted by the Commission at least every three years for most providers [every two years for NATSIFACP providers].

The *Aged Care Quality and Safety Commission Rules 2018* requires the Commissioner to give written notice specifying the day or days on which the site visit to the provider is to be conducted. And, fourthly, an assessment contact by the Commission with or without notice. Ms Anderson, the Commissioner, gave evidence in February that the standards most commonly found not met by approved providers of home care packages in the 2017/18 financial year were regulatory compliance, service user reassessment, care plan development and delivery, risk management and information management systems. In short, the standards not met

by home care providers appear to relate largely to administration and record-keeping and not direct care.

It is entirely appropriate that the regulatory framework includes record-keeping and risk management. However, the focus of attention does invite consideration of how well, if at all, actual service delivery is being considered by the regulator. The evidence suggests that the regulator has only scrutinised systems and records and that they use this as a proxy for inferring likely quality and safety outcomes. In the absence of actual measures of the quality of care, the presence of a care plan has become a proxy for quality. This has obvious dangers. The mere presence of paperwork is inadequate.

In one of the cases exposed by the evidence, the matter of a sanction process involving witness BC's organisation, BD, it can be seen that the same approach was taken to the point of inferring immediate and severe risk. I will return to this in a moment. Further, the case of BC suggests that the current regulatory framework leaves open the possibility of inconsistent approaches to the degree of process compliance looked for by the Department for the purpose of approval of a provider when compared with the approach of the Commission, or its predecessor, the Quality Agency. (Mr Barden agreed that there was a theoretical possibility of this, although he said he had never heard it said).

The Royal Commission has heard evidence in relation to regulatory processes involving two approved providers delivering home care. One of which was BC's case and the other of which related to witness BA and her business, BB Proprietary Limited. Let me address those two cases and interpolate some details of the regulatory system as I go through them. BB became an approved provider on 5 October 2017. Prior to applying for approval, BA sought the Department of Health's assistance in setting up a business to provide home care packages. BA was told the Department doesn't provide that sort of information. On 31 May 2018 the former Australian Aged Care Quality Agency (Agency) did an assessment contact. On 19 June 2018, the Agency provided an assessment contact report to the Department.

It reported that BA's company did not meet 16 of 18 of the expected outcomes of the home care standards reviewed. On 21 June 2018 the Department notified the approved provider that sanctions were imposed. On 6 July 2018 the Agency determined that two care recipients were at serious risk. The Agency sent a serious risk report to the Department that day. The *Quality Agency Principles 2013* require that if the CEO of the Agency identified a failure by an approved provider of a service to meet one or more expected outcomes of the applicable standards, the CEO must decide whether there is evidence that the failure has placed or may place the safety, health or wellbeing of the care recipient of the service at serious risk. If the CEO makes that decision, the CEO must provide a serious risk report to the secretary of the Department of Health as soon as possible.

An approved provider has an opportunity to be heard before the CEO makes a decision. In BA's case the CEO wrote to BA on 2 July 2018 and BA provided a

response as requested. The term "serious risk" was not defined in the *Aged Care Act* or the *Quality Agency Reporting Principles 2013* (which were in force at the relevant time). A regulatory bulletin issued by the Department says that "serious" is understood to mean important, significant. In this case, it took the Agency about 36 days to give notice of severe risk to the Department. Notice was provided to the Department about 15 days after sanctions had been imposed and related to two patients.

As part of the sanctions imposed on BB Proprietary Limited, BA was required to appoint an administrator and a nurse adviser to assist her to return to compliance. BA says that she spent nearly $120,000 on the administrators and advisers which she was required by the sanction to appoint. BA considers this is a significant amount for a business with nine clients. BA does not dispute that policies and procedures were inadequate. However, BA says that she was confident that clinical care was happening all along. BA further says that the guidance and direction received from the sanction process was the sort of information that she had been looking for before setting up the business. BA spent nearly $120,000 on the administrators and advisers required in order to comply with the sanctions which might reasonably be considered a disproportionate outcome for a business with nine clients.

She expressed concerns about the qualification and experience of some of the people sent out by the administrator and the adviser. BA considered they had no better qualifications than her own. On the recommendation of the administrator and adviser, BA purchased a client management system only to discover that the consultant had no experience using it and the work had to be redone. BA purchased a suite of policies and procedures for $26,000 which allowed BA to tick that box. The policies and procedures were not personalised in any way. The consultants were charging $2500 a day for their services. The sanction required an administrator and an adviser to be appointed for six months.

The issue of sanctions imposing an obligation to appoint an adviser and administrator is raised again in the case of BC. BC's company became an approved provider in March 2018. In or around August 2018, the company agreed to take on clients from another approved provider who was subjected to sanctions and who had sold the business. 15 care recipients transferred to BCs care in early October 2018. The company hadn't commenced providing services to six of the transferred care recipients as at 31 October 2018. On 30 October 2018 the department made a referral to the Agency. It was a type 2 referral. On 31 October 2018 the Agency conducted a site audit. BC was required to submit by 30 November 2018 a revised plan for continuous improvement showing how the standards would be met. Improvements were to have been made by 31 January 2019, and if compliance was not achieved the Department of Health was to be notified.

A quality review was to be conducted in December 2018. On 7 November 2018 the Agency provided an early release of the Agency's assessment contact report to the Department. The report identified compliance failures against each of the nine outcomes that were assessed. The Agency did not provide a serious risk report to the

department. The department undertook a risk assessment of the information provided by the Agency and determined that there was an immediate and severe risk to the safety, health and wellbeing of the care recipients. That conclusion was reached without hearing directly from the approved provider and in the absence of a serious risk report from the Agency.

The Agency had already put in place arrangements and a timeframe to assist the provider to become fully compliant. The delegate was concerned that BC lacked understanding of the company's responsibilities as an approved provider. The department must have been satisfied of BCs understanding in March 2018 when it approved the application for the company to become an approved provider. Sanctions were imposed requiring an administrator and an adviser be pointed by the company at the company's expense. Section 66.2 of the *Aged Care Act* provides for circumstances whereby revocation of an approved provider's approval doesn't take effect.

Relevantly, such circumstances may include the appointment of an adviser and/or the appointment of an administrator. Advisers are to assist the approved provider to comply with its obligations under the Act. The Act confers no specific powers or responsibilities on an adviser and advisers are not regulated in any way under the aged care system. In summary, in both cases, the Agency determined a pathway and timeframe for the provider to reach full compliance. But the department overrode that judgment based on the same factual material and imposed serious sanctions. The approved providers were not given procedural fairness because of the finding by the department that there was an immediate and severe risk to the safety, health or wellbeing of care recipients.

In the case of the company, the Agency personnel who conducted the assessment of the company, did not at the time of the imposition of sanctions by the department, consider there was even a serious risk. As emerged during the evidence of Dr Studdert yesterday, the department, in effect, inferred the presence of immediate and severe risk to recipients of home care from the company in the absence of relevant documentary systems of records. However, this weighty conclusion involved a leap of logic. In this respect Dr Studdert was taken to the notices of sanctions decisions dated 8 November 2018 imposed on BCs organisation, BD. The decision path to this sanction was a straight to sanctions pathway meaning that sanctions could only be imposed under section 67-1 if the delegate was satisfied that there was an immediate and severe risk to the safety, health or wellbeing of care recipients.

As you suggested, Commissioner Tracey, to Dr Studdert, a deputy secretary of the department, the reasoning accorded in that notice involved a non sequitur between the proposition that noncompliance of the company undermined its ability to properly provide for care recipients' health, safety and wellbeing, and the ultimate conclusion that therefore recipients were placed at immediate and severe risk. The leap in logic had important consequences because if the straight to sanctions pathway had not been used the company might have been able to put the necessary processes

and documentary systems in place after being given notice of intention to consider the imposition of sanctions and before a decision to impose sanctions was made.

Dr Studdert described the concept of an immediate and severe risk to the Royal Commission as follows:

> *Well, the situation where care recipients are not, we are not confident that they are getting care that is appropriate and necessary, as a care plan, would have indicated, and so in some cases the absence of a care plan alone would give us great cause for concern because there's no documentation by which you could verify that a recipient, a client, was getting appropriate care.*

But this is not quite right. Mr Speed described serious risk as a term that is defined in the Act. But that's not correct. A serious risk is not defined in the *Aged Care Act*. Having regard perhaps to Mr Speed's evidence, Dr Studdert appeared to equate a cause for concern as a severe risk. On two occasions, she described the threshold to impose sanctions as where there was a serious and immediate risk, although we assume that that was just a slip. The statutory test is of course immediate and severe risk. As a matter of ordinary language it is unlikely a cause for concern would amount to a severe risk. Dr Studdert also said that it was for the department to determine if there was a serious risk and it was not the Agency's role.

However at all relevant times the Quality Agency Principles 2013 required the Agency to provide a serious risk report to the secretary. Such a report is to be provided as soon as possible. The monetary price for the company complying with the relevant sanction requiring appointment of an adviser and administrator was extremely high. BC subsequently attempted arrangements with two successive alternate advisers. The first adviser engaged by BC was Aged Care Management Australia, ACMA. ACMA has not yet had an opportunity to respond to BC's evidence. The following is merely an outline of BC's evidence and is subject to assessment in light of any response to be received by ACMA.

ACMA has indicated that it does wish to make a response, and we submit that ACMA be given leave to respond to BC's evidence and this closing submission within seven days. But very shortly, BC's evidence, Commissioners, was that, first, the assessors recommended they contact Leading Age Services Australia, LASA. It was LASA who suggested they contact ACMA. Secondly, ACMA quoted $165,000 for six months advisory work. BC had to borrow the money to get through the sanction process. BC wasn't aware of what other options were available. She felt she had no choice and was distressed that she may not be able to keep her promise to a dying patient. When BC questioned the value of services being provided they were told that other clients were paying up to half a million dollars for the same service. BC had 12 home care package clients.

The relationship with ACMA deteriorated. There was an incident where a client was suffering chest pains. BC said that ACMA delayed calling an ambulance and advised that BC needed a contingency plan before treating the patient. BC

terminated the relationship with ACMA as a result of this incident. The new adviser said that he was shocked by the fees sought by ACMA. An hourly rate was agreed and an upfront payment of $5000 was made. The new adviser rendered a bill on a Wednesday afternoon and by Saturday was texting demanding payment. On Sunday, the adviser wrote to the department advising that they can no longer act as their invoice hadn't been paid. The invoice had been paid two hours earlier and, in any event, the money paid in advance meant that BC was still in credit.

A third adviser was then appointed at a lower hourly rate, and she completed the process efficiently, and with kindness and respect. BC wrote to the Department imploring them to do something about the first two advisers. However, BC received no response to this letter. BC says the advisers reported to the Department often not including them in correspondence and were not transparent about their qualifications. BC struggled to get timely information from the advisers about how BCs money was being spent. BC was concerned about criticisms made on some of ACMAs communications with the department and she disputed some of the content. BC eventually struggled financially and left the industry.

During her evidence yesterday, Dr Studdert accepted that it could be argued that advisers and administrators should be regulated. The Act conferred no power on the Department or the Agency in respect of an adviser or administrator other than the secretary is required to provide a report to the adviser or administrator of specified information under section 66A-4 of the *Aged Care Act*. The position at law appears to be that the adviser or administrator is a contracted service provider to the approved provider and owes duties only to that approved provider in accordance with the terms of the contract. Dr Studdert said that advisers or administrators owe their duty to the provider. During the period the advisers are engaged it has emerged that they were communicating with the department on occasion without informing BC.

This might be thought to be inappropriate in light of the fact that such advisers are retained to the provider and owe their duties to the provider not to the department and this is a point that Dr Studdert accepted. These two case studies, shine some light on the difficulty faced by smaller approved providers when dealing with the Agency on the one hand, and the regulator, the Department of Health on the other. Such difficulties should never be seen to excuse an approved provider from compliance with their legal obligations or to excuse unsatisfactory care or unsafe practices.

However, they are matters the Royal Commission should be aware of in considering the future of the aged care system and its regulation. The cost of compliance on both small providers was significant. Both providers reported unsatisfactory experiences with administrators and advisers appointed in order to having their approved provider status revoked. Administrators and advisers require no qualifications to be appointed and appear to be unregulated within the aged care system. A registered health practitioner such as a registered nurse may have obligations arising from that registration. The proportionality of compliance costs and the cost of rectifying

shortcomings may raise an issue about the market structure and the prerequisites for becoming an approved provider.

I note that Dr Studdert told the Royal Commission that she was not aware of the fees that administrators and advisers charged until she read BC's statement. A second issue arises in relation to what quality and safety means in the home care setting. Much of the conduct that was focused on by the Agency and the regulator did not involve direct clinical risks to care recipients. It appears that the current regulatory process is heavily focused on documents and systems but struggles to obtain any evidence of on the ground care. This may also mean that administrative skills are valued over clinical skills. Some approved providers might be good on paper, but they are perhaps assisted by boilerplate applications prepared by others, or by a suite of policies which allows the regulator to tick and flick this paperwork, however, may not reflect their ability to provide high quality and safe services on the ground.

One shouldn't overstate the position advanced in relation to BA and BC. There were apparent weaknesses in systems and processes that may have impacted on care delivery. It may be that intervention was warranted but the question is whether the regulator's response was proportionate in all the circumstances. The approved providers think that it was not. We anticipate inviting you, Commissioners, to make findings in due course that are consistent with the submissions I have just made about the two cases we've examined. Findings along those lines would give rise to a number of potential reform questions. Those matters will be addressed at a later stage of the Royal Commission's inquiry.

Can I turn now to fees and charges and the transparency of fee structures and the potential regulation of administration fees. This topic concerns the fees and charges imposed by providers of aged care services, including the transparency and potential regulation of administration fees. This week, the Commission heard evidence from home care recipients, Mr Josef Rack and Ms Lynda Henderson, along with Ms Raelene Ellis, who was a carer for her mother. Each witness raised concerns with the high level of administration or case management fees they were charged which ranged from 35 per cent to 50 per cent of the witness's total care package.

The Commission received evidence from Mr Howie of KinCare Health Services Pty Ltd and Ms Amanda Bowe of Mercy Health Group. The Commission heard evidence from Mr Moran and Ms Ford of Southern Cross Care, and Mr Sadler of Presbyterian Aged Care. It is apparent from this evidence that these organisations comprising both profit and not-for-profit home care providers charge people accessing their services administration or case management fees ranging from 26.65 per cent to 49 per cent. Both personal care workers and home care recipients share a concern over the high level of fees charged by providers for support services provided.

These high fees are eroding the amount of taxpayer-subsidised funds available to a person to obtain the support they need … These fees are in stark contrast to the base hourly rate of $24.65 paid to Ms Jackson, a personal care worker with a certificate III

qualification and 24 years' experience in the industry. Ms Buffinton said that evidence before the Commission that a person on level 4 could only afford 9 hours of support is very concerning. She said the department's expectation was that support should be more like 12 to 14 hours a week.

Further, the home care recipients all raised their concerns regarding the level of fees charged for individual services. These concerns were echoed by a number of the personal care workers who gave evidence this week. Mr Rack, Ms Henderson and Ms Ellis also gave evidence regarding the difficulty encountered by care recipients and their families obtaining access to information about these fees and charges. Issues identified included discrepancies in provider statements. Southern Cross Care acknowledged that transparency with respect to fees is an issue across the sector and recommendations are welcome to address this. Since 30 November 2018 it has been a legal requirement for all approved home care providers to publish their existing pricing information on the My Aged Care website.

However, as at 7 March this year, 22 per cent of providers had failed to do so. It is apparent on the evidence that care recipients currently lack bargaining power when it comes to negotiating fees with providers. Ms Ellis' experience of being told by the provider that there's no negotiation in relation to the percentage fee it charges is a clear example of this. People are also faced with hurdles when seeking to self-manage their funding. For example, Ms Ellis was unable to find a provider offering a self-managed option when one was sought. Also, Mr Rack gave evidence that HenderCare required him to pay a 15 per cent cash management fee for the first three months he obtained their services. He was told this period was necessary for assessment of his ability to self-manage his package.

In our submission, Commissioners, the following key points emerge. First, concerns have been raised about high fees and administration prices charged by home care providers. Second, greater transparency regarding fees and administration prices charged by home care providers is required to meet the needs of older Australians. Third, the current oversight of fee-setting arrangements may be inadequate to protect vulnerable members of our community. Four, there is a case for separate regulation of the level of administration fees, and their transparent separation from funding earmarked for the provision of care.

Regulation concerning transparency and comparability in home care pricing is an area currently undergoing change. On just Friday last week, the government announced that it has finalised new legislation that requires home care providers to publish their pricing information in a new standardised schedule on the My Aged Care website by 1 July 2019. The new legislation does not, however, require providers to deliver a consistent format to their monthly statements. During the course of its inquiry the Commission will monitor the scope of ongoing amendments to the regulatory regime and consider whether they adequately address the issues raised. Further reforms may be warranted in relation to setting of prices by providers or even by government as is the case in the National Disability Insurance Scheme, and oversight of provider practices in regard to pricing.

This is an issue flagged to receive deeper attention as the Commission progresses. Can I turn next, Commissioners, to consumer directed care in the administration of home care packages. The sixth topic, we say arises on the evidence in this hearing, relates to certain implications in the shift in 2015 to '17 to what is known as consumer directed care in the administration and funding of home care packages. Since 1 July 2015 home care packages have been required to be administrated by approved providers on a consumer directed care basis, meaning that the person under care has had choice, at least in theory, as to the particular services that the person should receive and from whom, to the extent that their allocated funding permits.

Since 27 February 2017, the provision of funding by the department of home care packages has involved remittals to the approved provider engaged by the relevant individual of funds to be held separately by the account of the individual, rather than on a block funded basis. This has meant that (a) HCP funds are allocated to each individual to whom a home care package was assigned and must be acquitted as having been expended for that person, (b) HCP assignees have tended to underspend their package entitlements and those underspent amounts are not available for the benefit of people who may need care and who don't have adequate funding entitlements assigned to them, and (c) the approved provider engaged by the relevant HCP assignee to receive home care will hold the amounts of funding allocated to but not spent on that person's care and will earn interest on those amounts.

As at 30 June 2017, the Aged Care Financing Authority estimated that home care providers were holding $329 million in unspent funds, being a combination of both Commonwealth and client contributions. In 2017/2018 providers returned approximately $103 million in unspent Commonwealth funds. Ms Buffinton gave evidence to the Commission that the Commonwealth does not give guidance to providers on whether interest may be earnt on package care funding and does not require interest to be paid to the Commonwealth if it has been earnt. When a home care recipient changes providers, their unspent home care amount will transfer to them to the new provider.

Ms Buffinton gave evidence that the existing provider is required to make payment to the new provider within 70 calendar days after the cessation date. Ms Ellis expressed concern that the delay in transferring funds might impact on the provision of service by the new provider. The Commission has heard evidence from Mr Rack that he was encouraged by his provider to save some of his package for a rainy day. That is what Mr Rack has done and now he has over $18,000 in accrued home care package funds. Ms Dowling has done the same and has been careful to stockpile funds even though she is receiving a lower package than she has been assessed as needing.

Commissioners, we foreshadow our intention to seek findings in due course of providers encouraging older people to retain allocated HCP funds represents a significant inefficiency in the allocation of badly needed public resources. Those unspent funds could be better applied to address the plight of older Australians in the queue and to be used to provide for their actual and entitled level care needs, or

otherwise held centrally for respite care. We foreshadow also, Commissioners, seeking findings that the status of entitlement to interest on unspent HCP funds is unclear, and that is unsatisfactory. The Australian Government does not publish any guidance to approved providers as to whether interest accruing on those funds may be retained, and does not require any interest accrued to be paid to either the government or the care recipient.

Can I turn, finally, to the issue of workforce, which is the seventh and final topic I will address today in the context of home care. On Tuesday you heard from a panel of four home care workers, Ms Hansen, Ms Jackson, Ms Warren and Ms Dale. Together they have had 44 years experience working in aged care services. They were able to provide to the Commission valuable insight regarding the experience of personal care workers in this country. Dealing first with education and training; there is a lack of mandatory minimum qualifications and training requirements for workers. This has had the consequence of additional strain and pressure on personal care workers.

Ms Dale expressed her concern that there are not enough workers who hold the certificate III. She says, "Those of us who hold that qualification are run into the ground, that many of the newer staff are students who are casual and don't have a certificate III and aren't getting the training they need to do the job." It seems to be the case that when entering the workforce on the job training can be extremely limited. Ms Jackson observed that in her experience new people entering the industry may only be provided with two to three shifts of on the job training with a personal care worker. Sometimes that personal care worker may not have been in the job very long themselves. The new workers are then thrown into situations they are unprepared for.

Ms Jackson gave evidence that training available to personal care workers has decreased during her time in the workforce. Her training has moved from face-to-face sessions involving practical scenario-based lessons to an online-based training system which she described as being more of a tick and flick approach. Ms Hansen raised in her evidence that in most instances in-home training will not be recognised outside of that employer. Dementia-specific training is a matter of concern to personal care workers. Ms Warren estimates that approximately 65 per cent of the clients she sees have been diagnosed with some form of dementia. Ms Dale told the Royal Commission that she has had lots of clients with dementia and some with mental health issues.

She put herself through training with the University of Tasmania on understanding dementia and living with dementia. That training was not required by or provided by her employer. Ms Hansen gave evidence that a large proportion of her clients are living with dementia yet she hasn't received any formal or ongoing training in dementia. Further, while she has certificates III and IV qualifications, dementia was only a small part of the course content. Can I deal with workplace health and safety. You have heard, Commissioners, that personal care workers are the frontline workers of the aged care industry.

Their role requires attendances day and night at people's homes in unfamiliar and uncertain situations. Ms Jackson told the Commission that personal care workers are often required to access areas at night that are not properly lit, and she is concerned that someone is going to be badly hurt. She recommends to the Commission that measures mandating better security at night-time for care workers are introduced. Ms Jackson suggests that staff should have a special safety beacon or button that links directly back to security and the police. There are other matters further impacting on staff retention. Personal care workers face financial instability.

The evidence before the Commission highlights that a lack of guaranteed working hours and low levels of remuneration are of key concern to personal care workers. Regular hours personal care workers are receiving are often being cut, and there is evidence of employers moving away from offering full-time employment. Further, the time allocated to a particular care recipient can be a cause of strain and stress for care workers. Ms Jackson gave evidence that there are instances where she is allocated 15 minutes to see a client. She told the Commission that she is on the time clock:

> *... and it can be quite distressing for myself trying to get the job done if the person is not quite right that day.*

This time pressure impacts on the quality of care that she is able to give. The evidence of the carers highlights that staff retention is an issue. The industry is perceived as a job that people take because they can't get anything else. It has been observed in evidence that there is an ageing workforce trying to look after an ageing population. Ms Hansen told the Commission that carers need to have the right personality to be able to interact with care recipients. She says:

> *It is difficult work and we should be rewarded for it appropriately.*

At this stage it is not proposed that the Commission make any findings in relation to the workforce issues raised in the evidence this week. The aged care workforce performs a critical role in delivering high quality, safe, person-centred care. They are an integral part of the success or otherwise of Australia's aged care system. Future hearings of the Commission will give detailed consideration to matters such as education and training of the workforce, and potential measures for recruitment, retention and remuneration. Let me conclude. Commissioners, as I mentioned earlier it would be appropriate for parties with leave to appear to have leave to lodge responding submissions within seven days. And a direction has been made, I understand, by you, Commissioners, to that effect.

COMMISSIONER TRACEY: I will certainly pronounce that before we adjourn.

DR McEVOY: Let me return to the point I made at the outset about the central importance of home care for the future of aged care in Australia. It is the mode of care that enables people to live out their lives where they choose to be. Each of the seven matters I have addressed is cause for great concern. But it is not beyond us to

find the necessary solutions. Secondly, I should reiterate the comments that have previously been made about the importance of receiving submissions from the public. If anyone listening has an account to share with the staff of the Royal Commission, they should contact us, please. The sooner we receive your account, the more likely it will be given its proper weight in the work of the Royal Commission.

Finally, the next public hearing of the Royal Commission will be in Sydney in May. It will focus on residential care and, in particular, the needs of people living with dementia. We urge people to contact the Royal Commission staff, if they have any relevant information about these topics or aged care in New South Wales more generally that should be brought to our attention. Again, the sooner the better. If the Commissioners please.

COMMISSIONER TRACEY: The Commission direction in respect to the hearing just concluding that (a) no party with leave to appear at this hearing is required to make a written submission; (b) any party with leave to appear at this hearing who wishes to make written submissions in response to Counsel Assisting's oral submissions of today's date must do so no later than 4 pm on Friday, 29 March 2019; (c) any party that has been the subject of adverse allegations in the course of Adelaide hearing 2, who wishes to make written submissions to such adverse allegations, must do so by no later than 4 pm on Friday, 29 March 2019; (d), submissions are not to exceed 10 pages; (e), documents referred to in submissions should be restricted to documents tendered in the course of Adelaide hearing 2 and must be identified by their document ID and, if appropriate, exhibit numbers; (f) submissions should be submitted to the solicitors assisting the Royal Commission; and (g) it is intended that submissions will be published on the Royal Commission's website.

The direction will also appear on the website for the assistance of any parties who may be affected by it. The Commission notes that this will be the last occasion on which it will have the benefit of the services of Dr McEvoy and wishes to record its sincere thanks for the very considerable amount of work done in preparing for the first two hearings of the Commission. Dr McEvoy will be missed but we extend to him our congratulations upon his judicial appointment. The Commission will adjourn to Sydney on a date to be fixed.

MATTER ADJOURNED at 3.59 pm INDEFINITELY

Index of Witness Events

Index of Exhibits and MFIs