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TRANSCRIPT OF PROCEEDINGS

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

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

SYDNEY

10.01 AM, TUESDAY, 1 SEPTEMBER 2020

DAY 89

MR P. GRAY QC appears with MS E. HILL as counsel assisting
MR S. FREE SC with MS A. MUNRO appears for the Commonwealth of Australia
MR P. ENGLISH appears for Mable Technologies Pty Ltd
MS V. HOLT appears for the State of Victoria
MS E. HILTON appears for Hireup

COMMISSIONER PAGONE: Mr Gray.

MR GRAY QC: Thank you, Commissioner. The first witness this morning will be Rosemary Milkins. I tender the statement of Rosemary Milkins, document RCD.9999.0484.0013 and the recording of the interview of Rosemary Milkins document RCD.9999.0484.0001 and a transcript of the recording RCD.9999.0484.0022.

COMMISSIONER PAGONE: Those three will be exhibit 20-3.

EXHIBIT #20-3 - STATEMENT OF ROSEMARY MILKINS PSM, RECORDING OF INTERVIEW, TRANSCRIPT OF RECORDING

MR GRAY QC: I ask the operator to play the recording of Rosemary Milkins' evidence.

VIDEO OF ROSEMARY MILKINS PSM BEGINS

MS HILL: This is an interview between Rosemary Milkins and Erin Hill, Counsel Assisting. Today's date is 26 August 2020.

The interview today is being recorded. The recording of this interview will be tendered at a public hearing of the Royal Commission into Aged Care Quality and Safety, commencing on 31 August 2020 in Sydney. The recording will then be made publicly available.

Rosemary Milkins, do you agree to continue with the interview today on that basis?

MRS MILKINS: I do.

MS HILL: Rosemary, could you please state your full name?

MRS MILKINS: Rosemary Milkins.

MS HILL: And what is your age?

MRS MILKINS: I am 66.

MS HILL: And what do you do for work?

MRS MILKINS: I'm a retired public servant and I still do a little bit of consultancy work.

MS HILL: And whereabouts do you live?

MRS MILKINS: Hornsby Heights, New South Wales.

MS HILL: Can I take you to 18 May 2019.

MRS MILKINS: Yes.

MS HILL: On 18 May 2019 did you make a submission to the Aged Care Royal Commission?

MRS MILKINS: I did.

MS HILL: If I could ask the operator to please display general tender bundle item No. 49.

Rosemary, do you see a copy of the letter that you attached along with your submissions in May 2019 on the screen before you?

MRS MILKINS: Yes, I do.

MS HILL: And is it in that submission, Rosemary, that you wrote about your experience of caring for your mother?

MRS MILKINS: Yes, I did.

MS HILL: And more recently you have provided some photos to the Royal Commission of your mother, including photos of your mother and yourself?

MRS MILKINS: Yes, I did.

MS HILL: Operator, could I ask for the photos that Mrs Milkins has provided the Royal Commission to be displayed at this point in time.

Rosemary, you have provided some photos of your mother to the Royal Commission?

MRS MILKINS: Yes, I have.

MS HILL: And you have also given some thought to how you would describe your mother, when asked in this interview, haven't you?

MRS MILKINS: Yes, I have.

MS HILL: Can I ask you at this juncture to share that description, share a bit about who your mum was with the Royal Commission.

MRS MILKINS: Thank you, I would be pleased to. My mum Dorothy saw herself

as an ordinary person with a humble background, a basic education and a worker all her life. She was born in 1925, before the advent of antibiotics and plastic, and she grew up in a tough but loving family, the third of 10 children, in Bermondsey, London, a really working class area. She lived through the depression as a child and the Second World War as a teenager and in fact their house was bombed out in 1942 during the blitz. She was a no fuss resilient and slightly shy person.

She married at 25 my dad Sydney, who was an ex-RAF pilot from the same area, who incidentally wasn't at all shy, and I grew up in that same sort of area of London.

In 1969 my dad suggested we migrate to what was then termed a new life. And so with them in their 40s and me as a teenager we came to Sydney and we just loved it --- the weather, the freedom --- and we settled in the Hornsby area, where I still live. We were a very close threesome.

When my dad died, my mum was actually in her 70s. And after a few years I noticed that she had dementia and so began a sort of 20-year journey. Of that 20 years, for 17 of them she still lived in her home and then she went into residential care.

She was fun, she was witty, she was unfazed by most things and unfussy. She was appreciative and loving and she had an absolutely wonderful sense of humour. You can't, as she would often say, take life too seriously.

MS HILL: Thank you. Rosemary, you have described your mum living at home for as long as she did in her later years. Why was it important for your mum to be able to stay at her home and why was it important for you that your mum could stay at her own home?

MRS MILKINS: I'm very much an advocate for the fact that, you know, the idea that older people should go into residential care as soon as they develop either dementia or any form of physical issue, I really rally against that and my mother would have as well. She grew up when old people were around you all the time, probably not as old as she grew to but they were, and overall we wanted her to retain her dignity and her ability to live her own life in an environment that was very familiar to her.

MS HILL: Sitting where you are now --- pardon me, Rosemary.

MRS MILKINS: Well, I would say it was a very positive experience overall, really; you know, it kept her in her home for 17 years. I was able to work full time during that period. It's really an absolute tribute to the hundreds of workers and people who actually came and helped her in her home and were able really to support her there. And that's actually a fantastic thing that was achieved and I'm very grateful for it.

MS HILL: Reflecting on the submission that you made in May last year and where you are now, what perspective do you bring today to the evidence that you want to share with the Royal Commission?

MRS MILKINS: Well, I suppose even though I regard the experience overall as a very positive one and one that was invaluable really to both my mother and I, I still am able to draw back on that and think about what were the things that I would like to improve, what went really well, and to think really through the larger situation of her care. And I feel, because it was a whole 17 years that I have a meagre something to offer about, you know, what that journey is like.

MS HILL: And do you now identify the key principles that you have learnt from, that you have drawn on from your mother's experience of receiving aged care services in the home?

MRS MILKINS: Well, I suppose when I look back on it, I think overall the big sort of wrap-around it is that it is a great privilege to care for people and I think in our society today we diminish that. We care for our children and we see that as a marvellous thing to do. I don't see why it can't be like for that old people and it should be done with a sense of them living with dignity and maximising their capacity to be independent and make their own decisions. That all sounds terribly cliched but it is also terribly, terribly important. When I pull back from that, I think I've really come up with probably a number of ideas of ways of looking at that journey that I would like to share.

MS HILL: Please do.

MRS MILKINS: So I suppose the first piece of meagre wisdom that I offer is that really we need to think about planning for aged care before we actually get to that point. So we should plan really our home, particularly for the future, and I don't think enough consideration is given to this.

One of the pieces of information that's often said is, "When are you going to downsize and, you know, move into a smaller place?" And I really fight against that. I think the whole concept diminishes older people. It's like you need a smaller space and therefore you are less important than anything. And I think that takes away some dignity.

Clearly the message is not about downsizing, it's about living in a home that is adequate for your older age. And we should think about that more, we should think about it before we really, really get there.

So I would really encourage people to build their homes, particularly as they get past their children and you're really in your home on your own, to think about, what will it be like for me in the next 5, 10, 15, 20 years if I want to stay in my home? Just to give you a really silly little illustration of this, recently I had lights put on the front of my house. They literally light up my back lawn like a netball court --- you could run training there on a Friday evening if you turned them on. But why did I put such bright lights and why did I bother with that now? It's because I want to be able to walk from my garage to my front door in a well-lit smooth transition --- not because

I can't do it now but I know that in 10 years' time that's what I want. And I'm starting to, if you like, age-proof my home now, in the same way that you child-proof your home when you've got children around.

I don't --- I found that in my mother's home, for example, I didn't know that I should think about those things. But people suggested that she modify her home, pull the bathroom out and make it easier, get rid of those steps, put a ramp in here, do this, do that. Actually, I'm a bit of a salmon that swims against the current. My mother didn't really want to do any of that because she felt that it took away from her the home she had lived in for some 40, 50 years. In fact I felt quite comfortable. We did put a handrail into the bathroom, but we didn't take the bathroom out because my father had built it, it was lovely and my mother was sentimentally attached to it. We worked with it. We didn't pull up the wool carpet to put a wooden floor down so that she could walk around with a walker because she found her way around the house with that wool carpet until she was 91.

So I'm not much for modifying your home, I'm for you thinking about that as you grow older and for us to encourage people to do that when they renovate, they should be thinking about the future.

Which leads really me to a second sort of idea which is much the same, which is we need really early intervention, we need to think about ageing before we get to what I consider to be the crisis points that you come to. I realised that my mother had dementia when she was in an acute setting and I thought --- I used to see her two or three times a week, but I thought, she just seems a bit more forgetful than usual. And I asked people if they felt that she needed some help and I was told, "No, I don't think so." But a nurse did suggest that I go to a geriatrician if I was concerned and I did that and it turned out that my mother did have dementia, a form of sort of vascular dementia. And we got tablets for her and really nothing deteriorated for quite some period of time, it was a very slow deterioration. I also knew that keeping her blood pressure and her tablets were really important. So I found out quite early.

But I hear a lot of people say, "Oh, my mum is getting a bit forgetful now, she's getting worse," but I don't hear them say, "And I've been to the geriatrician and I've done something about that." I think people see it as a natural part of ageing, which is it is, but it doesn't mean that you shouldn't treat it like a cancer that you might have on your face or a bronchitis that you might have. You should actually do something.

And I do think that geriatricians are overlooked in all the discussion that occurs. They can bring a lot to this space. And I don't think we do that; we depend on GPs and then we go into the acute setting. So yes, we should be early intervention for older people, particularly as they get, you know, into their 80s when dementia is a much more common occurrence.

That then means that what you do then is you then start to think about, well, what services do you need? And my third principle is you should start small. So if you start small, accepting some form of help that someone offers, it means that this

journey you travel can grow naturally. It's like travelling on a pathway, it just opens out more as time goes by.

So the start small for me was that somebody suggested they could send in some dementia support, which would be --- it was about an hour once a week or I think even once a fortnight, where someone could come and play a game with my mum or have a chat with her, keep her linked into things and see how she was travelling. And my mother really said, "Oh, I don't really want, you know, strange people in my house." But she loved Scrabble, so in the end I particularly told her, "It's free, Mum, we should take it." And she couldn't resist anything that was free. So in the end we started out with this little service that came.

And gradually over that 17 years eventually she was on a 3-4 package and we had the whole box and dice. But we got there without her ever saying, "I don't want that." She accepted everything as it changed. She trusted me and I trusted her, consulted with her, talked about what we were doing, but we started small and it grew naturally. It helps you become familiar with all the agencies in this era. You know, there are loads of them and all the processes that people use, you become familiar with what you're entitled to. So it's a sort of early entree on it.

Don't leave it until you get to that can't cope stage, because then everybody is angry, you know, my mother would have said, "No, I do not want it" and there would have been no persuading because they are fearful then. So get in early, start small.

Which then means you get to my fourth principle, which is you need to maintain their skills and their self-management as long as possible. It's a very fine balance when you're looking after someone or they're being looked after by carers between helping them do something and helping them supporting them do things for themselves. It's again like a child. When a child struggles to open the cap on the top of a bottle, we open it a little bit to allow them to finally take it off, so they feel that strength of being able to do it for themselves. And with old people it's entirely the same because the more that you take away from them in your attempts to help them, the more lacking in independence they become and their lives really, really change.

The worst thing that happened to my mother was one day I arrived at the house to find that there was a big red box on her dining room table. And I realised that the nursing that came in to help had put her tablets in this box and locked them up. Now, my mother had been taking her tablets out of a Webster pack for some years by this time, every morning very well, but at some point during this time she got a little bit confused and the nurse had decided, with no consultation with me or with my mother, to keep her safe ostensibly, that she would put the tablets in the box so that my mother could no longer take them herself. My mother was furious. Every fibre of her body was outraged. Because what it showed to her, this symbolic red box was, you are a fool now, you are daffy, you can't work it out for yourself, you're stupid, so we're taking it away from you, your toys and we're putting you in the naughty corner. I was outraged because it meant how the hell was my mother supposed to take her tablets then? Who would give them to her if she could not give

them to herself? And that would mean nurses would have to come every morning to do it and if she was given something that was three times a day, how were they going to do that? When in fact she was just confused for a moment. So it's that simple. You can actually take away someone's skill to do something that quickly.

I suppose the two areas that really concerned me was medication management, because carers are told they can't give medication to people, it has to be someone qualified. That's just really silly, they should do a short course and learn how to do it. And you can't have a nurse come every day to your home and you can't not have the person managing it.

The way --- you know, surely there's a technological thing we could think of where it dispenses at a certain time or it checks that they have taken it. But it's nobody's problem and it flicks across three people; nobody owns it really. So that's a real improvement area and I'm sure there's an IT or a sophisticated --- some innovative solution someone could bring to that space.

The other is continence. When I suggested my mother was struggling with incontinence of urine, somebody came to help her with that. And when I asked what had happened, I was told that the person had told my mum to do pelvic floor exercises. Well, if you've got dementia, clearly you're never going to remember to do those. There's not a lot of good solutions around the incontinence area and again it needs a lot of thought. Can we get different designed products, can we get people that can actually help? How can this be done in a much easier way? And I must say, anyone that calls them nappies is immediately giving a signal to someone that they're a child again, not an adult. I used to call them big girls' pants and every time I did my mother laughed and we just need better language in some of those areas not to diminish people.

My mother at 91 was still able to make her own breakfast and I was very proud of that.

My fifth principle is really there are experts and there are experts and everyone that has a sort of medical background appears to be an expert. But I'm not quite so sure about that. You do need consistent advice around medication and nobody tinkering with them, just because they fancy doing that. I knew that would keep my mother safe.

Don't buy one of those silly alarm alerts because someone will suggest to you that you did. My mum could never remember to do it and it was completely and utterly useless. The moment she did have a crisis she actually walked up to a neighbour's house because that's the built in her brain reaction that she would have used and she went for it straight away.

I do think there's some technology that could be used here. I would have felt a lot better in those early years, and particularly I suppose even towards the end, to have remote video in my mother's house so that I could see her getting out of bed, see her

eating her breakfast, see her doing things. Similarly, I'd quite like that when the workers go into the house --- I was thinking the other day, my daughter, when the children go to kindy, the teacher takes a little video of what it's been like today for your child. Why can't the carers take a little video of what it's been like for your mum today? It just makes the person, the family feel reassured about what's going on. We're not using any of those technological solutions.

Avoid general anaesthetics and hospitals generally. A doctor once said to me, "Your mother has got lots of lesions on her body, it would be much better if she came into hospital and I gave her a general anaesthetic and did it in one day." Well, it was much better for him but it wasn't much better for my mum. And I said no and we did them by local. So, you know, they say things like, "It's better," but you've got to think about for whom.

Avoid discharge nurses, physios or nurses who aren't experienced in aged care because they will actually cause trouble and make problems; any clinician who speaks too loudly to your mother and assumes that she's deaf when she's actually not. And it's really up to you to assess the risks and the expertise, it's not for others to really tell you what to do.

So then I'm now at my sixth principle. I'm getting through them, I hope at a reasonable pace. Take everything you can get. So maximise your entitlements. As I've said, my mum was on a 3-4 package towards the end. It was very hard to get that 3-4 package serviced, even though she had qualified. And I'm sure you've heard a lot about the wait for these packages and getting providers. It's a nightmare. But because, remember, I had been in this game a long time, I'd known my providers for a long period and in fact they patched me up a 3-4 package and I had really the entitlement to that before someone could formally give it to me.

I also was very lucky because I got something called a Balancing Work and Care package for me because I was still working and by this time I was a very senior public servant. And by having that Balancing Work and Care package I was actually able to still do regional visits to police stations and to fire stations, in my two jobs that I had then. I was able to stay away at weekends because carers would come from this package, helping me stay in work, and assist my mother and that was marvellous. If I had only had that 3-4 package I really would have been struggling.

It was great when the Commonwealth changed it to be something where it was about money, not time, and that you could buy what you wanted with your money. But there's much more flexibility needed in that space.

The other thing about taking everything that you can get is eventually my mother had people giving her showers, assisting her really with hygiene, and that helps that transition to residential care. If you have never had someone do that for you in your home, you're going to find it appalling to have it done to you when you get to residential care.

So take everything you can get. I did and I worked the system and I got to know people and build relationships, which is very important, and segues really to my last important, which is you --- you know, you --- and actually you will end up being the coordinator of this if you've got an aged parent. I've made the list, you know, the pharmacy; the fabulous GPs that I had; Meals on Wheels, who are unpaid heroes in this, they turn up every day and you know if you don't get a call that your person is safe. The lovely dentist, Dr Choo; Lawn Bob, who my mother really didn't know but came for 17 years and mowed my mother's lawn without ever really speaking to her; the local tradies that I found. And another suggestion, why not have an accredited list of tradespeople, dentists, who can be trusted to work with people with dementia and understand their needs? Optometrist is the other one.

The carers and administrators you deal with, community nursing, the ACAT teams --- mostly good, but the coordinators there have got a horrific job, there's always waiting lists. Had a fabulous one, restructured, lost her. You know, it needs to be stabilised. There's always a sense the system is changing. I found Centrelink really very poor, almost useless in providing advice and if I had listened to what they had said, I would have gone astray. Veterans' Affairs a little bit better. And the last part of all of this coordination is you become the attorney for your parent and then you end up doing all the financial management. The banks are really unhelpful in the extreme. And really it's very onerous dealing with money.

For example, I would spend at least two hours every weekend dealing with things for my mum because you have this crazy co-payment system where I'm paying a bit for the care, I'm paying a bit for the lawn, I'm paying a bit to the doctor. We need to get rid of this concept of co-payments. Have an annual charge. Goodness gracious, if people are eligible because they have worked all their lives, you know, and earned a certain amount or contributed a certain amount of tax, you know, find some way of making the way that it's funded just simpler for people to understand. It's very, very complex. I don't know how people would get --- who didn't have carers would manage to get their way through all of that.

So they're basically my seven suggestions of areas that you could work in in order to make this, you know, better.

MS HILL: Thank you, Rosemary. With those seven key principles in mind that you have just set out, what to your mind are the solutions that will keep older Australians in their own homes for as long as possible?

MRS MILKINS: Well, I suppose the first thing is I think we need to give aged caring a better profile and make it be seen as something that's really important in society. I really --- you know, we talk of dementia as, you know, death. What a silly thing to do. Now we're struggling during COVID days about are aged people just, you know, the cannon fodder of the war of COVID. I'm quite appalled by people's attitudes and I suppose what we need to remember is they were all young once and inside that old body is still the young person, the person that's got value.

So we need to actually have some really innovative goals and great plans about what we should be doing in the aged care area. We should be talking about that, we should be engaging in community consultation about it. It shouldn't just be a dusty document built by people in an agency. And for goodness sake, we need to sort of sort out, you know, who is actually going to lead the charge into setting those goals; by whom and how. And I would hope that Government, both State and Federal, would take notice of the results of this Commission in order to drive forward on that agenda and have it given a much larger public profile.

We should be improving policy across the board. It should be brave, it should be innovative. It should actually fix some of the issues that people constantly talk about, rather than pointing at others: it's not me, it's yours. It needs to be more audacious than it is. It clearly is the lost land. And that really is an indictment of our values. It needs, above all, stronger leadership. I'm sure it's said to politicians every day of the week but for the sake of repeating it, no one --- no one --- is interested in the fight between the Federal and State Government on who does what. What people are interested in is that it works and that it's joined up and that it makes sense. So there needs to be politicians need to get together, Government departments need to get together and work out, how do we work together to make this something so fabulous that we are a leading exemplar, where we are proud of how we treat our old people, instead of being, to some extent, vaguely ashamed.

We need to invest and that really means we run a lot of our services on the NGO sector and private sector. The NGO sector, the Catholic Community Care was the major provider for my mother, and I would say they have got considerable expertise. But they, along with smaller NGOs, need much more investment and support from government across the board, otherwise we end up with what we have got now, which is poorly paid workers, sometimes ill-trained, who want to give of their best but can't because of the impediments that sit at that policy level. So let's invest and, above all, let's provide coordination and let's pull things together. We can coordinate most medical care. We coordinate schooling for young people. I see no reason why we can't coordinate aged care for older Australians.

MS HILL: Thank you, Rosemary. I'm now drawing to the close of the questions that I have for you this afternoon. Before we conclude, could I ask you to tell the Royal Commission what motivated you to share your and your mother's story with the Royal Commission today?

MRS MILKINS: I suppose what's prompted me to do it was that I felt we had a considerable and positive experience together. You can spend a lot of time focusing on the negatives, the things that go wrong, but we overall had a positive experience and I would encourage people to go down that pathway. I thought, as I said at the beginning, we --- I had some humble wisdom to provide in that area. Of course, being by trade a sort of bureaucrat used to dealing with these big strategic things, I could also see the larger frame in which it sits and whatever. I love reform work and, you know, almost want to get my fingers into the pie and sort through all of that. So I thank the Commission for the opportunity to make a bit of a contribution.

MS HILL: Thank you, Rosemary. That concludes the questions that I have for our interview today and we thank you for the time and the thought which you have been able to give the Royal Commission.

MRS MILKINS: My pleasure.

VIDEO OF ROSEMARY MILKINS PSM CONCLUDES

COMMISSIONER PAGONE: Thank you. I'm not sure whether Ms Milkins is listening to the live feed. If she is, and I hope she is, I wanted to thank her for the evidence that she has given, the immense amount of time that went into the preparation of that evidence. Evidence of that kind is really very important to the Commission for the work we're doing, but also for the public to hear those stories. What you've had to say really speaks to very many people and makes very many very good suggestions that we will give consideration to and which Government should give consideration to, even as we speak. So thank you for that. Mr Gray.

MR GRAY QC: Thank you, Commissioner. I call Associate Professor Gillian Caughey of the Register of Senior Australians.

ASSOCIATE PROFESSOR GILLIAN CAUGHEY, AFFIRMED

EXAMINATION BY MR GRAY QC

MR GRAY QC: Professor, you're a Principal Research Fellow at the Registry of Senior Australians, ROSA, is that correct?

ASSOCIATE PROFESSOR CAUGHEY: Correct.

MR GRAY QC: And you're also associated with the Healthy Ageing Research Consortium and the South Australian Health and Medical Research Institute?

ASSOCIATE PROFESSOR CAUGHEY: Correct.

MR GRAY QC: And you, with a colleague, and perhaps with other colleagues assisting you, have prepared two reports for the Royal Commission in your capacity as a principal research fellow at ROSA?

ASSOCIATE PROFESSOR CAUGHEY: That's correct.

MR GRAY QC: Thank you. The major report that you've prepared for the Royal

Commission has been published. It is Research Paper No. 8 published on the Royal Commission's website and it concerns international and national quality and safety indicators for aged care. That's so, isn't it?

ASSOCIATE PROFESSOR CAUGHEY: Correct.

MR GRAY QC: We might just ask the operator to bring that up. It's also included in tab 60 of the tender bundle.

Professor Caughey, I will ask you some questions about this report and then I will ask you some questions about a further report that you've prepared which focuses on quality indicators in the context of home care. But we'll start with this large report, Research Paper No. 8.

ASSOCIATE PROFESSOR CAUGHEY: Okay, great.

MR GRAY QC: Firstly, if you could just, operator, please, turn to the first page of that document following the cover page. And then the next page. This is the report you prepared for the Royal Commission in relation to international indicators?

ASSOCIATE PROFESSOR CAUGHEY: Yes, that's correct.

MR GRAY QC: And based on the research that you conducted or supervised for the purposes of preparing that report, are you able to say that to the best of your knowledge and belief the information in it is correct and the opinions in it are opinions you hold?

ASSOCIATE PROFESSOR CAUGHEY: Yes, that's correct.

MR GRAY QC: Thank you. Operator, I'll just ask you to display tab 62 which is the report relating to home care indicators. Professor Caughey, is that the second report that we spoke about a short time ago?

ASSOCIATE PROFESSOR CAUGHEY: Yes, that's correct.

MR GRAY QC: And, again, the same questions: to the best of your knowledge and belief, are the facts in that report true and correct and the opinions in it are opinions that you hold?

ASSOCIATE PROFESSOR CAUGHEY: Yes.

MR GRAY QC: And what is your research background, in broad terms?

ASSOCIATE PROFESSOR CAUGHEY: For the last 20 or so years, I've been researching the care and medication safety in older people, and by training I'm a pharmacoepidemiologist which means I look at medicine used at the population level. In the last 10 years I've expanded that to look at models of care and

appropriate care and clinical indicators, as I said, focusing on the older population.

MR GRAY QC: And ROSA, the Registry of Senior Australians, that was previously known as the Registry of Older South Australians, is that right?

ASSOCIATE PROFESSOR CAUGHEY: Yes, that is correct.

MR GRAY QC: And what is the, if I can use the expression, "mission" of that organisation?

ASSOCIATE PROFESSOR CAUGHEY: ROSA was established to utilise existing aged care and health data to set up the Registry of Older Australians with the goal to use this data to improve the quality of care and ultimately care and health outcomes for our older population, specifically those receiving aged care services.

MR GRAY QC: Thank you. And was it thought that there was a gap in official Government analytics of those data?

ASSOCIATE PROFESSOR CAUGHEY: Most definitely. It was quite the shortcoming and it was a real opportunity that we had to link this data to conduct research that will ultimately improve care and inform policy as well, to ensure our older population have the best care and quality of care that we can give them.

MR GRAY QC: And for about how many years has ROSA now been conducting that data-linking work and that analytics work?

ASSOCIATE PROFESSOR CAUGHEY: It started --- we're into our fourth year now. So, as I said, it started four years ago. I joined the team just over a year ago.

MR GRAY QC: Thank you very much. Now, I want to ask you about the first report, the longer report that's been published as Research Paper No. 8. In this report there's a description of what ROSA calls an "Outcome Monitoring System for residential aged care." That's correct, isn't it?

ASSOCIATE PROFESSOR CAUGHEY: Yes, that's right.

MR GRAY QC: Is that a recommendation that ROSA is making about a potential suite of quality indicators that could inform the quality and safety of residential aged care in Australia?

ASSOCIATE PROFESSOR CAUGHEY: Yes, that's correct.

MR GRAY QC: I'd like to ask you some questions about how ROSA came to make its recommendations about the Outcome Monitoring System, which is also known as OMS, in that report. I'll do so in just a minute. But firstly, in order to understand the context of the home care quality indicators that are the subject of your second report, is it the case that there's quite a strong link between the two reports?

ASSOCIATE PROFESSOR CAUGHEY: Yes, most definitely, and a lot of our work was extensively done in the residential aged care setting and then the home care quality indicators followed on from that.

MR GRAY QC: Thank you. In a way, does the longer report, while it has a focus on making recommendations about an OMS in residential aged care, it, in passing, makes a number of references to international learning, international examples and appropriate indicators for home care as well?

ASSOCIATE PROFESSOR CAUGHEY: Yes, that's correct.

MR GRAY QC: Thank you. Professor, the report appears to be documenting a two-part process or a two-part study, the first part of which involved a detailed exercise in comparative research relating to systems for quality indicator monitoring in 11 countries. Is that the case?

ASSOCIATE PROFESSOR CAUGHEY: Yes, that's correct. Yes.

MR GRAY QC: And the second part involved considering the 134 indicators that were identified in part one for their appropriateness in the Australian context. Is that right?

ASSOCIATE PROFESSOR CAUGHEY: We actually identified, I think it was, 304 individual quality and safety indicators in the first part of our report and then in the second part we examined the 134 that we could actually look at in our data. So there were some indicators, for instance, that we weren't able to examine using the data that we have currently available.

MR GRAY QC: Thank you for that clarification. And if we could now bring up the Executive Summary, that's tab 60, please, operator, beginning at page .0005. If we could just call out the text in the middle describing parts 1 and 2. You've covered those points, Professor. Part 2 is described as "Examining the performance of Australian aged care facilities and home care providers." Just pausing there, you haven't actually done a performance review so much as formulated some recommendations about whether the data is available to review the performance of those providers; is that a correct interpretation?

ASSOCIATE PROFESSOR CAUGHEY: Yes, somewhat. What we aimed to do in Part 2 was to, where we were able to do comparisons to the international literature for each of the indicators, we analysed it in the Australian data, obtained a prevalence of what we can examine using our data, and then compared that to the prevalence that was reported from the other countries.

MR GRAY QC: Thank you. And was that a process which was important to the consideration of --- that the indicators that an advisory body on the study recommended for the Australian context?

ASSOCIATE PROFESSOR CAUGHEY: So I think that you're getting the sort of two parts a little mixed, if I may. We developed our ROSA outcome monitoring system, which was --- initially we conducted an extensive literature review of the national and international scientific literature on aged care quality and safety indicators, and then we presented them to our Expert Advisory Panel, which included experts in aged care such as geriatricians, GPs, aged care providers themselves and consumer representatives. And that's how we've ended up formulating our 12 indicators from --- I think we had 23 in total that we identified from international literature and then through that process, through our expert advisory committee, and of those indicators that were able to be examined using the data that we have available, we came up with our 12 indicator set.

In Part 2 of the report, we went through the 305 indicators that we identified from the international literature. This is an extensive systematic search worldwide of what's currently done, and from those we then made data rules, if you like, or where we could allow to be examined, meaningful comparisons with those international indicators. We did that comparative study, if you like, so we examined trying to use the same data rule set that they may have used in the international studies so we could have this comparative analysis, if you like, to see if we can do --- measure the same things in Australia and specifically to see how it compares to the other countries.

MR GRAY QC: Thank you. Could we go to page .0022, please, operator. And, Professor, you mentioned a minute ago that the product of the evaluation in Part 2 was an identification of 12 indicators. Are they the 12 in the right-hand column of the box?

ASSOCIATE PROFESSOR CAUGHEY: Yes, that's correct. The 12 indicators on the right-hand side there, these are the ones that we have developed and included in our ROSA outcome monitoring system for residential aged care and the ones on the left were ones that we considered and we took to our Expert Advisory Committee to get their feedback about which ones should be prioritised for inclusion in our outcome monitoring system.

MR GRAY QC: Thank you. And in your second report on page --- well, it's at tab 62, if we could bring that up, please, operator? And the table at pages .0312-.0313. You've identified here, have you, Professor, a series of quality indicators that you regard as available for use in home care. Could you explain how you reached that conclusion and explain the criteria for the decision?

ASSOCIATE PROFESSOR CAUGHEY: Yes. Thank you, Counsel. So we undertook a similar process when we were developing the indicators for our ROSA Outcome Monitoring System for residential aged care as we did for these home care quality and safety indicators. So that is that they were identified from international literature and potentially were associated with poor health or placed people at increased risk and were those, importantly, that were what we could actually

examine using data that we have available.

So, for instance, in the other countries that have home care indicators, a lot of them look at changes in functional ability, for instance, or changes in cognitive abilities, our quality of life and those things that are not available currently in our data. So it was based on what data was available and what we could use using that data.

Again, we presented a larger --- a list to our Expert Advisory Panel, sought their feedback about which ones they thought had the potential to ultimately improve care and the quality of care for older people receiving home care services, and again, those that could be meaningfully examined in our data.

We came up with this list, if you like, and whilst we haven't published the final findings of the home care indicators, we're still currently refining them and validating them in terms of data rules behind these indicators, and many of them overlap with what is in our ROSA outcome monitoring system for residential aged care.

MR GRAY QC: Thank you. In the introductory words just above that table, there's a description as follows, "The following table provides a summary of home care quality and safety indicators which either have been implemented in other countries or were recommended for monitoring in this population." Just to clarify, what recommendation does that refer to, Professor? Who made that recommendation?

ASSOCIATE PROFESSOR CAUGHEY: That was just recommendations that we found from our literature review.

MR GRAY QC: Thank you, "or have been associated with poor outcomes and increased risk of harm." So any one of those criteria was sufficient?

ASSOCIATE PROFESSOR CAUGHEY: Yes.

MR GRAY QC: And a necessary criterion was that the indicators are feasible in Australia using existing aged care and health care data sets?

ASSOCIATE PROFESSOR CAUGHEY: Yes, that's correct, Counsel.

MR GRAY QC: There are then three or four data sets referred to in various of the rows relating to each indicator. For example, the first one, "High sedative medication load", the data set is PBS, is that the Pharmaceutical Benefits Schedule, or Scheme?

ASSOCIATE PROFESSOR CAUGHEY: Yes.

MR GRAY QC: And then there are mortality records, is that the NDI?

ASSOCIATE PROFESSOR CAUGHEY: That's correct.

MR GRAY QC: And State-based hospital records?

ASSOCIATE PROFESSOR CAUGHEY: Correct.

MR GRAY QC: And the Pharmaceutical Benefits Scheme?

ASSOCIATE PROFESSOR CAUGHEY: That's correct.

MR GRAY QC: Now, are all of those data sets currently available for data linking and analytics through the Australian Institute of Health and Welfare, or do some of them require extra permissions such as State-based hospital data?

ASSOCIATE PROFESSOR CAUGHEY: Well, we have to get permissions from each of the data custodians and that includes the State-based hospital data of which we've been able to obtain approvals for South Australia, Victoria and New South Wales, and actually have that data linked to our ROSA registry data. It's all done by the AIHW, the linkage, and we've also just received access to Queensland hospital data, although we haven't received that data yet. And the data's actually housed through the Sax Institute, so we access that remotely as well.

MR GRAY QC: Thank you, and the AIHW, or the Australian Institute of Health and Welfare, it's very well-known to the Commissioners but just for the public, that is a body which collects and analyses health and welfare-related information over time and publishes information on a website called Gen Data, is that right?

ASSOCIATE PROFESSOR CAUGHEY: That's correct.

MR GRAY QC: Now, it sounds like the State-based hospital data is a class of data that's not directly available in the case of all States, but the data does exist and it's a matter of obtaining access to it by obtaining permission. Is that correct?

ASSOCIATE PROFESSOR CAUGHEY: Yes, that's correct. So each of these data sets, we've had to obtain permission from the data custodians, as I've highlighted, and we've also had to obtain ethics approvals from all of the data custodians, our associated universities as well. So part of the process over this four-year journey in establishing ROSA, you know, the first sort of two and a half years were essentially trying to get these approvals and access to linkage and ethics approvals was an extremely lengthy and extensive process that we had to undertake.

MR GRAY QC: And it sounds like not all jurisdictions have yet provided access to the hospital-related data?

ASSOCIATE PROFESSOR CAUGHEY: That's correct, yes. As I said, we have approval to get the Queensland hospital data, we haven't obtained that yet. And there's potential limitations in accessing other States' hospital data.

MR GRAY QC: Would you be asking the Royal Commissioners to give

consideration to doing what they can to ensure that that authorisation is forthcoming?

ASSOCIATE PROFESSOR CAUGHEY: That would be wonderful. We've, you know, tried, and been quite relentless in trying to get access to data. One of the current limitations that we have is actually getting the most recent data that's available. So we've only got data up to 2017 and we have been trying. We've got approvals. We've been trying to get data from 2018 and 2019 to no avail. And ideally, we would --- you know, I think it's really important that we also have access to data from 2020, given the current situation we've got with COVID and the situation in --- especially for people in residential aged care. I think it's a real opportunity that we can actually examine this, the quality and safety indicators, for the first half of this year to, you know, inform policy and monitor quality of care given to people in residential aged care.

MR GRAY QC: Thank you. Turning now to home care, is it correct that the list on the screen of the indicators that are available for use in home care, subject to those approvals or authorisations being obtained, that that overlaps with the indicators in residential aged care save for the last three indicators?

ASSOCIATE PROFESSOR CAUGHEY: Yes, there is a large overlap with residential aged care monitoring system. One of them wasn't included was polypharmacy which is about five down the list, and also the last three on the list, so the wait time for Home Care Packages, chronic disease management plans and medication reviews. And two of the indicators from the residential aged care, including weight loss and pressure injury, weren't included for this home care in this instance.

MR GRAY QC: And why is that? Is that because --- just taking weight loss and pressure industry, is that because there's difficulties in attributing responsibility for weight loss and pressure injury for a person who is living in their own home?

ASSOCIATE PROFESSOR CAUGHEY: It was partially due to that and partially that it was, especially for weight loss, the prevalence was quite low when we measured it in our residential aged care, and as were pressure injuries. Because we're using hospitalisation data to capture these two indicators, we really are capturing people who are being hospitalised for these conditions or these conditions are contributing to a hospitalisation episode. So we're really not capturing people that may have just lost 5 kilos in 90 days, for instance, or have a stage 1 pressure injury which potentially wouldn't be captured in our hospitalisation records, and potentially these aren't as pertinent to the home care population.

MR GRAY QC: And that prevalence point you make, if the prevalence is low, does that then impact on the reliability of trying to include an indicator of that kind?

ASSOCIATE PROFESSOR CAUGHEY: No, not necessarily. Maybe the prevalence is actually low but, you know, I think that we --- you know, one of the strengths of our data outcome monitoring system is that we do use existing data but

it's also important to recognise there are limitations with the existing data such as I mentioned in terms of using hospitalisation as a proxy for weight loss. And importantly, I think that what we can see, while we're recognising those limitations, is that we can still actually measure variation in care because we can look at differences for each care provider in terms of whether the population that they're caring for actually falls within the accepted range, if you like, for these outcome indicators.

MR GRAY QC: And the other three items in the home care list, one of them is specifically about home care because it's about wait lists for packages. What about the use of chronic disease management plans and use of medication reviews? Why are they specifically appropriate for home care and not necessarily recommended --- well, not recommended by ROSA for the residential care OMS?

ASSOCIATE PROFESSOR CAUGHEY: Both the chronic disease management plan and the medication review were considered as part of our residential aged care indicator suite in the first instance. However, for the home care population, there is significant potential to provide the services that are provided by the Government. So a medication review is provided by a clinical pharmacist and it's subsidised by the Government, as is chronic disease management plans provided by the general practitioner. And these services, if you like, really do have the potential to improve health outcomes and for those people that are, you know, at the other end of spectrum potentially in terms of health conditions, we felt that these are services that are available that potentially can help to keep people at home for longer in terms of medication reviews, it potentially can identify medication-related harms or the potential for medication-related harms.

We know 250,000 people a year are hospitalised for adverse medication events. Another 400,000 present to the emergency department for a medication-related adverse event. So there really is potential if people, where appropriate, do access these services, that we might be able to stop them from having harms associated from medication use and to keep them at home and healthier for longer.

A chronic disease management plan I think really offers an opportunity to provide patient-centred holistic care plan for these people receiving home care services and to help also coordinate their care. We know older people are increasingly having multiple chronic conditions, they have multiple people looking after them. So if a person has a care plan that includes what their individual patient preferences for their care and their goals are, I think that that will also then help to provide an opportunity to help to keep these people at home for longer.

MR GRAY QC: Thank you. Can I just ask you about the current state of quality indicator monitoring in Australian aged care. If we go back to tab 60, please, operator, and we go to page 0019? There's a section in your report referring to the current quality indicator regime and, Professor, you mention under heading 2.4, which will come up shortly, that mandatory quality indicator collection is only a very recent phenomenon in Australian aged care, beginning in July last year. That's

correct, isn't it?

ASSOCIATE PROFESSOR CAUGHEY: Yes, that's correct.

MR GRAY QC: And there is, over the page please, operator, a description there of the three groupings of indicators that are mandatorily collected --- reported and collected in residential aged care in Australia. And, Professor, it's the case, isn't it, that there is some aggregated reporting of those data that are collected as a result of that regime or that quality indicator program?

ASSOCIATE PROFESSOR CAUGHEY: Yes, that's correct. And the first report from that has just been published this year.

MR GRAY QC: And there's an aggregated report on the Gen Data website that I mentioned which has some degree of regional analysis of the data that are provided, but there isn't any provider-by-provider reporting --- sorry, public reporting of those data. That's correct, isn't it?

ASSOCIATE PROFESSOR CAUGHEY: That's correct.

MR GRAY QC: So your list of 12 indicators for the OMS in residential care is more extensive than the current regime. That's clearly so, isn't it?

ASSOCIATE PROFESSOR CAUGHEY: Yes, that's correct.

MR GRAY QC: And you're also suggesting that there are a number of other indicators that could be collected in home care. What's the status of indicator reporting for home care in Australia at the moment? Is there any quality indicator reporting at all?

ASSOCIATE PROFESSOR CAUGHEY: No, it currently doesn't exist.

MR GRAY QC: And in essence, in your second report at tab 62, you've identified --- subject to those authorities being granted by those State departments which administer hospitals in the various States, there are data that exist from which all of those indicators that you've identified in your second report could be the subject of reporting in home care without any further data collection activity being needed. Is that right?

ASSOCIATE PROFESSOR CAUGHEY: That's correct, yes.

MR GRAY QC: All right. Now, can I ask what would be the purpose of collecting and analysing those data, and it occurs to me there are a number of potential purposes. There might be the purpose of tracking the performance of the aged care system at a system-wide or regional level, but there might be other purposes as well. For example, considering the performance of particular providers and possibly some of these data might actually help with the care of the individual person along the

lines that you were suggesting a little earlier when you were explaining the importance of medication reviews. Could you tell the Royal Commissioners what purposes collection and analytics of these data would serve?

ASSOCIATE PROFESSOR CAUGHEY: Do you mean in terms of an outcome monitoring system as well as ---

MR GRAY QC: Yes. Is it all about tracking the performance of the system or could it be used to determine the performance of providers and even to assist in individual care planning?

ASSOCIATE PROFESSOR CAUGHEY: Yes, I think it's all of the above, what you mentioned, Counsel. I think it's important in terms of appropriate monitoring of the quality and safety of care currently provided. It also serves as a metric of measuring care provided by individual care providers and one of the things that we really want to highlight, the reason for this is not to necessarily just to point out where care is done badly, it's also to point out where care is done really well and what can we learn from these providers in terms of, you know, what are they doing that is giving such, you know, positive outcomes and care?

And I think ultimately what we want to be able to examine is that the implementation of this outcome monitoring system will ultimately help to improve care through potentially helping to formulate detailed care plans for individuals and also to, you know, mitigate risks of harm from the care that people receive.

MR GRAY QC: Thank you. There would be privacy concerns relating to tracking the individual --- the indicators relating to the care of particular individuals, I assume, would they have to consent to the use of that data for that purpose?

ASSOCIATE PROFESSOR CAUGHEY: Yes. So, currently, outcome monitoring system is based on the historical data that we have access to through the establishment of our registry. We also are trying to establish a perspective cohort. So that is we --- when people have their aged care assessment, it's actually an opt-out form that they are able to provide us their data in terms of using this for research purposes, and also to provide our perspective outcome monitoring system.

So whilst we have approvals from the individuals themselves, we just don't have access to the data yet.

MR GRAY QC: Okay. Can I ask about the following issue: if those data were going to be used, these quality indicators were going to be collected for the purpose of tracking the performance of particular providers, there would be a problem to be faced, wouldn't there, by reason of the fact that different providers have different mixes of clients, people in their care, and some providers might have clients that have more acute medical needs, for example, and that might skew the results produced by the quality indicators that you've itemised in your report. Is there a solution to that problem?

ASSOCIATE PROFESSOR CAUGHEY: Yes, you're exactly correct, Counsel. Yes, in doing our ROSA outcome monitoring system, all of the indicators are case mix adjusted. That is, they're adjusted to account for the varying profiles of individuals in aged care. In our outcome monitoring system, at minimum we adjust for age, gender, and number of health conditions, and for each of the individual indicators we have some extra case mix adjustments such as things like mobility, the presence of certain conditions such as osteoporosis or dementia or prior hospitalisation. So this is really important to account for the differences in the characteristics of people that are receiving these aged care services and is crucial when making comparisons, as you mentioned, between the quality and safety of care given between providers.

So this is currently done in other countries as well and I think it's an essential part of having a robust outcome monitoring system.

MR GRAY QC: So assuming that case mix adjustment is done, would it be appropriate and useful, in your opinion, for the results at a provider level to be made available to the public so the public can judge the performance of the provider on those metrics over time?

ASSOCIATE PROFESSOR CAUGHEY: Yes, I do believe so. I think internationally they are provided in various forms online at various reporting intervals and I think it's important in terms of improving transparency of the system and also to help people making informed decisions about what care providers they ultimately choose to have their loved one cared for.

MR GRAY QC: Professor, when you were explaining the processes that were employed in the study, you mentioned that there weren't any data available from which I think you said quality of life could be measured or reported. Is there any work being done to try to formulate some way of measuring quality of life outcomes and what's the progress on that work? Do you see any possibility of being able to have a quality indicator that captures quality of life in the future?

ASSOCIATE PROFESSOR CAUGHEY: Yes, definitely. I think having quality of life is a really important indicator to have included within an outcome monitoring system. Other countries such as the UK, Sweden, and Netherlands do have a quality of life within their outcome reporting systems. I know of Julie Ratcliffe and her team at Flinders University are developing a quality of life tool specific for aged care, and I think it really is important that something that measures quality of life or consumer satisfaction is essential to the delivery of person-centred care. And whilst potentially it may be time-consuming, potentially, in terms of including this as a data collection, I think it needs to really be integrated within the standard aged care data collection and measured routinely and regularly over time, so longitudinal repeated assessment of quality of life is really needed to help ensure that this data collection process is part of the inherent product of delivery of person-centred care. And I think that, you know, when that is --- the quality of life is tools being examined or

assessed in an individual, then that should then be used to inform care delivery at that sort of point of care time, if you like. So I think it really is important.

MR GRAY QC: Just returning, finally, to one of the purposes for which these data could be used, which is to track the performance of the system overall, and to be able to understand how the system is performing in different regions, whether there are better or worse outcomes in terms of the hospitalisations, the use of many medications, the use of the antipsychotic medications, all of those indicators you've mentioned, whether there are places where there's variance, variation in outcomes, how would that be useful to the management of the aged care system overall?

ASSOCIATE PROFESSOR CAUGHEY: That's ultimately the goal, is to provide insight into where care is being done well and potentially where care can be improved so that then the providers themselves can identify potentially these shortcomings to implement quality improvement programs, targeted strategies, if you like, to understand why, potentially, care is suboptimal and then to hopefully implement change to result in improved quality and safety of care for their care recipients.

MR GRAY QC: Is there a role for Government in understanding how the aged care system is performing differently in different places and whether it has shortcomings by comparison with international benchmarks?

ASSOCIATE PROFESSOR CAUGHEY: Yes, I think it's --- you know, given the current state of our aged care system, I mean, there are instances where it is done very well but I feel like there is so much more that we can do for, you know, one of our really vulnerable populations in terms of improving the quality and safety of their care, in terms of monitoring whether they are getting the appropriate care needed, whether they are getting person-centred care, so just not --- it needs to be individualised to suit each person's needs and I think there's a huge opportunity and imperative that we need to do for our aged care population and this also includes our home care population.

Increasingly, in other countries, there's use of home care services, and in Sweden, it's actually been shown to reduce institutionalisation of our older population over time. So we know people want to stay at home, they want to stay at home and stay well, so I think we really do need to implement some type of quality and safety outcome monitoring system that's done routinely to help improve transparency of the current system but also, most importantly, to improve the quality and health outcomes for this vulnerable population.

MR GRAY QC: Thank you. I have no further questions.

COMMISSIONER PAGONE: Thank you, Mr Gray. Commissioner Briggs?

COMMISSIONER BRIGGS: Thank you, Commissioner. I just have one question. I find your evidence very compelling, Professor. I suppose I would like to

understand, if all the ducks were lined up, as it were, how long would it take to introduce and start applying a national system of quality and safety indicators of the sort that you're suggesting for both residential aged care and for home care, please?

ASSOCIATE PROFESSOR CAUGHEY: If it wasn't limited by data access and resourcing and staffing, I think it could be implemented within six months.

COMMISSIONER BRIGGS: Oh, that's very encouraging. Thank you.

ASSOCIATE PROFESSOR CAUGHEY: Yes, that's okay ---

COMMISSIONER BRIGGS: No, go on, please.

ASSOCIATE PROFESSOR CAUGHEY: The data is all there and I think what we're proposing is a starting point, if you like, for outcome monitoring for aged care in Australia. What we see is we've got this existing data, it would be remiss not to actually use the data to provide this outcome monitoring system and what we see is that it actually evolves over time. So where we can, say, have quality of life added to our data collections or where there's other data collections that can be added to this suite of indicators, then it would evolve over time to include all the things that would be important to include that we are unable to currently capture. And I think it's also important that it's continually evaluated and refined. So it's not just put it out there and that's how it is, it's like we need to develop benchmarks to ascertain what is an appropriate level for each of the indicators so then people have clear goals of what they need to target these outcomes to, and as I said, I think it would evolve over time in terms of looking at how it's actually helping to improve health outcomes as well.

COMMISSIONER BRIGGS: Thank you. That's all my questions, Commissioner.

COMMISSIONER PAGONE: Thank you, Professor, for your expertise and being available to explain it in the way you have done. It's been very useful and helpful information. It's wonderful that we've been able to get access to the kind of expertise and knowledge that you bring to the issues that we need to consider. So thank you for that time and effort and for being available. I think I now need to formally excuse you and you are formally excused. Thank you.

ASSOCIATE PROFESSOR CAUGHEY: Thank you.

THE WITNESS WITHDREW

MR GRAY QC: Commissioner, should there be a short break and then a resumption at 11.30?

COMMISSIONER PAGONE: Yes. We will resume at 11.30.

ADJOURNED **[11.21 AM]**

RESUMED **[11.32 AM]**

COMMISSIONER PAGONE: Mr Gray.

MR GRAY QC: Thank you, Commissioner. I call Robert Fitzgerald AM and Kathryn McKenzie.

ROBERT FITZGERALD AM, SWORN

KATHRYN MCKENZIE, AFFIRMED

EXAMINATION BY MR GRAY QC

MR GRAY QC: Mr Fitzgerald, you're the NSW Ageing and Disability Commissioner?

COMMISSIONER FITZGERALD: Yes, that's correct.

MR GRAY QC: Ms McKenzie, you're the Director, Operations of the same Commission, is that correct?

MS McKENZIE: That's correct.

MR GRAY QC: You've both prepared a joint written statement for this Royal Commission. I'll ask it now be displayed. It's at tab 73 of the same tender bundle, document code WIT.0786.0001.0001. Are you able to see that document displayed on the screen now?

COMMISSIONER FITZGERALD: Yes, I am.

MS McKENZIE: Yes.

MR GRAY QC: And directing this question to both of you, are you both satisfied that the contents of the statement are true and correct and that the opinions in it are opinions that you hold?

COMMISSIONER FITZGERALD: Yes, I am.

MS McKENZIE: Yes, that's correct.

MR GRAY QC: Thank you. Now, could I ask you some background contextual questions about the role of the NSW Ageing and Disability Commission. I'm happy to direct these questions to Commissioner Fitzgerald in the first instance, and perhaps we could adopt the modus operandi of the Commissioner referring any matters to Ms McKenzie that he wishes to.

COMMISSIONER FITZGERALD: That's fine.

MR GRAY QC: Thank you. In broad terms, what is the role and mission of the Commission?

COMMISSIONER FITZGERALD: The Ageing and Disability Commission was established by the NSW Government on 1 July last year, 2019, so it's a very young and new Commission, and it arose from work that was being done by the NSW Ombudsman's Office in relation to vulnerable adults with disability, and from work that had arisen both through the elder abuse help line that had previously been funded by the State Government and work of the NSW Law Reform Commission, both identifying that there needed to be an agency that would look at prevention and responding to abuse, neglect and exploitation of older people and of adults with disability. So the Commission was formed to have that particular primary role; prevention and responding to abuse, neglect and exploitation.

It has a number of statutory functions, quite a large number of them, but the critical ones are we establish a help line, an elder --- sorry, an abuse help line for both people with disabilities and older people. There was previously an elder abuse help line in New South Wales. It's able to take formal reports in relation to matters of abuse, neglect and exploitation of those two groups. It can conduct detailed investigations in relation to those reports. It's able to conduct public hearings in relation to certain types of investigations with the powers of a Royal Commission. It also has a number of statutory functions which I won't go into, except they include administering the Official Visitor Scheme which visits residential services, and in our case we deal with disability services, boarding houses, and on behalf of the children's guardian, out-of-home care residential services, and it also has a number of issues in relation to systemic matters.

So that's its function and its purpose. And ultimately it's based on the rights of all people to be able to live free of abuse, including, in this case, older Australians.

MR GRAY QC: Thank you, Commissioner. In connection with the potential for abuse, neglect and exploitation of older people, and in particular older people living at home, in their own home or outside a residential facility, I want to ask you about the concept of safeguarding. Now, in your statement you refer to five or six important aspects of safeguarding. But could you please give our Royal Commissioners an outline of what the concept means in that context?

COMMISSIONER FITZGERALD: The ultimate aim is to ensure that older people living in the family and in community contexts are able to live free of abuse, neglect and exploitation. Abuse, broadly defined, is the conduct that gives rise to harm, or significant detriment to an individual, in this case an older person. And the context within which we primarily operate, as you've indicated, is the home, family and community settings.

The second thing I'd say is this all sits within a broader context. The first is the notion of anti-ageism. You would be aware, Commissioners and Counsel, that there's been a very significant campaign in relation to the recalibration of the way in which we see older people in the Australian community, largely called anti-ageism, whereby we see and value older people as important parts of our community, not simply seeing them as people that are fading. Indeed, the greatest risk that all of us face in the Australian community is when we become invisible and older people tend to become invisible.

The second context that it is important in the safeguarding regime is the very heavy emphasis we're starting to see at all levels in relation to elder abuse specifically, and elder abuse, however you define that, is largely around those issues that I've described, of abuse, neglect and exploitation of older people. Elder abuse is, in fact, an important framework within which a safeguarding regime, both in aged care but also in relation to home care, sits.

So the third thing I wanted to say is safeguarding is about the way in which we think and the culture of the organisations and that's about a culture that thinks safety. If you look back on our workplace health and safety legislation and regimes, Australia was a nation that actually accepted that people would become ill at work, would die at work, or suffer injury. We no longer think in that way and the workplace health and safety regime changed the way in which we saw workplaces. We now think, act, and hopefully abide by the regulations to create a safe workplace.

So when you go into the safeguarding for the family or the home environment, what we are trying to do is to create an environment where people can live safely. Whether they live in isolation or alone, whether they live within a family setting or whether they live with non-family members, it's very important that they're able to be safe. And we've indicated, and Counsel, I'm happy to go through them, a number of component parts to a safeguarding regime.

But, ultimately, it is about two things: the rights, the rights of individuals to live free of abuse and neglect and exploitation, and the second thing is it's about relationships. A safeguarding regime is about relationships. It's not just about policies and procedures and if it was only that, it will fail. It's about the relationships that the vulnerable person or the person at risk has with people, people that as carers, whether they're paid or informal, the service delivery system, the legal supports and systems and a number of other component parts. So safeguarding is actually a way of seeing an issue, that is, keeping people safe, but it's also about rights and relationships.

MR GRAY QC: Thank you, Commissioner, and I will come to those aspects that you've enumerated in the statement and I will ask you about them in a little more detail in a minute. But can I just first confirm that, conspicuous by its absence in what you've just told our Royal Commissioners, was any real reference to external monitoring and regulatory compliance action and things of that kind. It seems that the conception of safeguarding that is most useful is to consider it as something perhaps related to, but different from regulatory compliance action. Is that correct?

COMMISSIONER FITZGERALD: Regulatory compliance action is very important in two ways. Firstly, it in fact drives cultural change, both within society and in institutions. In the wash-up of the Royal Commission into Child Sexual Abuse in Institutions, there was a recommendation for child safe standards, 10 in fact, which have now been adopted by COAG. The first of those is about institutional leadership, governance and culture. Now, that's not simply wishing it would change. There are a number of elements that have to be put in place for it to change and one of those elements is regulation and oversight. And so it's a driver of cultural change and practice.

The second thing is external overview and regulations simply acknowledges that where we're dealing with a very expansive service system with multiple agencies providing services and supports of variable quality and frankly variable cultures, without a regulatory framework, in fact bad things will happen and are likely to increase over time. So regulation and oversight are very important in actually making sure that the system functions effectively from the viewpoint of the consumer or the client.

The third thing, however, is that regulation by itself won't get you there, and so this whole issue about community education, putting it within the broader context that I have, trying to ensure that there is a real understanding, not only by service providers but by carers and family members, by trying to educate the legal profession, by working with the police services, all of those are important, but Counsel, there's no doubt at all that good quality regulation and oversight proportionate to both the risk and the nature of the services being provided, is essential. But it's only part of the suite of measures that are necessary to bring about a safe environment.

And I think I go back to the workplace health and safety to see how we as a nation have looked at one particular area of safeguarding.

MR GRAY QC: Thank you. In your joint statement, this is at paragraph 4 or section 4 covering three pages, pages 2 to 4, you address the point that no one or no single safeguarding option is failsafe and effective safeguarding requires multiple mechanisms that interrelate. Now, drawing on your experience in either the disability sector or the context of older people, what are the various mechanisms that can be used to achieve safeguarding in circumstances where it's very difficult to have what's called in the statement a line of sight into care provided on private premises?

COMMISSIONER FITZGERALD: So, Counsel, that point is very important to

understand. The highest risk for older people in the aged care system is within the home. I know all of the attention focuses in on the residential settings, and there are high risks in those. As you're aware, I was one of the Commissioners into the Inquiry of Older Australians in 2010/2011. But the risks that occur at home are quite substantial because there is not the line of sight that you normally see in residential services.

It's not to say that people are more harmed or more damaged in the home, but without the line of sight that exists, the risks are higher. Now, that's the first point we'd make.

The second thing is, and I'm sure Kathryn will have some points on this, it starts in relation to the provision of services, it starts with the assessment of the needs of the individual and those assessment tools need to be able to identify vulnerabilities or risk early and on an ongoing basis. The point that's about this is the vulnerability is not necessarily because of the condition of the individual, that is, their physical condition, or their mental acuity, which are important. Risks occur because of the settings within which they currently live and those risks are articulated in various documents already.

So you have to start from the assessment of the needs of the individual and the risks and the vulnerabilities that that person has at the earliest particular point in time.

The third thing is, then, in terms of actually moving to one very important part about safeguarding for older people is making sure that they are at the --- it's not only at the centre of the service delivery system, but they're an active participant in it. That is, the capacity to make decisions on behalf of themselves and to influence decisions made on their behalf is critical. And often, what we tend to do is we tend to be concentrating on the provider to the exclusion of the participation of the older person.

One of the difficulties we face in our Commission is that we're often dealing with people that are at risk of abuse or being abused. The bell curve centres around 75 to 85 years of age, and many of those people are starting to lose various levels of capacity. So it's not a permanent state. But what we do know, so long as a person has capacity, one of the most important parts of safeguarding is the ability of that person to actually make decisions on their own behalf or to influence those decisions in a very robust way.

The issue about invisibility that I referred to, the reality for all of us that will get older, is that not only do we become invisible but our voice becomes unheard and in a safeguarding regime it's critical that the voice of the individual is heard and their preferences are acknowledged. Without that, you won't have a safeguarding system.

We've identified a number of other issues in this paper, as you've indicated. Do you wish us to go through some of those, Counsel, or not?

MR GRAY QC: Well, can we just take those two a little further, and I don't know if this is a point at which Ms McKenzie might want to participate. We've previously tendered in the Royal Commission's proceedings the assessment form that is used by aged care assessment teams to conduct comprehensive assessments of the needs of people seeking Home Care Packages. It's exhibit 7-1, tab 45. The operator will bring that up now. I hope the message reached you, Ms McKenzie, that I'd refer to this document, and Commissioner. Thank you.

Now, we'll just show the first page. There it is. So that's the National Screening and Assessment Form, NSAF. There is on page --- native page 3 of the document, page _0002, there is a field for specification of risk of vulnerability. That seems to be a topic somewhat aligned with what you just said, Commissioner, about the need for a safeguarding regime to begin with identification of vulnerability during assessment. So this form is prompting the assessor to think about that and there's some detail available on _0023 later in the form.

The relevance of these matters is said to be linking support, what's called linking support. There's been a little bit of evidence about linking support previously. I will be asking some witnesses tomorrow a bit more about it, but there's then a number of points raised about the possibility of risks and vulnerabilities.

Is this the kind of inquiry that you had in mind, Commissioner, and Ms McKenzie, if you wish to explore whether any of these prompts are useful or whether additional prompts would be needed, that would be of assistance to our Royal Commissioners?

MS McKENZIE: So, yes, we're familiar with the assessment form. To our mind the questions and the components of it are quite useful. They cover the key components of, I guess, the higher level of risk or indicators of potential risk to individuals that we would seek to have covered. So things like, you know, higher levels of cognitive impairment where there's risk of abuse of individuals, where there's high level of dependency on others, social isolation, a whole range of factors that go to increasing risks for individuals.

I think what we would say about the assessment form, though, and obviously this is coming through the lens that we particularly have in this organisation which is around abuse, neglect, and exploitation of older people, is that while there's a question in the assessment and components that go to asking the older person about their personal safety and it goes to issues around risk of or suspected or confirmed abuse that feeds into the section that's on the screen at the moment, the feedback that we get from the sector and from individuals is that those questions are not always asked in the assessment process for various reasons. So at times because the assessor is uncomfortable to ask those questions, the stress that that may cause to the older person, but also because at times, and depending on who else is present for the assessment such as family or others, it may not always be safe to ask the older person those questions.

So our emphasis, we think that this, in the main, does cover the key areas that we

would seek to identify, to identify people that are at greater risk, and that might need links to increased range of safeguards, but it's in the practice, it's in the consistency, I suppose, of asking some of those more difficult questions, but also providing the safe space in which to ask and to obtain information relating to those risks.

MR GRAY QC: Thank you. And in the case of the person who might have some degree of cognitive impairment, what can be done to support that person in addressing these very difficult topics?

COMMISSIONER FITZGERALD: If I might make a couple of comments, and Kathryn, I'm sure, will add to them. We deal in the world of people that are slowly losing cognitive capacity. But the assumption has to be, in the first instance, that they have cognitive capacity and that's very important.

On the page prior to the one that you've got up on the screen there is a section about personal safety and there are several guidelines that go with that question. One of the questions we'd want people to be asked is "How do you feel about living in the environment that you're in"?

MR GRAY QC: I'm sorry, Commissioner, I'll ask the operator to go back to the preceding page, 0022. Sorry, Commissioner, go ahead.

COMMISSIONER FITZGERALD: So even in the assessment phase there's a real opportunity, down the bottom there you will see "Personal safety". There are a series of guidelines that help the assessor fill that particular box in, but that's the sort of area where you start to actually ask the questions of the person and the most important question is do they feel safe? It's also the point at which you start to see whether or not cognition, you know, is being impeded in a significant way or not. And, of course, the most important thing is that there's a reassessment process as you go through. So that's one point.

The second point is in relation to people that are in vulnerable environments. It's very important that they sometimes are able to access independent supports. So there's a couple of those that I think are important and I know you're considering. One is the absolute need to be able to obtain advocacy. In the disability area, advocacy is a given. Now, there are arguments about the nature of the advocacy, the funding of the advocacy right throughout Australia. But what is important in this space is that there is the capacity for an individual to be able to have some sort of advocate to act on their behalf when cognition is starting to fade.

The second thing is it's very important that they're able to access supports through legal support systems, especially where they believe they've got the capacity, but they're being denied that capacity by other people. So we have, in fact, entered into various relationships with Justice Connect, the NSW Commercial and Administrative Tribunal, and other organisations, so that people can be put in touch with and supported by legal practitioners and the legal system where that's important.

The third one is, I think, a more contentious issue. We, as you know, have responsibility for the Community Visitor Scheme in NSW for people that live in residential care. There is a real issue as to whether or not we need to expand community visitor schemes generally in the aged care area, and importantly, there is an aged care visitor scheme that does operate largely as a companionship scheme, not an oversight scheme, and the question is whether that should be extended so that there is an external presence in the family, either in a formalised way like in a community visitor schemes operate generally, or the way in which the current aged care visitor scheme operates.

So they're some of the elements that aid people that are starting to lose cognition generally. But Kathryn might have some specific points to make.

MS McKENZIE: The only point I was going to add, Commissioner, was just in relation to there are actually a range of tools and mechanisms that can support assessors and other individuals to be able to obtain relevant information as much as possible from individuals, even with more significant levels of cognitive impairment, and it is about identifying what supports are available but it's also understanding the person's needs and the best way to communicate with them and to obtain information from them. But there are existing tools and supports that exist to support that.

COMMISSIONER FITZGERALD: And I should, Counsel, just make reference to the fact that around Australia there has been a move to move to two different types of approaches in relation to guardianship issues and the like. One is to move from "best interest" to "will and preference" and that is being undertaken in a number of jurisdictions.

The other one is a much more contentious area and that's the establishment of supported decision-making regimes that would apply to people with disabilities and, in fact, to vulnerable older people. In New South Wales there's been detailed consultation but there's been no response from the Government in relation to that. And supported decision-making may be a way by which we can help older people that are transitioning to the need, maybe, for substituted decision-making. So I just want to make the point that there are considerations of trying to have formal supported decision-making regimes put in place and I understand that Victoria may have already moved down that road. So there are some more formalistic mechanisms beyond advocacy, community visitors and general supports.

MR GRAY QC: And do those proposals for supported decision-making involve an independent person assisting the person who needs to make the decision?

MS McKENZIE: Not always an independent person. It needs to be someone that doesn't have a vested interest in the decisions that are being made. But often what's more frequently used is to identify someone that the person knows well and they trust and, again, the key part is that they don't have a vested interest in the decision.

So at times, support workers at times are being used to provide supports for people to

make decisions because they've been working with them for a long period of time, the person --- they understand how best to communicate with the person, how the person best receives information and how they best communicate their wishes. So it doesn't always have to be an independent party, but it does need to be someone that doesn't have a vested interest.

MR GRAY QC: Advocacy programs, there is an aged care advocacy program called the National Aged Care Advocacy Program, NACAP, and there's a body or network called OPAN, Older Person's Advocacy Network conducting that program. Have you had interactions with it? Do you have any impressions? Does it have enough funding to get the job done? What are your impressions?

COMMISSIONER FITZGERALD: Sorry, in New South Wales we have a close relationship, in fact a memorandum of understanding with Seniors Rights Service which is a member of OPAN, as we do with a number of other peak bodies in the ageing area. And so we work with them.

What's interesting in the ageing area is it doesn't have the network of advocates that you see in the disability area and space and so I think there is an issue as to whether or not there is, in fact, enough accessibility to advocacy in the aged care sector or the ageing area, and I'm not sure there's enough diversity of advocacy. But I wouldn't want to comment specifically in relation to those services because we do have a very meaningful and good relationship with Senior Rights Service.

But I think if you're looking at just this one statistic, and I know that you're very attuned to this, in the original --- in the Inquiry that I did in 2010/2011, the projection was that by 2050, 3.6 million Australians would receive aged care; 3 million of those will receive it in the home; 600,000 in residential care. And that 600,000 will decline if we're able to reduce the progression of dementia in our system. In fact, many of those 600,000 will be there solely because they are living with dementia of some form.

So if you're looking at 3 million receiving services in the home, the question is what sort of advocacy system you would need, not to support everybody, because many of those don't need that support, but it's not going to be anywhere near the levels that we've currently got. So I think, looking forward, a robust advocacy system which has multiple functions, so community education and awareness and all of those things I think is going to be critically important.

The second thing I would simply say, it's also very important that we are actually providing advocacy for and support of the carers and in a number of the areas that we're dealing with, people who ultimately do the wrong thing didn't start off with that intent. They started off as caring carers. But over time, things have gone wrong and the care of those people that are both informally and formally supporting people who are ageing is a critical element in that. And there are advocacy bodies for those groups, as you're well aware. Nevertheless, they are an important part of the whole arrangement and sometimes they themselves need that sort of advocacy support and I

don't think we pay much attention to that.

MS McKENZIE: Do you mind if I just add something there? The only other bit that we would add to that is at the moment some advocacy support in the --- for older people is really limited to people that are receiving aged care supports. If you look in the disability sector, people with disability, access to advocacy isn't premised on receiving specialist disability services. Advocates provide assistance to citizens of New South Wales, the Disability Advocacy Services New South Wales provide assistance to people with disability more broadly and interaction with mainstream and other supports, the whole range of concerns that people with disability have and that would be great to see replicated in the ageing space.

MR GRAY QC: Thank you. And community visitors, and, Commissioner, you mentioned an official Community Visitors Program in New South Wales overseen by your office that extends to residential aged care but not into private homes, and you mentioned the Community Visitors Scheme, the voluntary Community Visitors Scheme, in the aged care setting which is a very different thing, isn't it? It's companionship, as you pointed out, and doesn't have an official monitoring role.

What would be the risks that extending an official visiting scheme into the home might be seen as intrusive, and what also would be really the difference between enlisting an official visitor scheme on the one hand, compared with resourcing the quality and safety regulator to conduct such visits on the other?

COMMISSIONER FITZGERALD: Counsel, just to be clear, our community visitors deal with disability services, residential services, not aged care services.

MR GRAY QC: Thank you.

COMMISSIONER FITZGERALD: So ours is disability boarding houses and on behalf of the children's guardian, out-of-home care.

In relation to the community visitors, the official community visitors schemes as they operate in many of the States, firstly they are schemes where they are directly reportable to the Minister, they're the Minister's scheme. They were designed so that the Minister would then have a direct feedback as to what has happening in the services ultimately that they were responsible for when governments used to run the disability service system. Now they feed information to the Minister who is a shareholder or a stakeholder in the NDIS. So they have a very important role of being able to identify issues on behalf of the Minister.

Secondly, they're absolutely designed to resolve disputes with the local provider. A community visitor, first and foremost, listens to and works with the resident in the case of disability services and then, in fact, seeks to have those matters dealt with by the provider at the lowest possible level. So they're not a complaint handling body in the nature of the arrangements.

But the third thing is they can raise complaints. They can raise complaints with us, they can certainly raise complaints with the National Disability Insurance Scheme Quality and Safeguards Commission. They can, in fact, make complaints to the departments responsible directly. But they have a very formal terms of reference. They are statutorily appointed and they have certain protections that go with that.

The Community Visitor Scheme, as I understand it that operates in the aged area, as you've indicated correctly, is very much lower level. It's a scheme funded by the Commonwealth, it's delivered through non-government organisations and it is largely designed to provide some sort of comfort or support or companionship to older people that are deemed in need of such support.

I think the challenging question, as you've put, is whether or not you move to a more official, formalised scheme within the aged care area where people are living at home and the risks, as you've indicated, in public policy terms, is how far should Government intrude into the private space?

What I think the COVID has shown is that there is a group of older people, and there are a group of people with disabilities living in their homes that have significant risks and vulnerabilities. In the NDIS system, what the NDIS system has identified through its own assessment processes, those groups of people that were vulnerable and then put in a particular support system where people were phoned on a regular basis and if they didn't answer somebody would go and visit them.

The NSW Government did something similar to that in relation to social housing tenants. What's clear to us is that there is a cohort of older people that would benefit from having some more formal visiting program. The questions, however, are complex. Who would identify that person? What would be the risk factors that would trigger such intervention? Does the person have the option of opting out of that, in other words, saying they don't want visitors? So I think there's a number of issues that surround the way in which you'd design that scheme.

But I have to say, the point you made is absolutely right. Public policy has to be very careful about intervening in the family space. Having said that, my Commission lives in the family space. It lives in that home environment. So we are learning more and more about that environment, both the risks and the opportunities it provides, but I do think that there is a need for an expansion of some form of visitor program within the aged space where people have identified as having special needs or special vulnerabilities.

MR GRAY QC: We're told that the vulnerability assessment flowing from that assessment and screening form that we spoke about a little earlier is not provided to the quality and safety regulator, that information is not provided to them. It may be that it's available to providers, and it seems clear that it is used to inform a decision about whether linking supports are included in a person's package. Perhaps that's not accurate, but in any event, whether linking supports are made available for a person. I withdraw what I said about inclusion in a package.

Now, do you have any knowledge, either Ms McKenzie or Commissioner Fitzgerald, about the efficacy of those linking supports in providing that sort of check-in support, visitation of the kind you've just outlined as necessary in the aged care space for a certain cohort of people receiving home care?

MS McKENZIE: No, we wouldn't --- we don't have information about that. It's not --- it's rare in the matters that we see for there to be --- for us to see, and I suppose this is why we emphasise the need for the assessment of risk or the assessment of the person to identify those that are particularly at risk, but then to link people in with appropriate safeguards and one of those may be a home-visiting scheme as the Commissioner was mentioning. But we're not currently aware the extent to which that's currently done. So mechanisms to link in with the existing community visitor scheme in aged care or otherwise.

MR GRAY QC: Thank you. Now I want to go to another one of the facets of safeguarding identified in your joint statement. We don't have time to unpack all of them in the same detail, so I will skip some of what you've said on page 0003, going to the bottom "Ensuring community connection and social networks". And you make the point that --- I think you said this somewhere in the statement, as many eyes as possible on what is happening behind closed doors are preferable and are an important feature of a safeguarding framework for an older person, and you make the point that there are abundant, in many cases, abundant community resources available but it requires local knowledge to connect an older person with those services. Do you have an impression as to, in contradistinction to the program known as "information linkages and capacity building and the role of local area coordinators in disability", do you have any impression as to whether there are similar services being provided in aged care and whether there is the need for improvement in connecting older people with locally available community resources?

COMMISSIONER FITZGERALD: I might just make a couple of comments, and then Kathryn will. The first thing is the system, the aged care system in terms of also connecting to community supports is a difficult system. It is not easy to navigate and one of the recommendations that came out of the 2011 report was the establishment of a comprehensive gateway. That was never established. And that gateway would have had, as part of its remit, not only community information referral but very much about the ability to navigate the system, including access to whatever is called aged care. I noticed proposals in relation to social supports, you know, assistive technology, respite and then, of course, care within the home is a framework that's been contemplated.

So the first thing is we need to ensure the system is easily able to assist carers and people that are ageing to navigate it.

The second thing is, however, older people still very much rely on local connections. So in New South Wales, my Commission and previously the elder abuse help line,

facilitate and support 17 collaboratives. Each of those collaboratives have, within them, a number of players, including generally the local health district, the local police command, the local council and a number of community service providers. It's the intention of our Commission to increase that number significantly because what we've discovered with older people is that they are still connected at that local level, including through local government, including through local libraries, including through the ever-shrinking number of local newspapers and so on.

So, to really support older people, you have to have that network at a local level. So the Commission is facilitating that, without any additional funds to do that. So I think there's a second level. There's the sort of the systems level approach but then there's this also located connectedness.

Sometimes that will happen naturally but we're finding that if an agency such as ourselves can facilitate that with very modest means, it's a very effective way of providing local support.

The third thing, however, I think is, just going to this, there probably are some needs for some formal services that concentrate exclusively in this space. And at the moment, as you well know, we have a number of CHSP providers that provide a range of services, including social supports. And those agencies have been very effective in doing that. As you know, they're block-funded and it's subject to review. Whatever the ultimate system is that you recommend, it is very important that there is a formal level of service provider that is concentrating on providing some of those social supports.

My last comment is the most tricky of all and that is this: Australia will not be able to afford to fund the social supports that are necessary to minimise risk for vulnerable older people in and of itself. And so we have to reengage the community, as we have done through the COVID period, in being part of the solution, part of the solution to this issue. The notion of community development, the notion of community inclusiveness, the notion that the community itself is part of the solution is something that Australia has lost. COVID has demonstrated, beyond any shadow of a doubt, that a society doesn't function well when that's gone. And in the case of older people, those community connectedness, the neighbourhood connectedness, is very important.

I think there are ways to achieve that but they are, in fact --- it is a very important strategy and I think recent times have shown that we have a capacity to do that through enormous social efforts and energy. So I think there's three or four levels to this particular approach.

MR GRAY QC: Thank you. I will ask the operator to bring up a document which is available publicly on "Reportable incidents in the NDIS safeguarding framework", and to go to page 5 of that document, please, operator. Commissioner, in your joint statement, this is in section 5 on page 0005, you refer to one of the differences between the approach to safeguarding in aged care and disability, is that there is a

mandatory reporting scheme for incidents in private settings in the disability sector but not in the aged care sector. And we've located this list of the matters that are mandatorily reportable in the disability sphere, irrespective of the setting in which those incidents occurred. Would a similar regime be appropriate in the aged care sphere as well for incidents that occur in the home? Or is there some reason why there need not be such a scheme? At present there is no such scheme extending to home care.

MS McKENZIE: We would definitely support the extension of a serious incident reporting scheme to in-home settings. So, where the conduct of staff in home settings, we do think that's important.

We would, however --- the scope of the incidents that are reportable under the NDIS, as you can see there, is significant. It covers a really huge number of incidents. I think we've recently seen media relating to the volume of reports, the volume of incidents that are reported to the NDIS Commission. Prior to working at the Ageing and Disability Commission, I was at the Ombudsman's Office in New South Wales where we did operate a reportable incidents scheme for the disability sector. That had much smaller remit. It was focused on people in disability supported accommodation and a smaller range of allegations against staff, so focused on abuse, neglect and exploitation, including sexual misconduct, and even that, the volume of those matters was really significant.

We had indicated in the set-up of the NDIS Quality and Safeguarding Framework that it's better to start small, it's better to start with a smaller scope of the type of incidents that need to be reported in order to see the matters that are coming in and to see where it needs to be extended. We would still support that and I know that what's proposed in residential aged care is still not as extensive as what's on the table here that is currently in place for registered NDIS providers. We would still be of the view that, one, that there does need to be a scheme that applies to in-home support services and settings but there is a need to limit the type of incidents that are reportable in order to make that scheme workable.

COMMISSIONER FITZGERALD: One or two observations. So Kathryn's absolutely right. Reportable schemes have to be capable of delivering and what we've got in many of the reportable schemes is they're too expansive in what's being sought to be reported. As a consequence, the agencies are not capable of dealing with the reports in the way that is required.

The second thing is, just to understand in New South Wales, where the alleged offending might be taking place by a worker, that matter is referred to the NDIS Quality and Safeguards Commission or to the Aged Care Quality and Safety Commission. Where the abuse may be happening by a non-worker, that is, a family member, a neighbour, a community person, then it comes to us.

So one of the things that would happen is we would not see either the NDIS Quality and Safeguards Commission nor the Aged Care Quality and Safety Commission

dealing with matters where is the abusive behaviour is by a family member or a non-worker. I think the scheme in New South Wales, whilst it's early and we're waiting to see how well it works, I think it is important that State-based organisations deal with matters that are relating to family and community involvement.

The other point is these schemes don't exist in isolation. The referral pathways by the receiving agency of the reports is critical. So, again, taking New South Wales, we will have a memorandum with NSW Police and as you know, in New South Wales there are now 12 aged crime prevention officers that have been appointed. That number will go to 60 within the next three financial years.

So I won't go into it other than to say a reportable incident regime can look good and they are essential and we would support it in the home care provision for older people. But they need to be well-targeted, they need to be adequately funded and then they need to refer matters to other agencies at a State level that can deal with matter that is are not necessarily in relation to the provider. Otherwise, we will overwhelm all the systems to the point that they become incapable and the community will lose respect in those systems within a very short period of time.

MR GRAY QC: Thank you. Again, a difference you identify in the statement between the disability sphere and safeguarding in aged care, the topic of worker screening or, as we have already formulated a proposal, worker registration. Would that be appropriate in an aged care sphere, some form of being able to identify workers who may have been involved in inappropriate conduct in the past so that they do not continue to work with vulnerable older people in the in-home setting?

COMMISSIONER FITZGERALD: So a couple of points to make, and Kathryn may add. The first thing is that the workforce that we're dealing with is a mobile workforce that moves across both ageing and disability and, to some extent, health. So we are dealing with the same people. So it makes sense that there is in fact screening processes which are relatively consistent and coherent across the human services sector but including ageing. I think that's universally agreed.

What's not helpful is if we end up with multiple discipline systems in the human service system across nine jurisdictions. It would be a fatal flaw if that were to be the case. In fact, it would be unmanageable. So the answer to your question in a simple term is, yes, we believe in screening.

The second part, however, is we have different views in relation to accreditation. This has been a universal issue of variance of views. I think there are some levels or some types of workers that should be accredited. There is less surety about some workers, and those are particularly the ones that are providing what's called social supports or living supports, and you would have heard from various providers in relation to that workforce. And if you do have accreditation, what does that actually mean? Does that require a minimum level of education, you know, through certificates or what have you?

So the first part of your proposition, yes, absolutely, screening. The second part of the proposition I think is much more complex and I'm not sure that we'd say that all workers in aged care should be accredited. But this has been the discussion that I'm sure that you've had and certainly I've been involved in for over a decade.

MR GRAY QC: Operator, you can take down that document now. I've got one last question and then I will hand over to the Commissioners to see if they have questions. We've seen in your statement that you've identified a distinct difference of experience in dealing with the NDIA on the one hand and what you describe as My Aged Care, possibly the Department of Health, on the other. When it comes to matters of gaps in supports or gaps in services, if I could describe things that way, is it the case that you have a good working relationship with the quality regulator for aged care in respect of cases where aged care services are being provided and it's alleged they're not being provided properly but there seems to be a gap when it comes to people who are being neglected by not having access to services? And if you could tell our Royal Commissioners a little bit about what you see as room for improvement in that respect. If you're able to do that very briefly, that would be great.

COMMISSIONER FITZGERALD: Kathryn will be able to give you more details but I just want to make one overarching comment. My Aged Care is not well-positioned within the system and I think it's because it sits in it by itself with a very constrained set of particular functions. My own view is that it's poorly constructed. I think the Quality and Safety Commission, an integrated regulator like the National Disability Insurance Safeguards Commission, their basic integrated nature is appropriate. There are weaknesses, and you're identifying some of those weaknesses.

I think when we come to the rest of the system, it's not a well-integrated approach and I think My Aged Care is a poorly-constructed concept in terms of the structure. But as to how it actually functions, I will just hand over to Kathryn.

MS McKENZIE: Thanks, Commissioner. So, you're right, when we refer to My Aged Care we're talking about Department of Health, and you're right, we do have a good relationship with the Aged Care Quality and Safety Commission. We've got essentially information-sharing arrangements that enable us to --- not a formalised MOU but we do have arrangements in place that enable us to refer matters across to the Commission and to get a response back from them about the outcome or the actions that they've taken in relation to the matters that we've sent across that sit within their jurisdiction. We meet with them on a quarterly basis and we do have a productive working relationship with them.

But I would say that because of the nature of our work, most of our contact with relevant agencies is not in relation to providers, which is where, obviously, the focus of the Aged Care Quality and Safety Commission is. The majority of our contact is with the bodies that fund or that are focused on the person or the participant. So in the disability space in relation to Commonwealth agencies, our primary contact and

the party that we have most involvement with is the NDIA, the National Disability Insurance Agency, and in relation to the aged care system, it's what we refer to as My Aged Care. That's the primary kind of point at which we would seek to have contact in relation to the matters that we have.

So if I talk to you about the type of relationship that we have with the NDIA, we've now got an MOU settled with the NDIA, but even prior to that, we've had a really productive working relationship with them from the start of the ADC. We share information with them. A key part of what we do is to flag, bring to the NDIA's attention individuals, so participants, who we've identified that there are significant risks, where we've identified that they require additional supports, where we've identified that there are additional steps that need to be taken in terms of the provision of specialist disability supports to assist the person and to address the risks that exist for them.

We've done that really effectively and continue to do that really effectively. So we bring those matters to the attention of the NDIA and the outcome from that, and again, we're not directing the NDIA, we're just bringing relevant information to their attention and seeking advice --- information back from them. But the result of that work is that we see individuals that have reviews of their plan and increased funding as a result of that. Individuals that are linked in with support coordinators, people that are linked in with --- or linked to more complex support pathways.

MR GRAY QC: Ms McKenzie, thank you. In a nutshell, are you not seeing that from My Aged Care?

MS McKENZIE: In a nutshell, no. It's incredibly difficult for us to do that and the interactions that we have had have been really bureaucratic and it's been very difficult for us to --- the information sharing arrangements at the moment don't exist.

MR GRAY QC: Thank you. Commissioner Briggs?

COMMISSIONER BRIGGS: Could I follow that up, please, and I suppose I want to know why, but also why there isn't a relationship with the Department of Health? Is it that it's too hands off and not connected to what's happening on the ground, or what's actually going on?

COMMISSIONER FITZGERALD: Can I just make a couple of comments. The first thing is just to put this in context. The NDIA, as you know, is an entitlement-based system based on eligibility and need and the aged care system is not. The aged care system is a rationed system, largely based around packages of care, not talking about the aged care system, it has an entirely different way of seeing the world from NDIA. They are entirely different in structure. And so, therefore, the players act entirely differently.

Secondly, the departmental model, I think is not an appropriate model for the delivery of the sorts of services that we referred to in the PC report as the gateway. I

think a separate agency, independent of the Department, would be appropriate for that. But that goes well beyond the operational issues. So I think that there are different contexts within which My Aged Care operates.

In relation to the Department of Health generally, the way we would have to have that relationship would be through My Aged Care, the actual subset of that. There's no reasons why we won't enter into an MOU.

But the point I want to make here is when we're dealing with the abuse, neglect and exploitation of people within their own home, one of the issues there is the ability to get in services to change the environment for that person quickly. It's extremely important the system is responsive, otherwise the risk factors that give rise to abuse, neglect and exploitation remain. Bearing in mind that the person that's perpetrating the abuse is likely to continue to be their son or their daughter, which is the majority of the cases, and going to have contact with the person. So changing the service dynamic is important.

The second part is we sometimes have to find alternative accommodation rapidly and quickly in the same way that sometimes it's necessary in relation to child protection, although we're not comparing the two systems.

So unless the system responds quickly, in fact, it's going to leave people vulnerable. I think the NDIA now gets that. Certainly, they get it in a way that we see as more responsive. I don't think My Aged Care gets it and perhaps hasn't been designed to get it. So I think it's not as responsive as it needs to be, particularly in the sort of client groups that we're dealing with where it is all about changing the dynamics within the family including that of service provision.

MR GRAY QC: Commissioner, I have no further questions.

COMMISSIONER PAGONE: Thank you. Commissioner Fitzgerald and Ms McKenzie, thank you very much. I really don't need to tell you how helpful your information and evidence has been. I'm sure that you appreciate exactly how useful it has been to be able to tap into the detailed information and learning and experience that you're having on the ground. But for the benefit of everybody else, let me make it clear that it has been very helpful indeed. We've learnt a great deal from it and it's been wonderful to be able to rely upon and have access to the kind of learning and experience that you have developed in this sector. So, thank you very, very much and if you have any other bright ideas, please don't hesitate to let us know.

COMMISSIONER FITZGERALD: Thanks, Commissioner.

THE WITNESSES WITHDREW

MR GRAY QC: 1.30?

COMMISSIONER PAGONE: Yes, we will now adjourn to 1.30. Thank you.

ADJOURNED **[12.34 PM]**

RESUMED **[1.32 PM]**

COMMISSIONER PAGONE: Mr Gray.

MR GRAY QC: Thank you, Commissioner. I call Dr Fiona Macdonald, Dr Jim Stanford and Professor Andrew Stewart and in respect of Dr Jim Stanford, I understand that Dr Stanford is currently in Canada. So along the lines of my application yesterday, I would ask that any need for an oath or affirmation from Dr Stanford be dispensed with.

COMMISSIONER PAGONE: It's unlikely to be required for Canada, but we'll follow that line.

DR FIONA MACDONALD, AFFIRMED

PROFESSOR ANDREW STEWART, AFFIRMED

DR JIM STANFORD, CALLED

EXAMINATION BY MR GRAY QC

MR GRAY QC: Dr Macdonald, what's your full name?

DR MACDONALD: Fiona Macdonald.

MR GRAY QC: What's your current role and your institution?

DR MACDONALD: My current role is Senior Research Fellow, School of Management, RMIT University.

MR GRAY QC: Prior to this hearing were you provided with a set of propositions, 10 propositions numbered HC1 through to 10 for the purposes of consideration at this hearing?

DR MACDONALD: Yes, I was.

MR GRAY QC: Have you prepared a document responding to certain of those propositions for use by the Royal Commissioners. It's at GTB, general tender bundle, tab 48, please, operator.

DR MACDONALD: Yes, I have.

MR GRAY QC: Thank you. Professor Stewart --- that's Dr Macdonald's response document now on the screen, is that right, Dr Macdonald?

DR MACDONALD: Yes, it is.

MR GRAY QC: Thank you. Professor Stewart, what's your full name?

PROFESSOR STEWART: Andrew John Stewart.

MR GRAY QC: And what's your current title and the institution you belong to?

PROFESSOR STEWART: John Bray Professor of Law at the University of Adelaide.

MR GRAY QC: Thank you. And, similarly, were you provided with a set of propositions HC1 to 10 before the hearing?

PROFESSOR STEWART: Yes, I was.

MR GRAY QC: Thank you. Now, you also have prepared a document responding to certain of those propositions. It's at tab 16, please, operator, of the general tender bundle. That's correct, isn't it, Professor?

PROFESSOR STEWART: It is.

MR GRAY QC: I'll just ask you to identify it once it appears.

PROFESSOR STEWART: That's my response.

MR GRAY QC: That's it, that's at tab 16, thank you very much. Now, before being provided with those propositions and in connection with certain other workforce related issues of relevance to the Royal Commission's inquiry, you provided a statement dated 26 June 2020 for the Royal Commission, didn't you?

PROFESSOR STEWART: I did.

MR GRAY QC: I will ask that that be displayed and I will just get you to adopt it. It's in fact already been tendered, Professor. It's at tab 36 of the tender bundle. Is

that the first page of the statement?

PROFESSOR STEWART: It is.

MR GRAY QC: And to the best of your knowledge and belief, to the extent that the statement sets facts out, are those facts true and correct and are the opinions in the statement opinions which you hold?

PROFESSOR STEWART: They are.

MR GRAY QC: Thank you. Members of the panel, the purpose of this afternoon's session is to bring your expertise to bear on certain of the propositions, in particular those propositions that raise workforce-related issues, and Dr Stanford, what's your title and the institution to which you belong?

DR STANFORD: I am Jim Stanford, and I'm an economist and Director of the Centre for Future Work.

MR GRAY QC: And what is the Centre for Future Work?

DR STANFORD: The Centre for Future Work is a research institute. We're affiliated with the Australia Institute based in Canberra, and we focus on issues related to employment, working arrangements and the future of work.

MR GRAY QC: Thank you. So all three of you have extensive expertise on workforce-related issues, and Dr Macdonald and Professor Stewart, you have a focus that includes consideration of complex legal issues that relate to workforce issues, is that a fair summary, Professor Stewart?

PROFESSOR STEWART: Yes, it is.

MR GRAY QC: That to be accurate? Dr Macdonald, is that a reasonable summary of your ---

DR MACDONALD: That's a reasonable summary of my experience and my knowledge stems from the application of regulation in practical, you know, in real life circumstances as opposed to a detailed study of labour law. That would be Professor Stewart's expertise. Mine is more industrial relations, so a broader regulatory socio-legal expertise.

MR GRAY QC: Thank you very much. And Dr Stanford, what's your perspective? Obviously, it encompasses matters of economics. Can you give us a brief description of your perspective?

DR STANFORD: Yes, I'm trained as an economist and so I tend to approach these issues thinking about the economic determinants and consequences of different work relationships, and while I am familiar with some of the main areas of labour and law,

and how they impact on employment and work practices, I'm not a lawyer, I would be more well-versed in the economic and regulatory aspects of those issues.

MR GRAY QC: Thank you. During the session, we'll be occasionally referring to the document at tab 1 of the tender bundle, the propositions, and I know that each of you has reflected on those. To the extent that you might wish to refer specifically to a particular proposition in the course of responding to one of the topics, please feel free to ask for that proposition to be displayed and the operator will be able to comply.

Now, firstly, Dr Stanford, I'll direct this question to you. There's been evidence in this hearing on the benefits to consumers, so its said, in being able to engage workers directly through a direct communication facilitated, say, over an online platform and we've heard from Mr Peter Scutt of Mable and Ms Jessica Timmins of Hireup about the functionality of online platforms. Both witnesses have told the Royal Commissioners that these platforms confer benefits on both consumers and workers in the nature of relationship building and they do this, so it's said, by means of enabling the person seeking support or care to indicate their particular needs, enter that information into the platform, and for a person whose electronic profile, information about that person is on the platform, to be able to be offered as a worker for that person seeking support or care.

Now, Mable is said to be an independent contracting service whereas Hireup is said to be a service that employs a casual employment model. My question: what are the implications of online platforms in health economic terms in circumstances where they're available for use by people who have home care packages and, in particular, are there any benefits conferred by one or other of the two models, direct employment or casual employment, and are there any risks posed by those models?

DR STANFORD: Yes. I think that there are some generic risks of using a platform-based matching system to try and connect individual clients or customers with individual workers who will provide various services for them. That would apply to both a casual employment model, as in Hireup, and a contractor type of model, as in Mable. Of the two, I think that the risks are more acute in the contracting model such as with Mable, but I think the risks are still very highly present in the casual employment model that Hireup use.

These business strategies, of course, have been applied in a whole range of different consumer service industries now. You know, we're all familiar with the use of digital platforms to organise work in different consumer service industries such as ride-sharing and food delivery. They're also used increasingly in a range of different human and caring service applications. There's been some experience with these models, of course, under the NDIS system which similarly involved trying to match the needs of individual clients or customers with particular providers who are going to give them services.

Through our centre, we've studied some of the NDIS experience and some of the

impact on the stability of work and the quality of work and the quality of services that are delivered and even when it's --- even when the providers are engaged on an employment basis, and that overwhelmingly now is a casual employment basis, there are, I think, very significant risks and problems that are raised in terms of how the work is organised, how the --- how we ensure the quality and qualifications of the service providers, how the time of the workers is organised to ensure that they have sufficient time to perform the duties that they'd been contracted to do, the capacity of the client or customer to organise this whole process.

It's actually quite a task to make arrangements with various service providers, even if it's, you know, through a convenient meeting place like the platform, but it's quite a task to ensure that the right services are being provided and to be able to distinguish quality providers from others who might be advertising their services. So I think for all these reasons I'm sceptical of the efficiency of these platforms for delivering quality service.

I think there's risks to both the client or the customer and the workers of this type of arrangement, and I think that those risks would be more severe in the case of a contractor model, at least with casual employment. The arrangement is going to ensure that the service providers are paid minimum wage and some of the other basic requirements of a labour standard, whereas in a contractor model, even those provisions would be at risk.

MR GRAY QC: Thank you. I'll open the topic up a bit more broadly to the other panellists. Dr Macdonald, I turn to you. There's a recent report of the Inquiry into the Victorian On-Demand Workforce available to the Royal Commission, at tab 23, please, operator. It identifies information about the prevalence of work engaged over platforms and it identifies information from a national survey of workers described as "on-demand workers", including workers who are engaged over platforms, and it identifies motivations of those workers. And I understand you have a familiarity with the subject matter of the report. What are the risks for the workers in providing services as independent contractors, including over these platforms, what are the benefits that the workers see that are motivating them to use these platforms?

DR MACDONALD: I have some familiarity with that report but I would draw also on my own research which has involved interviews with disability support workers working under the NDIS through platforms and also ongoing analysis of the working arrangements and employment arrangements and benefits provided to workers on platforms.

I think there are three main risks for workers, first, which I will address before benefits. One is the risk that's associated with independent contracting in care work generally, which is the absence of a support --- a relationship providing support and oversight supervision, absence of access to training, absence of peer support mechanisms, absence of ability to --- absence of any support for decision-making when encountering changes in care needs, unpredictable issues, things that happen all the time. My experiences are mainly in understanding the issues encountered by

disability support workers but I believe many of them are very relevant to home care. So, isolation of the worker, I think, is a really big one for workers performing that work and I think it is one of --- it can be seen to lead to intentions to leave due to the sense of not being able to provide appropriate supportive care. But that's general kind of contracting issues that also apply to workers where they're employed in kind of on-demand casual arrangements.

A second issue, I think, is the pay. The absence of employment protections and benefits that come with being an employee for contractors which both are risky for the worker as well as present risks for the person that they're providing support to. So that's absence of paid leave, absence of superannuation payments, and absence of --- and all these things go to pay and costs as well, the need to provide for your own --- provide your own equipment. You need to provide personal protective equipment and cleaning equipment, is something that's come up since --- in the COVID situation. Workers were unable to --- individual workers being unable to access that, but also the need to provide all those things as an independent contractor yourself.

And then the main issue with --- the added issue with the platform arrangement is that workers' pay --- I know that this is disputed by the platform, some of the platform providers, but many, many workers on those platforms, and you can see that by scanning the platforms that have open access are advertising their services for less than the equivalent of the award, if you take account of the benefits and entitlements that a worker would be eligible for. A good example would be social support services provided at a minimum SCHCADS level 1.2 pay rate of $22-$23 an hour.

MR GRAY QC: Just to stop you there, SCHCADS, is that the award?

DR MACDONALD: Social Community Home Care and Disability Services Award. The level 1.2 is the minimum level a worker would be providing social support and domestic assistance under. The minimum award rate currently is $22-something and if you added a 25% loading to that, which a casual employee would receive in lieu of paid annual leave and sick leave, and then if you added a 9% to that to account for the employer's superannuation contributions an employee would receive, and then you add the platform fee to that amount, a worker would need to be charging $33.43 an hour on a week day during the day.

That's not taking account any of the extra costs of running their own business, which it's assumed they are paying for. If part of their job is transporting a person to the shops or to activities, they're paying their own costs of transport for that. If they're required to spend any other money in conducting the work, they're expected to pay those costs.

So the same calculations can be applied to a disability support worker providing personal support work at level 2.3. Now. That's the level at which the NDIS, and that's my knowledge, of the NDIS pricing model accounts for award wages plus an amount for training and --- labour on-costs or the costs that I mentioned before, an amount for training and supervision, and then there's an amount for overheads and a

2% margin. So at overheads of 10% and a 2% margin in that NDIS price, a worker, unless --- either the training and supervision allocation is going to the worker or the worker --- or that training or supervision allocation is just going on cheaper care and disappearing completely. So the worker has ---

MR GRAY QC: So there's an erosion of the conditions, including the remuneration levels that a worker would expect to receive in an employed relationship, in your opinion, is there?

DR MACDONALD: Yes, and at the system level, there's a lot of that training and supervision allocation. I know that the benefits for people directly engaging contractors, whether through platforms or not, is the ability to have some decision-making over selecting --- have some control over selecting their own workers. The other main benefit that the literature identifies, both the international literature and the ---

MR GRAY QC: Can I just ask the operator to put up --- I'm sorry, you go on, Doctor.

DR MACDONALD: It's cost, it's cheaper. And that's a benefit that's identified by consumers in the NDIS. I think the research that's been done also in aged care by Carmel Laragy identifies that this cost is the other benefit. So people engaging contractors can get more hours of care for their money. Now, I suggest that the reason that is, is that the pieces, the pricing, the funding that's available for training and supervision is what's lost and goes to either extra hours of care or goes in part to platform fees. However, platform fees are equivalent generally to the overheads amount that --- yes --- and disability support - a disability provider would normally spend on rostering and that's not a service provided by the ---

MR GRAY QC: Sorry. Is there a tension between economic efficiency, in particular that point you just made about the cost of labour being cheaper under independent contracting arrangements, and a longer term goal of attraction and retention to the workforce here? Or do you think that's --- do you think that's a false framing of the issue, there's not really a tension?

DR MACDONALD: I think it's a false framing of the issue because I think the longer term sustainability of the system, if we accept that that is going to be on the basis of a workforce that is more stable, a workforce that can be retained and supported to be skilled and deal with the complex issues that come up providing care, that requires access to supervision and training, possibilities for professional development, good oversight, and again, I'm talking about the NDIS model that I know best.

If you take the amount of the funding that goes to that, to providing that support, then you're undermining the system. So it will have --- and it is the international experience of individualised funding where cash is --- cash benefits can basically be cashed out to buy a particular --- like vouchers to buy particular services or more

freely to provide a diversity of services, that it is cheaper care based on less-qualified, more transient, less-experienced labour and more risky, lower quality care.

MR GRAY QC: I'll come to that point about whether there's some sort of causal correlation between individualised funding or individualised budgets on the one hand and independent contracting on the other, and I will come back to you and ask you some questions about that.

Before leaving this topic of potential benefits and whether they are real benefits, can I ask you about the perceptions of workers as to benefits? According to the national survey conducted for the Victorian Inquiry that I mentioned, if we ask the operator to go to page 0102 of tab 23, there is a summary of some of the findings based on the survey. The strongest motivation in the second point in the box was earning extra money. Other key motivations related to flexibility. "Working the hours I choose, doing work that I enjoy, choosing my own tasks or projects, working in a place that I choose, and working for myself and being my own boss." From the worker perspective, these sound like powerful motivations for some individuals. What do you say to that?

DR MACDONALD: In relation to the care sector, I think that the context of those labour markets are --- and the context of the organisation of work currently is that there are very high levels of under-employment as organisations attempt to manage under tight funding constraints and recruit and engage workers on an on-demand basis to meet peaks and troughs.

So in my own research, there are workers working very, very fragmented working hours, short shifts, with lots of unpaid time in between on work-related travel. Those workers are invariably the ones seeking other jobs or are multiple job holders. So getting the extra hours and earning extra money, I think --- and I think it was actually discussed in some length in the Victorian On-Demand Inquiry report, the idea of earning extra money and having a second job is often viewed as if it's in addition to a full-time job and that's not the case for many workers doing this work. They're actually patching together little jobs, multiple little jobs.

I do believe that workers in the care sector enjoy being able to not work for somebody, not work with somebody who they find it difficult to work with and will make that choice to not --- which might be a more difficult thing to do as an employee, to choose not to work with a client who they don't like. But I don't consider that many of the workers who --- if the workers that I see advertising on these platforms are similar to the workers that I've interviewed, they're not particularly motivated by being their own boss. They are --- they look for work and they find work on platforms because that's where it's advertised. They often haven't --- they answer ads that say "Do you like old people? Have you got an ABN?" I'm making these broad statements, I'm sure they don't apply to everybody but I think I'm trying to highlight that the circumstances of the nature of the labour market is such that it's not one that --- not one in which workers are looking for this kind of work to

have a level of control that they would not otherwise have with an employer, other than to find work that fits into the hours that they have left remaining after they've --- you know, their other work and other activities have taken up their time.

MR GRAY QC: Professor Stewart, I might turn to you and ask you some quite technical questions about mechanisms that might be available within the aged care legislative framework to address some of the issues raised, not only by independent contracting points that we've been traversing so far, but some other points about minimum contact times with people in care, with provision for transport or costs and the like. There are a host of issues raised in the propositions which are directed to making a career in aged care more attractive, with the idea of growing the workforce and retaining the workforce and offering career paths in the workforce.

But how would we go about that? In submissions in February, Counsel Assisting for the Royal Commission, Mr Rozen, submitted that we must look to existing mechanisms to the extent that they are able to prioritise labour standards and where they're unable to do so, we ought to consider what's needed and re-conceptualise the role of Government in regulating employment standards in aged care. There's a possibility raised in one of our propositions about using the aged care regime to improve labour standards in this area. What are your perspectives on that from a technical, legal point of view and what are the connections between attempting something of that kind in the aged care legislative sphere and the overall industrial relations legal framework in Australia?

PROFESSOR STEWART: So, logically, there are three possible options in what you just said. One would be to look at improving wages and working conditions through general existing mechanisms. The other would be trying to achieve that objective through the aged care regulation system, and the third possibility is of course a combination of the two.

Trying to achieve everything from the aged care regulatory system would pose an enormous number of challenges, particularly if we were trying to do this for workers who were accepted not to have an employer. If you're employed, even if you're employed as a casual, you automatically become entitled to a range of benefits and protections; minimum wages, controls on working hours, shift lengths, Workers Compensation insurance is necessarily going to be there for you. If you earn enough in a given month, you're entitled to superannuation. So all of these benefits automatically apply if you're an employee. If you're not an employee then, generally speaking, they don't.

You could have a regulatory regime through the *Aged Care Act* or replacement for that legislation, which laid down incredibly detailed standards in terms of wages, working conditions, leave entitlements, superannuation, Workers Compensation and so on for workers who were not --- in the sector who were not operating as employees. But it would involve a huge amount of work and it would be just a massive exercise.

There are one or two existing examples of fairly detailed regulatory systems for non-employees. One of them, for example, in New South Wales for certain transport workers that's been around for many decades now. But even there, that's a bolt-on to the State's industrial system and it operates by reference to the State's general laws about employment.

So try to design it, it seems to me, would be extraordinarily challenging and arguably very inefficient. To my mind it makes much more sense to focus primarily on ensuring - that's obviously one of the propositions I put to the Commission - that for the most part workers in the sector are employed. That means they're automatically entitled to existing protections. It means that also provides a framework where additional --- well, first of all, where improvements can be sought through the general system of regulation. So in my statement back in June, I identify ways in which wages might be improved through pursuing higher award rates, through enterprise bargaining, through equal remuneration orders, through work value claims. All of those existing mechanisms are there that don't require --- they're all there, available to be used, and that are capable of generating improvements.

On top of that, you might well expect, for example, that if a new aged care system requires providers of aged care services to be licensed, that they might well have certain additional responsibilities over and above what's provided in the general system which apply to aged care workers. For example, in relation to training for example, in relation to codes of conduct, forms of supervision. All of these are matters which are sometimes dealt with in the general framework but often aren't. They could be dealt with as an additional layer of regulation designed to achieve the kinds of quality of care and services, for example, in proposition HC6(c) which deals with quality regulation.

So I would be suggesting that a combination of general regulation through employment standards and additional sector-specific regulations through the aged care legislation would be the most efficient, most beneficial way to seek to meet those various goals.

MR GRAY QC: Thank you, Professor. I'll just take the opportunity to ask you a couple of further questions about what you've said. Firstly, in your statement in June, after considering various options, you come down to a recommendation to our Royal Commissioners that the best mechanism to use, should the Royal Commissioners wish to make recommendations in this area, would be to include, in effect, criteria or relevant considerations, guidelines, directions - perhaps not directions, but relevant considerations to be taken into account by the Fair Work Commission in reviewing the relevant modern awards as they come up for review, and then relying on the "better off overall test" to influence any enterprise agreements as a result. Is that a fair summary?

PROFESSOR STEWART: It is, I suppose with one caveat which is that I do also see value in a system of industry level bargaining. But that would really require very substantial changes to the existing system of regulation. So if we're talking about

taking the *Fair Work Act* as we find it, without making major changes to the Act overall, then it seemed to me that of the various mechanisms for improving wages and conditions that I was asked to consider, that awards held out, changes to award rates, changes to award conditions, held out the best approach.

There certainly is a precedent for legislation directing the Fair Work Commission as to how it goes about undertaking its job. That's already done in relation to --- or it has been done in relation to a creation of the current modern awards which was the responsibility of what was then the Australian Industrial Relations Commission back in 2008/2009. The *Fair Work Act* did previously, although this has now been removed but it did previously impose requirements on the current Fair Work Commission as to review and improvement of modern awards.

So it's not as if we haven't had examples in the past, including sector-specific examples of Parliament directing the Fair Work Commission not to achieve a particular outcome but to have particular regard to certain considerations, and in the case of the sector we're now talking about, these could well include requiring the Commission to have regard to the need to make wages and working conditions sufficiently attractive so as to help bring into the sector a huge number of extra workers which every workforce projection I've seen has suggested are going to be required over the next few decades.

MR GRAY QC: And for example those directions, not as to outcome but as to manner of decision-making, could include a relevant consideration of achieving parity with conditions that exist in sectors that compete for the same workforce such as the health sector, would that be right?

PROFESSOR STEWART: Yes, absolutely.

MR GRAY QC: And, Professor, the propositions which we gave you included one proposal which might address another thing that you just mentioned in the course of your evidence over the last five minutes, and that is trying to ensure that there is, predominantly at least, a direct employment model adopted in this sector. Now, that strikes me as more challenging than might be supposed. We have a proposition here which I regard as one that needs to be tested very thoroughly, for providers to be required to deliver a set percentage of their care hours through care workers they employ directly. You might recall that from proposition HC6(b). Perhaps, operator, if you could just display that?

Now, firstly, as a matter of legal technicality, is that possible? Secondly, in your view, if you're able to express a view on this, is that practical and appropriate? And thirdly, are there alternative mechanisms that occur to you to try to achieve that objective of a predominantly directly employed workforce?

PROFESSOR STEWART: In answering that, I think we should accept at the start that the premise of this is that a decision has been made to identify class of businesses or other organisations who are providers of services. But right away,

we're talking about organisations who are taking on a responsibility to provide services.

In my response to the propositions, the draft propositions, I draw a distinction between businesses that operate as providers and as intermediaries. So here we're talking about organisations that have responsibility for providing services.

So to your questions: the first one, is it technically possible to require providers to deliver a set percentage of care hours through directly employed workers? Yes, clearly it's possible to draft legislation. That is something that we might expect to find in the aged care legislation, not made a part of the Fair Work legislation. There's no reason why that couldn't be done.

I think my argument would be, though, that it shouldn't be done because it's too arbitrary an approach. For a start, the set percentage, presumably that is the same for, you know, large providers, small providers, does it vary? But in any case, I think I would be arguing more strongly that it would make more sense to have a general rule, and this is the suggestion I put to the Commission, that there be a general rule that workers who are performing services on behalf of providers, whether they are engaged directly or not, should be employees and then to articulate exceptions to that proposition.

So one type of exception might be, for instance, if you're talking about highly-skilled allied health professionals such as physiotherapists, occupational therapists, for instance, I can quite see an argument to say that suggests that for highly-skilled workers of that kind who are part of a recognised profession, who are responsible to standards set by professional bodies, who have to have licences to practise in that field, that it might well be considered that there is no particular value to be gained by insisting that those kinds of workers should be employed.

But for lower skilled workers in particular, it seems to me that there is a strong argument for engagement as an employee and the two reasons that I put forward to the Commission for that are, firstly, that it's far more compatible with achievement of objectives relating to achievement of quality standards in relation to care, and the reason for that is that an employee is necessarily somebody who can be closely directed in the work they do.

An independent contractor, by definition, ordinarily is less subject to direction but more than that, as I tried to explain, for businesses that are seeking to avoid an employment relationship, often to lower the costs of running their business, they have a clear incentive to try and minimise at least the appearance, if not the actuality, of the control that they might otherwise direct relevant workers.

So if you are trying on the one hand to ensure that service providers have to have certain and discharge certain responsibilities about the care and quality of services that they provide, allowing them to minimise their direction and control over their workers, to me doesn't make a lot of sense.

The second broad reason is the one that we've effectively already talked about which is if workers are employed, they're necessarily subject to a large number of minimum rights and protections and processes which can deliver them higher minimum standards of wages and working conditions than they would be if they were not employed, but which also provide ready vehicles through which to pursue improvements in the future in those wages and working conditions.

So hence my argument that it makes more sense to have employment as a general rule and then exceptions, rather than to say minimum percentage of employees.

MR GRAY QC: Thank you, Professor. Dr Stanford, if I could turn to you again. One of the things Professor Stewart just mentioned, and in a way it was by way of an assertion without any reference to any particular evidence, but it was, in effect, an assertion that there's a connection between employment and quality and that's indeed something you, Dr Stanford, mentioned in your very first response to something I raised. Can we now go to that question in a little more detail?

Is there evidence correlating direct employment in the sphere of human services in the nature of care for people, particularly older people, if there is any such evidence, is there evidence correlating direct employment as opposed to independent contracting, and quality outcomes?

DR STANFORD: Well, I can speak to the evidence that we've developed through our own research, through the Centre for Future Work. We did detailed case studies of people working through the NDIS system and how the quality and stability of their work was affected by the shift to that kind of individualised model, and the evidence that we gathered was certainly consistent with the view that a more stable work relationship was positively correlated with better quality of care that those workers could deliver to their clients. Now, that again was not solely about whether it was an employee versus a contractor, there's also a second issue about "what kind of employee are they?". In some of the more fragmented and unstable casual employment relationships, you did see some of the same problems about inability to provide the care that the staff felt was the goal of their profession.

So I think in general it's safe to say that the evidence is consistent that the more stable is the job, the higher quality is the care that those people are going to provide and there's a continuum. It's not just a black and white argument, are you a contractor or an employee? There's also an issue about the stability of work arrangements for employees, and people who are in very fragmented and insecure casual-type relationships will have similar challenges to their ability to do the job to the quality that they would like to and that the clients want to see.

In my reading of the literature that we did as preparation for that research, that correlation between job stability and quality of service that's delivered is quite robust.

MR GRAY QC: And does any of that evidence extend to the care of older people,

including care in their home?

DR STANFORD: Certainly in terms of the broader literature that we reviewed as part of that research, there were absolutely studies and published findings related to aged care, both in their own home and in residential facilities. And in the work that we did in the NDIS space, they weren't aged in the sense of being over 65, but they were certainly delivering similar services to people in their own homes who had complex problems, limits on their ability to organise their care packages, et cetera, et cetera. So I think our findings from the NDIS research we did would be quite comparable to the delivery of aged care in home for senior individuals.

MR GRAY QC: And Dr Macdonald, just on that point about evidence correlating direct employment and quality, do you wish to add anything to what Dr Stanford said?

DR MACDONALD: Yes. The international evidence hasn't really looked at independent contracting a lot because in many countries that hasn't been --- it's been much more direct engagement as an employee by the person in --- you know, individualised funding or kind of cash for care arrangements, individual care recipients have been the employer of their worker. And the evidence there is that it's really mixed. The large studies that have looked at those arrangements often include many, many workers who are actually relatives of the person receiving care, so it's an intra-household transaction often. And there are also many studies, many small pilot studies, where people who directly employ their own workers have said that, you know, the benefits they've found in increased satisfaction and wellbeing, but they're very --- there's very little available evidence that actually compares that to anything sensible. So the pilot studies are where the person receiving care was not receiving very good care or was not having care very well-managed in a poor system in the first place.

In relation to independent contracting, that's now become more common in the UK with the emergence of platforms, however, the platforms there really only cater for people who can add to the public funding for their care. So the platforms don't tend to operate and so there isn't an independent contracting sector of any size in the publicly funded sector.

MR GRAY QC: Dr Macdonald, in your response to our propositions, I might ask the operator to put that up on the screen so it can be seen. And I read out the tab number for it a moment ago, 48. On the first page in respect of our proposition HC3 which proposes a shift or a reorientation of the content of what's called consumer-directed care in the home care context.

Consumer directed care under the user rights principles currently requires an approach by which a provider and a person who holds a package will, in partnership, organise the way a budget is to be spent and there's a great degree of latitude in the way that's to be done and a practice has developed which might be called self-management whereby a person is allowed, through that process, to in effect

manage their own care, when it occurs and precisely what it is.

We are proposing in HC3 that the management of care should be shared rather than entirely left to the person who holds the package. Now, that's attracted some criticism from some witnesses and it remains to be seen what the Royal Commissioners will think of this.

But you've said in your response at tab 48 that there has been promotion in Australia and internationally of self-management, but you say there's a limited body of research on this and it's difficult to draw clear conclusions, in effect comparing the benefits of self-management and the benefits of shared management.

We are going to hear, I expect, from Dr Carmel Laragy tomorrow. She's an evaluator of the COTA self-management trial, and she points to evidence which demonstrates better outcomes, particularly in the US, from self-management, and I will be asking her a bit about what those better outcomes are.

Have you considered whether there is some way of reconciling these apparently inconsistent bodies of evidence? On the one hand there seem to be, to some extent, correlations between direct employment, close supervision by an organisation, and quality outcomes; and on the other, there seem to be, at least for some people, or in some circumstances, better outcomes from empowering them to manage their own care. Do you see any way to reconcile these bodies of evidence? Are they dealing with different risk criteria? Are they dealing with different circumstances and people who have different needs?

DR MACDONALD: I think to some extent that is the case because some of these studies, and they are --- on the whole, they're a range of very small studies, which have the problems and largely a lot of the research comes out of the UK. The US research, we'll talk about in a sec. But a lot of those smaller studies with comparison is to very little support in care beforehand. It could be in scientific terms the placebo effect or the effect of just having attention paid when you hadn't had any attention paid before.

So pilots conducted under circumstances where the alternative has been particularly poor beforehand. I do think that there is --- there is evidence that some people have benefitted from the sense of empowerment that they have, in being able to control their services where they have had very, very, very poor opportunity to have any say in decision-making or control prior to that. So it's the comparative that's the question. Better outcomes than what --- and I think that goes to some of the different interpretations of the evidence.

The other thing is that some of the benefits --- it's disputed as to whether it's a benefit where the benefits people experience are in being able to manage and direct their own care workers. There's also evidence that that's not necessarily always an outcome that leads to good quality care and support, even though the person reports that they benefit greatly from having that control and there's a lot of evidence in

relation to not actually being particularly --- being very risky for care workers.

In relation to the US evidence, there are some very large studies of the care for counselling programs, there are a range of programs there, Federal and State programs, that operate a bit differently in each case. So again, you know, the nuances of these, they're all --- you almost have to read each study very, very, very carefully to see that they're actually talking about quite different things and it can be the level of funding associated with the self-management as opposed to the alternative and as I think I mentioned before, in many of the individualised funding arrangements that we would call consumer-directed care in the United States, a very high proportion of the care workers are actually family members often living in the same household which reflects the origins of many of those programs.

It didn't come from independent living movement origins; rather, they came from welfare-based programs that were providing support to carers in recognition of their unpaid care and their inability to be in the labour market externally from their --- due to their caring responsibilities.

So, as I said, the programs are about intra-household funding. So the money paid to the carer is bringing --- it comes into the household of the person, the same household where the person is receiving care. So that brings up all those issues of whether or not you're paying a family carer in the household and that's not something, I believe, that our system has been contemplated in Australia.

MR GRAY QC: We're not proposing that. Thank you, Doctor.

DR MACDONALD: There's many underlying differences.

MR GRAY QC: Thank you very much. Now, could I open this next topic up for all three of you and I'm happy to start with you, Dr Macdonald, since we're with you at the moment. There's a question being raised on the evidence so far in this hearing about whether facilitation of the ability of the home care provider through its care manager to communicate with an independently-contracted worker will be sufficient to ensure high quality care is provided.

Now, there might be circumstances in which the services in question are, on the face of things at least, relatively simple services such as lawn mowing, but there might be cases in which the relevant care the subject of independent contracting, is quite complex care involving quite specialised needs such as caring for people with complex clinical conditions in accordance with a plan that's been formulated by a clinician.

So, the question is, if the brokering organisation, be that an online platform or some other organisation, allows the home care provider's care manager to communicate with the independent contractor, will that be sufficient? It raises this question about the inability to direct, which is a point that you, Professor Stewart, mentioned earlier. So I'll open that up for discussion. Dr Macdonald?

DR MACDONALD: The legal complexities of that I'll leave to Professor Stewart. But at a practical level, based on the research that I've done with workers who are going out to provide support and care in people's homes, the issues that they deal with are changing needs, unexpected and predictable things they encounter, need to spend more time urgently, need to stop and communicate with family carers, so to provide the care particularly in changing circumstances that --- to provide good quality care they need open communication and accessible supervisors who know them and understand their work and can support them, with peers if necessary, and that's not an uncommon occurrence in the disability sector at least, that somebody may need another worker to actually come and be there when there's some kind of crisis.

So that, I think, would stretch the resources of an organisation that wasn't funded to --- wasn't able, first, to manage that worker's time and say, yes, well, you can be there for another half an hour, and you will be paid. Manage another worker's time or manage a supervisor's time to talk them through something or to provide a debrief, or to organise a peer meeting of the collective group of carers who are working with that, if it's a person with fairly complex and significant needs there's likely to be more than one care worker involved. So to bring a team approach. It's all of those things.

I think if it's very simple --- if it's lawn mowing, that's a different question. But in the question you're talking about, I think it's logistically --- I don't know how it would work. I can't see --- I think it would be extremely difficult to do that and do it well.

MR GRAY QC: Thank you. Dr Stanford?

DR STANFORD: I think the idea that merely facilitating communication between a client and a contracted service provider, or even an agent of the client, if it's a care manager, that's still not somebody who is in the house with the client and necessarily aware of what the client is needing and experiencing on a day-to-day basis, that that will, somehow, ensure the quality of the service delivered, I would say that idea is naive and, in fact, dangerous.

Many of the clients in both the NDIS setting that we studied and I would suggest in the aged care setting, simply don't have the personal capacities or cognitive and planning abilities to be able to discern from a whole roster of potential providers on a website who's going to deliver quality care and who isn't. And even if there's a care manager inserted into that process as another middleman, it's like a middleman between the client and the middleman which was the broker or the website, that's not going to ensure that the client's needs are being recognised and looked after. Particularly because we're dealing in an aged care setting with people whose needs are evolving as time goes by. That's the whole reason for their need for care.

So I don't think facilitating communication in the sense that a market will somehow

efficiently match suppliers and demanders and make sure that quality is rewarded is at all an adequate response to the need for more, I'd say, deliberate and intense regulation of the quality and protection for the clients involved.

MR GRAY QC: Thank you. Dr Stanford, and indeed Dr Macdonald as well, I should have asked you to identify the work that you'd done in the NDIS sphere formally at the outset, but if the operator will put up tab 38, that work is encapsulated in a report you wrote in 2019, entitled "Precarity in job instability on the frontlines of NDIS support work", September 2018, is it not?

DR STANFORD: Yes, counsel, that was one of the reports. There were about five publications that came out of this research project that we worked on in the Newcastle area on NDIS provision. Some of them were published in peer-reviewed academic journals. This is one that was published from Centre for Future Work directly.

DR MACDONALD: As to my work in relation to NDIS work, I've been involved primarily in studying the work organisation and experience of workers in individualised funding systems since 2013 through a major Australia Research Council funded grant and in addition have undertaken a number of other commissioned studies for industry, as well as this research.

MR GRAY QC: Now, before we come back to the point I wish to raise about causal connection between individualised funding and fragmentation of the workforce, instability, precarity and independent contracting, casualisation and the like, I should just ask Professor Stewart, particularly from a technical legal perspective, we just go back to the topic that Dr Stanford and Dr Macdonald were just commenting on, the point about whether the facilitation of communication between a provider's care manager and an independent contractor retained directly by the client, whether that is sufficient to ensure quality, you've heard the answers that Dr Stanford and Dr Macdonald gave, do you wish to add anything bringing your technical legal perspective to bear?

PROFESSOR STEWART: I suppose the thing that I would add is that the way that incentives work in relation to labour regulation is there is a clear incentive for organisations to avoid employment.

If a regulatory system simply takes that as a given and then tries to cope with it, it will struggle to ensure the maintenance of particular standards, the achievement of particular objectives. So my strong argument would be that the decision must first be made for certain services, what are the requirements for quality of standards and quality of provision of services and does that goal require that an organisation be providing rather than an individual?

It seems to me, even without the same level of expertise on care provision of either of the other two panel members, it seems to me that there must logically be forms of work where it is appropriate to allow an individual to provide those services, but it

may very well be essential to ensure that those individuals have sufficient levels of experience to be able to cope with the kinds of difficult issues that Dr Macdonald, for example, mentioned.

I can imagine there could be circumstances in which an independent contracting model would be okay, provided there are safeguards in place, provided intermediaries are still required to meet certain standards, but the important thing is to make the decisions first about the quality of care and the mechanisms that are needed to produce that, and then impose requirements or make allowances about the legal forms used for work arrangements, not to simply allow the market, and in particular the incentives for the invasion of employment arrangements or the avoidance of employment relationships, to drive the kinds of complex structures and regulatory problems that can happen under the existing system.

MR GRAY QC: Dr Macdonald, I'll now come back to the point you wished to open some time ago and that is the connection, if any, between individualised funding, called in this home care context Home Care Package, but it has different names in different systems, and you, I think, referred to vouchers. Is there a correlation between - a necessary correlation - the use by Government of individualised funding and the fragmentation of the workforce and the incentivisation or the encouragement to use independent contracting, casual labour and the like? Or is it more a case of the funding mechanism being one thing and the employment model being essentially neutral, the choice of engagement model being essentially neutral and subject to the sorts of potential regulatory solutions that have been discussed so far?

DR MACDONALD: I think, well, my understanding of my fairly extensive review and ongoing review of this literature is it's the combination of the funding arrangement, the funding level, in an individualised funding system with poor employment regulation and poor care regulation combined to produce poor outcomes in terms of care and poor employment outcomes. But in each case, poor care outcomes are not the result only of care regulation but of the interaction of care regulation and employment practices and the ways in which regulation allows those practices. And the outcomes for workers, similarly, are a result of the combination of those factors.

So where employment regulation is poor and the funding provides an incentive to engage labour as cheaply as possible, and the employment regulation allows that, then you will get poor outcomes. I'm basically saying it's very difficult to --- there's no straightforward answer. It is an interaction. There's definitely --- and there's strong evidence that the interaction of those three factors and the fourth factor, which we're not contemplating, I believe, is the engagement of family members, but related to that is where care is regulated and interacts with Government regulation to support informal engagements in the care system, that leaches into the rest of the system in formalising and devaluing care work.

MR GRAY QC: There is no proposal for packages to be converted into cash that can be spent at the discretion of a package-holder such as I understand exists in

Germany. There is no proposal for a mechanism of that kind. So the proposal is for in relation to care in the home as opposed to respite, social support, transport, meals, assistive technology, and home modifications, that there would be a process of assessment of the needs of that individual and a process referable to cost reviews of the actual costs to providing care to meet those needs, which will probably involve an independent review of cost data over time, and a combination of the assessment and that cost data would produce a budget for that person.

Now that budget would be, in effect, directed to the provider of the person's choice and the care would have to be provided that meets the needs assessment that has been generated in relation to that individual.

Is there anything about that process that necessarily results in workforce fragmentation or are you saying that it could be addressed --- it could be addressed by proper care regulation and employment regulation?

DR MACDONALD: Yes, I am, because it goes to what I was saying before. If you can --- if that budget --- if the allocations within that budget for training and supervision can be leached out and directed elsewhere and you can still make a profit as an intermediary, for example, and people receiving care can get more quantity, if it gives the people an incentive to do that because they can get more quantity of care, that's when you start having quality problems.

I think, you know, and it happens in direct engagement as well as currently providers use labour hire because it gets them out of the problem of having to deal with workers' performance and workers' development. If a worker is not performing well or a person being supported doesn't like them, that worker just goes back to the labour hire agency and circulates around and gets sent out until eventually people stop engaging that worker. But that happens again and again and again in the current system where workers ---

MR GRAY QC: Thank you. I'll go to Dr Stanford on this. Dr Stanford, what's your response on this point I've raised about whether there's a necessary connection between individualised budgeting and these workforce precarity and fragmentation issues that can have flow-on effects to quality, on your evidence?

DR STANFORD: I think that the individualised budgeting opens a door to a kind of downward competitive bidding-down of the standards and quality of care for some of the reasons that Dr Macdonald mentioned. People naturally want to sort of conserve on their individual allocation. They want to, you know, get the most bang for the buck. They may be finding ways to reallocate the resources to other services or commodities that are within the overall package. I think those problems could be managed and controlled, but in the context of something other than a competitive market-driven delivery of services.

You could still have consumers who are granted an entitlement to a certain set of --- or a certain bundle of services or a certain level of care that could be, you know,

considered their voucher, if you like, and they would still have choice and input and control over how that budget was spent from among a number of different providers, all of which were high-quality, well-regulated organisations providing these services and among the different regulations that these organisations would have to meet would be regulations around the skills and qualifications and management of their staff.

So, in that type of situation, I think you could conceive of a combination of individualised funding and high level of consumer choice, but with a strong regulation on the supply side of that market, to ensure that people providing the services were not being undermined by this sort of competitive market pressure that would otherwise be unleashed.

MR GRAY QC: Thank you. I think we've probably just got time for one more question before I invite the Commissioners to ask you any remaining questions. Professor Stewart, our proposition HC8 is quite an ambitious proposition. It extends outside the aged care legislation itself, I think, and I'd like to invite you to comment on it and for the public, and I'm sure the Commissioners have got across it, but for the public, HC8 is a proposal for the entrenchment of rights of people who are caring for older Australians, older people, to buttress existing rights to ask for flexible work arrangements and, Professor Stewart, I'd invite you to comment on that and in the ways that those rights can be buttressed and made more concrete.

And also for two years' unpaid carers' leave with a guarantee of return to the same position at a no less advantageous set of conditions. So over to you, Professor Stewart.

PROFESSOR STEWART: Thank you. Both propositions have enormous merit. There is an easy precedent for the first one which is up to two years unpaid leave to care for an older person. The Fair Work Act already provides for exactly that form of leave for care for a newborn child or a newly-adopted child. The right under the National Employment Standards as part of the *Fair Work Act* is for an automatic entitlement for up to a year away to care for newly-born child, newly-adopted child, and then with a right to request an extra one year which can be considered and either granted or refused on reasonable business grounds.

I see no reason why that couldn't and shouldn't be extended to cover care for an older person. So the model is there to be extended. Yes, it would be --- of course it would be a significant change, but even since the *Fair Work Act* has been created we've already seen one significant addition to leave entitlements under the National Employment Standards to reflect the importance attached by the community to dealing with a particular situation. That's for victims of domestic or family violence. So that is a new right which has been added. It seems to me that this would be an appropriate recognition of the significance of care of older people in our community, particularly with an ageing population.

So the first one, I think, is straightforward. The second one, which is entitlement to

flexible work arrangements, it is already the case under the National Employment Standards that requests can be made for flexible work arrangements to accommodate caring responsibilities and that would include care for an older person. So the right to ask is already in the *Fair Work Act*. However, it's one of the peculiar features of the legislation, it was hotly debated at the time the legislation was enacted, it's been regularly debated ever since, every time the Act has been reviewed this point has come up.

The right to request is a right only to get an answer from your employer in writing. That answer cannot be challenged. So if at the moment I were to go to my employer and ask for a shift to part-time employment, for example, from my current full-time position in order to care for an aged parent, if my employer said no, I would have no basis on which I could challenge that request unless my employer had formally agreed that there could be a system of independent dispute resolution over that request.

It would clearly be open to the Royal Commission to make a recommendation that the existing mechanism in the *Fair Work Act* be strengthened by providing, not that employers were required to accommodate requests for flexible work, but at least to allow any refusal based on business grounds to be subject to some form of independent dispute resolution or review, most obviously by the Fair Work Commission.

However, the issue that the Royal Commission would need to be aware of is that that would necessarily create a tension in relation to rights --- sorry, in relation to requests for flexible working arrangements, all other purposes covered by the current provision in the National Employment Standards such as care for a younger child, care for a person who has suffered family or domestic violence, et cetera.

The Commission, I assume, would not want to buy into that debate but it might note that there has been an ongoing debate about the wisdom of strengthening that right. Certainly, though, every reason, in my view, and I think there are a lot of other commentators on the legislation who take - certainly academic commentators - the same view that this is a right which should be strengthened. But in this context, for the benefit of care for the elderly, but arguably for the benefit of many, many other caring arrangements as well.

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

COMMISSIONER PAGONE: Commissioner Briggs?

COMMISSIONER BRIGGS: No, I don't have any questions but I do want to thank the panel. It's been a most helpful session. Thank you.

COMMISSIONER PAGONE: Professor Stewart, I wonder whether I might just ask one point of clarification in respect to the answer that you gave to Mr Gray a moment ago in relation to proposition HC8, the entitlement to two years, there's an

entitlement to unpaid leave. How would you see it operating by reference to multiple employees whether it be of the same employer or of different employers in respect of the same older person?

PROFESSOR STEWART: Thank you, Commissioner. I'd be suggesting that it operate exactly the way that the unpaid parental leave system works which is that where you have multiple employees, there is a right to share the care between them, but they cannot take more than the set amount of leave. So either the one year or 12 months in the first instance, and then up to a further 12 months. There are some slight exceptions to that in relation to parental leave where there can be a relatively short period of concurrent leave taken around the birth of a child. There would be, on the face of it, no reason to have a similar arrangement in relation to the care of an aged person. But it would certainly be possible to adopt the same kinds of rules that effectively mean that you can't have two people both simultaneously claiming up to two years of leave from different employers. They would need to make the decision as to who was the carer.

COMMISSIONER PAGONE: What about concurrently? I understand simultaneously, but what about concurrently, one after the other?

PROFESSOR STEWART: I don't see there's any reason why you couldn't, again, have a decision made by a couple, for example, that the first one would have a period of care and then the other. So that is contemplated in relation to parental leave under the existing entitlement. I can't think of a reason why you wouldn't want to give a couple the opportunity to make a similar decision in relation to care for an aged person.

COMMISSIONER PAGONE: So you're contemplating that there would be a maximum of two people seeking the leave over concurrent periods?

PROFESSOR STEWART: Sorry. Forgive me for being slow, Commissioner. Yes, of course, you could have many more than two people. I'm thinking of a couple because I'm thinking of the parental leave. But let's say I'm one of four brothers, let's say that four of us want to share the care. I wouldn't see a problem in terms of the design of the right as to why you couldn't have --- bear responsibilities and the leave that goes with it passing from one person to another. But clearly once you get to an extension there might then be an issue about whether you limit that in order that multiple employers are not being --- are not having to cope with a constant series of departures.

So you might want to put some sorts of limits on how many people in total and in particular for the purpose of that extension. But in principle I can't see why it wouldn't be appropriate to have an ability for potential carers to make decisions amongst themselves as to who takes on the responsibility. In terms of the cost on business, not allowing simultaneous people seems to me to be a reasonable approach.

COMMISSIONER PAGONE: What I was really asking is whether you'd given any

thought to the question of concurrent and/or cumulative leave being sought and whether you would regard the relevant model as being, in respect of parental leave, in broad terms, you've got two people, maximum of whatever the period is, but in the case of aged care you might have, in the example you've given, four brothers, each of whom might have either the same or different employers, each of whom might decide to deal with it cumulative over a period of, say, eight years.

All I'm really asking is, have you given any thought to that aspect of it and if so what do you say should happen?

PROFESSOR STEWART: Again, it seems to me ---

COMMISSIONER PAGONE: It's perfectly all right for you to say you haven't, if that's the position.

PROFESSOR STEWART: The answer is I hadn't given it any strong thought. I had thought about the two partners, but what I'd be --- I guess what I'd be saying to the Commission is, taking the parental leave provisions as a template seems to me --- and then thinking about whether it makes sense to depart from that template, has certain advantages in terms of design of the legislation, familiarity of businesses, how the system works. You could of course decide to adopt a completely different model but, no, I haven't given the thoughts to what those very different models could look like.

COMMISSIONER PAGONE: Thank you, Professor. And thank you to each of the three panellists. It's of great assistance for us to be able to draw upon your respective depth of experience and knowledge and research. I thank each of you for having taken the time to prepare for this session and then be with us to help us develop our thinking on these topics.

I think I should formally excuse each of you. Thank you for your attendance.

DR STANFORD: Thank you, Commissioners. Thank you.

THE WITNESSES WITHDREW

COMMISSIONER PAGONE: Mr Gray?

MR GRAY QC: Commissioner, we next seek to play evidence of an interview with Eileen Kramer and also present, Dr Maggie Haertsch who is a friend of Eileen Kramer in relation to Ms Kramer's experiences, in particular using home care packages before she went into residential aged care and using the online platform you've heard of, which is Mable, and there are four documents already tendered. I don't need to tender them: a statement of Eileen Kramer, a statement of Dr Maggie Haertsch, they're at tabs 89 and 90, a video of the interview at tab 91, and a transcript

at tab 92, and I understand some arrangements are going to be made now because the recording is a 55-minute recording.

COMMISSIONER PAGONE: Thank you, Mr Gray. As a matter of form, we will formally adjourn until 10.00 tomorrow morning but we will keep open the live stream for those who are able to stay on to listen to the interview. That will enable us to free up some administrative, technical and support staff that don't need to be connected or have their time involved keeping us active.

The live stream will, however, continue. We've had the advantage of seeing the material and I encourage all those who are able to stay on to listen to the live stream.

Eileen Kramer is a very significant Australian. She has done a great deal in the dancing field and as an ambassador for Australia in that field. She has now reached the age of 105, I understand, and very proudly so, and is very proudly continuing to inspire many Australians by the work that she continues to do.

Dr Maggie Haertsch, as you've said, Mr Gray, is assisting her in the process of giving evidence to us and we're very grateful for that also.

Having had some familiarity with the evidence that she gives, I wish to say in advance of it being broadcast how grateful we are that she has participated with the staff in gathering the material and then putting together the 55-odd minutes of video that will now be heard. So we will formally adjourn, but the live stream will continue for those who are able to stay on and listen to that.

ADJOURNED **[3.09 PM]**

VIDEO OF MS EILEEN KRAMER AND MS MARGUERITE HAERTSCH BEGINS

MS HILL: This is an interview between Eileen Kramer and Maggie Haertsch and Erin Hill, Counsel Assisting. Today's date is 26 August 2020.

The interview today is being recorded. The recording of this interview will be tendered at a public hearing of the Royal Commission into Aged Care Quality and Safety, commencing on 31 August 2020, in Sydney. The recording will then be made publicly available.

Maggie Haertsch, do you agree to continue with the interview today on that basis?

MS HAERTSCH: I do.

MS HILL: Eileen Kramer, do you agree to continue with the interview today on that basis?

MS KRAMER: I do.

MS HILL: Thank you, Maggie, thank you, Eileen.

Good afternoon, Eileen, how are you?

MS KRAMER: I'm very well. Looking forward to this.

MS HILL: Thank you. As am I. And how are you, Maggie?

MS HAERTSCH: I'm very well, although I have a slightly croaky voice. I hope it's clear enough.

MS HILL: It certainly is. Thank you.

Starting with you, Maggie, could I ask you please to introduce yourself? What is your full name?

MS HAERTSCH: My full name is Dr Marguerite Frances Haertsch.

MS HILL: And what is your age?

MS HAERTSCH: I'm 56.

MS HILL: And what do you do for work?

MS HAERTSCH: I work as a specialist consultant with a consulting firm called Anchor Excellence and I also am a writer.

MS HILL: Eileen, if I may turn to you, what is your full name?

MS KRAMER: Eileen Stella Kramer.

MS HILL: And what is your age?

MS KRAMER: 105 and a half.

MS HILL: And you are a dancer, a choreographer, a writer, as well as an artist?

MS KRAMER: I'm still a working woman at those things.

MS HILL: Maggie, how do you and Eileen come to know each other?

MS HAERTSCH: We first met when Eileen arrived back in Australia, when Eileen was 99, so that was close to six years ago. It happened that one of my board members of an organisation I was working for at the time met Eileen, sitting on a

park bench, next to a cafe in Sydney, and there was just a conversation struck up. And at that point the board member that I'm referring to, Shane Carroll, is a dancer herself and suddenly recognised, when Eileen said that she still works, that Eileen was from the Bodenwieser Ballet and that Eileen is actually a National Living Treasure and needed to be introduced and we needed to support Eileen; and from there a friendship grew. So that's how it started.

MS KRAMER: It's true, Maggie, it's the best time of my life.

MS HAERTSCH: I feel the same too.

MS HILL: Eileen, together with Maggie, you have prepared a submission for the Royal Commission, haven't you?

MS KRAMER: Yes.

MS HILL: I'm going to ask the operator to please display the submission.

Maggie, can I ask whether you can see a copy of the submission that you prepared with Eileen on the screen there in front of you?

MS HAERTSCH: Yes, I can see it clearly.

MS HILL: In that submission, Maggie, do yourself and Eileen provide details and the observations that the two of you have made as to the aged care services that Eileen has received over the past few years, both at home and, in more recent times, in residential aged care?

MS HAERTSCH: Yes, it details it thoroughly.

MS HILL: Eileen, at 105 and a half years of age, could I ask you to share with us, what does it mean to be 105 and a half for you?

MS KRAMER: To tell you the truth, I don't feel very much different from what I've always felt. I don't take very much notice of ages. But of course 105 is a little bit surprising. I didn't really expect to reach that age. But I like it.

MS HILL: How do you feel ---

MS KRAMER: And I know a lot. I know more now at 105 than I did when I was five.

MS HILL: How do you feel, Eileen, around the language that is used to describe ageing or that people are getting old or getting on a bit?

MS KRAMER: Would you repeat that, please?

MS HILL: Certainly. What are your thoughts around the language that is used to describe people that are older, that are ageing or might be seen to be getting on a bit? What do you think about that?

MS KRAMER: I think it would be better if they didn't talk about age so much. I think it would be better if somebody did not say, "Oh, I'm getting old." There's too much emphasis on age.

MS HILL: What would you like the emphasis to be on, Eileen?

MS KRAMER: What?

MS HILL: What would you like the emphasis to be on? What would you prefer to be the language to be that's used?

MS KRAMER: I like people to talk about their work and to be a little bit frivolous, sometimes, I don't mind that. I don't like people to talk about age. I think often, if I hear people talking about age all the time, I start to feel like that myself. So it would be better if they didn't talk about it. And, of course, they have to keep their body healthy if they can, that's one of the main things, is to be able to function physically. But I think more attention should be paid to the spirit.

MS HILL: How do you feel, Eileen, about the experience of ageing?

MS KRAMER: I don't feel very much about that. I enjoy being able to learn more things, to learn more and to be able to do my work more efficiently, I like that. Physically, of course, we do change a bit and I'm still doing what I like most of all. I like to dance with my upper body more than with my feet and legs, so I'm still able to do that. And it wouldn't be a bad idea if people could cultivate that part of their life.

MS HILL: Eileen, you have provided the Royal Commission with some photographs that have been taken at different points in your life.

MS KRAMER: Hm.

MS HILL: Operator, could I ask please that the photo collage that has been prepared is displayed now.

Maggie, if I may turn to you, are you able to see the collage of four photographs on the screen there before you?

MS HAERTSCH: Yes, I can.

MS HILL: Could I ask you, Maggie, to describe each of the four photographs on the screen and perhaps Eileen you might like to respond to what Maggie is saying as she goes through the photographs.

MS HAERTSCH: Yes. So let's start in the bottom, what is that, the left-hand corner, which says "Bodenwieser Ballet." It's a program with Gertrud Bodenwieser, that has the main face, who was the founder of that ballet company in Australia. And right next to her, standing in an Indian love song pose, is Eileen. And that was a program that was developed on a tour of South Africa. And that was where Eileen toured extensively with the Bodenwieser Ballet for about 10 years, I think Eileen was in the company. Eileen?

MS KRAMER: Yes.

MS HAERTSCH: Would you like to add anything about the program?

MS KRAMER: Well, that's just one of the programs. Most of our programs had photographs or art work on the covers. So that's the only one I possess. I didn't collect photographs very much of the Bodenwieser. But that particular one, perhaps because I'm standing up there, I kept it.

MS HAERTSCH: Yes. So above that one is a more recent photograph, probably about two years ago I think, and that was a rehearsal for a production that Eileen had put on, produced, choreographed and so on, and also made the costumes. And that is a love scene with Raghav and that's --- I find that a very beautiful image. And Eileen is there, you know, in that pose, very much in the moment with Raghav.

Eileen, do you want to add anything to that?

MS KRAMER: That was quite recent dance work I've done since I came to Australia. It's called A Buddha's Wife, when I was in India, I heard a few legends about the Buddha's wife --- well, Prince Siddhartha before he became the Buddha --- and that inspired in me a wish to make a dance work called A Buddha's Wife. And I didn't do it until I went to New York, where I had more dancers to work with. So that picture was not taken in New York, it was taken here when I repeated the dance work A Buddha's Wife and how she dealt with her life when her husband left her to go in search of his spiritual life, and she had to deal with that situation. So she found --- according to the legend in India --- she found her own peace. We could do that too.

MS HAERTSCH: To also add to that story, I think it's important that that was the second production in the six years that Eileen has been back from living in America, the first one was an early production, and both of those were crowd funded by the public and that's actually what launched Eileen to being quite popular. But we could probably touch on that later.

MS KRAMER: The early ones, I did also, I did it in New York, it was called Songheart of the Dreamtime and it was inspired by Aboriginal stories. But when I came here, I didn't want to give the impression that I knew all about Aboriginal stories so I changed the name, I called it A Buddha's Wife.

MS HAERTSCH: The early one, it was the early one.

MS KRAMER: Yes.

MS HAERTSCH: If we move over to the other cover, that is "Elephants & other stories". This is really quite remarkable. This is the close-up image of a self-portrait that Eileen did as a submission to the Archibald Prize last year. But the editor, Cathy Gray, has taken a close-up shot and then used that as the front cover of Eileen's latest book. Eileen has --- this will be her second book, as in proper publication, since being back in Australia; the first being "Eileen". That was 34 stories and 206 pages, that was launched in the Art Gallery of New South Wales in 2018. But this one is waiting for a publisher and it is 30 stories and 200 pages and that was produced in eight months. Like, this is Eileen working.

And the one below that image --- Eileen, I'm sorry, do you want to add anything to your current book, anything more to say about that?

MS KRAMER: I can't see that very clearly, what she said.

MS HAERTSCH: It's just if you wanted to add anything to what I just said about your short stories and the latest publication.

MS KRAMER: Well, during lockup I had nothing else to do so I've written a story every day. It's getting bigger and bigger. And I'm not really bothered by being locked up. I'm glad that Lulworth House is taking great pains to keep everybody safe here. And as far as I'm concerned it's given me time to have more stories.

And also I'm preparing for an installation and a film that Sue Healey has produced of my dance work. So we're working behind the scenes, as it were, preparing for what we will be able to do when we're all released from this lockup.

MS HAERTSCH: That's great.

And so just the one at the bottom, on the bottom right in the corner there, that image of Patrick and Eileen in the middle and Allie at the top, leaping forward over Eileen, it's worth noting that those costumes were made by Eileen. And that's a scene in Lady of the Horizon, which was in a previous version --- say it, Eileen --- it's Isis and Osiris ---

MS KRAMER: Isis and ---

MS HAERTSCH: --- which was an Egyptian inspired dance drama. What's of note in that particular image and one of the reasons why this is included, because it is beautiful, it was taken by Sue Healey, it's because Allie is the dancer who became known to Eileen because she was employed in her home care package to work with Eileen, and from that experience of Mable --- which was an online platform for

matching, for getting carers to come and support people with their home care, in this instance --- Allie was a dancer who could come specifically to work with Eileen on her creative projects within her home care package. And it was quite innovative at the time and I believe it's a very, very important role. They have gone on to create a wonderful collaboration with further dancing and an ongoing relationship since Eileen moved into residential care.

MS KRAMER: That's true. Allie is, besides whatever she did with me, she's quite an exceptional dancer. So I think she has a great career before her.

MS HILL: How important was it to you, Eileen, to be able to have someone caring for you and working with you that shared your interest in dancing?

MS KRAMER: Let me say that I grabbed her, immediately we found out that we were together in spirit, and Allie is quite young, and I really feel young myself, so we worked together very well and we created a book together, a book of images of A Buddha's Wife images from that ballet. And we sat every day at a great big table sorting out photographs, writing things, and finally we had the book printed. And now I hope we will do another one with Isis and Osiris.

I must say that since I came back to Australia I have got around me a wonderful team of talented people: Anca and Patrick, they were with the Contemporary Dance Company in London and now Anca and Patrick do their own work but they also work with me; and Allie, this girl we were just talking about, she will be in the installation I'm planning; and Raghav, the Indian young man who is in the photograph with me, the love scene. Probably those people who have worked with me before will work with me on this new project. So in a way they are all artists in their own right but they are working with me and I'm very thankful for them.

And also it's something to do in Sydney and the dance scene here itself, people are willing to take part in projects. My motto is, you build it, they will come. And it works out like that.

MS HILL: Thank you, Eileen. Maggie, did you want to respond to anything that Eileen has just said?

MS HAERTSCH: Yes. Look, I think it's worth paying particular attention to the way the home care package worked, if I could, Erin.

MS HILL: Certainly.

MS HAERTSCH: I think that Eileen has had two different types of service delivery models, if you like. The first was a more traditional one, where there was the same amount of resources and money but there was less value in terms of time and choice and the personalised attention that she could get, depending on what her needs were. So what was originally one carer, we ended up having --- interviewing a range of people and Eileen chose, with my other colleague, my friend Shane, who we both

share support for Eileen around --- and what we found was that we could get for the same money and time a physiotherapy that helped Eileen with her balance, which was important, and we also could get Allie, who was a dancer; she wasn't a carer, she didn't come from that caring background, but she was perfect for Eileen, as Eileen has explained. And then there was a person who was a carer who would come and help Eileen with more personal care matters that she needed at the time and some food and so on.

It was a wonderful, wonderful experience and I think that that is a testament, just what's happened since with that relationship. It is very much around the relationships that you build and that kind of really tailored, knowing that person and the support that that person needs.

Eileen, do you want to add anything else to what I've just said?

MS KRAMER: No, you've said it.

MS HAERTSCH: Okay.

MS HILL: Eileen, you have also provided the Royal Commission with a video that you have asked to be played today.

MS KRAMER: What did you say?

MS HILL: You have provided the staff at the Royal Commission with a video, and I'm going to ask now that that's played.

MS KRAMER: I can't quite get it. Are you asking me what I feel about the video?

MS HILL: I'm letting you know that we have got the video that you have provided to the Royal Commission and we are about to play it. And I would be very pleased, perhaps once the video is completed, to hear what you think about that video, how you feel about it. So I might ask that that's played now, if you are comfortable with that, Eileen.

MS KRAMER: Yes. Do you want me to talk now or after the video?

MS HILL: Perhaps after the video, as I understand there's sound that will follow.

MS KRAMER: Yes.

(Video played)

MS KRAMER: I can't describe how beautiful Madame's dance made us feel; not exactly spiritual but spiritually beautiful and very much aware of the breath. It

wasn't so much to do with ideas of God as the mystery of life and growth.

(Video concluded)

MS KRAMER: That dance is called The Waterlilies. It's been done by several couples, people. It's not a typical example of the Bodenwieser Ballet because there's a lot of very strong work in Madame's choreography. But I was always given soft parts and I like that.

I should say that meeting Madame Bodenwieser, seeing her work for the first time set the pattern for my future life and that pattern is still quite valid. I still work the way she taught me. And the work that I produce, I should say, is a good representation of the early modern dance in Sydney. So that first glimpse of the Bodenwieser Ballet changed my life. As I said, it set the pattern for my future life and I've never wanted to change it.

MS HILL: Maggie, could I ask you to share with us why it was important to share that particular extract of footage?

MS HAERTSCH: Yes, that's very rare, it's very rare to see that dance work on film because there weren't a lot of films made of the Bodenwieser Ballet at the time. That was part of a bigger documentary that Compass produced and broadcast just after Eileen turned 100. It was to really celebrate Eileen's 100th birthday. I introduced Eileen to the production company and also to the ABC and, you know, that I think is really important, to recognise what Eileen has actually contributed.

I mean, the Bodenwieser Ballet was the first --- what I understand, and I'm not a dancer, but certainly I have come to appreciate that Eileen is really still dancing and dancing very much in the style of Bodenwieser. But it was the first modern dance, professional modern dance company in Australia, back around the 1940s, 1930s. Eileen, for people who want to know, Eileen is in the background, Eileen is the second person, not the first person, in that footage.

MS KRAMER: What did you say?

MS HAERTSCH: I just said that you were the second person behind the first dancer.

MS KRAMER: Yes.

MS HAERTSCH: Just so that people understand and recognise you. I think it's ---

MS KRAMER: Madame Bodenwieser was not the only modern dance company. There was another person, named Margaret Barr, she was also doing modern dance, but I don't think she became a really professional company. We were very professional and we toured a lot throughout Australia and overseas as well. And we

were always working.

And I didn't expect anybody would remember. But when I first came here, I said to Shane Carroll, outside Brickfields Cafe, "I belonged to the first modern dance company," and she said, "Oh, yes, the Bodenwieser Ballet." So I was very happy that someone remembered the Bodenwieser Company.

And I must say that in America I went to live in West Virginia and there I joined a professional dance company and so Madame Bodenwieser's name became very well known to that small town in America. So that's how things spread throughout the country. Things spread and you don't realise it. I think I feel quite pleased that Madame Bodenwieser's name is known a little more now than it did when I first came back here.

MS HILL: How does it feel, Eileen, for your contribution to be recognised and to hear Maggie say earlier that you're a national treasure and of the contribution that you have made?

MS KRAMER: I don't know. I was a little surprised to hear that. I'm sure there are quite a few national treasures.

MS HILL: I'll ask the operator --

MS KRAMER: I am now probably one of the few remaining dancers of the Bodenwieser Ballet still working. And Barbara Cuckson has collected all of Madame's publicity, everything, so her name is kept alive in the libraries in Canberra, in the dance world. So I'm really very happy about everything.

MS HAERTSCH: Erin, would it be useful to just say here that Eileen is prolific with her creativity?

MS KRAMER: Pardon?

MS HAERTSCH: You are prolific with your creativity. What you have been able to do --- and I was doing a bit of a tally in preparation for this, is that you have actually got one publication ready to go to a publisher, you have already published one book two years ago, you have done three dance works, three properly well produced on-stage dance works and we are talking within six years, we have done huge crowd funding campaigns, because Eileen at her age, she doesn't fit any of the criteria for getting grants and we just can't wait that long to get the grants. So doing crowd funding and the public getting behind your work has been phenomenal. You have collaborated with Brigid --- I can't remember her last name --- Brigid --- help me Eileen, Brigid's last name?

MS KRAMER: Yes, it's ---

MS HAERTSCH: With the scarves, remember, and your illustrations on the

scarves?

MS KRAMER: I went to a dance festival in Queensland and a dance festival in Adelaide, I think, and there I had to deal with a few hundred people in a very big group. I had never done that before. But I suppose my training had its effect. They were quite successful. I would like to do that again.

MS HAERTSCH: Eileen has been taking dance classes in art galleries, also at the New South Wales Art Gallery. It was Brigid McLaughlin, I apologise, Brigid McLaughlin is the fashion designer who did the scarves with your illustrations on them. Your creativity is immense. In the six years I've known you, it's been constant and it's more than one anyone can pretty much manage. And so when people say you're just keeping busy, you're actually working.

And I think that that's a really key point and goes kind of to the heart of what's important here around the concept of age and that it's not about age, right, it's about understanding what it is that you do and your purpose and meaning.

MS KRAMER: Yes. And if you're working on something like that, you're not interested in age. I'm not at all interested in age. It's true that I've been alive for 105 years but that doesn't interest me at all. What interests me is that my spirit is still at work. That's what I would say, that people --- this is the wrong thing to say --- I said, should be educated to prepare them for old age. If more people had work that they loved, there would be no such thing as age. And they are very good here at Lulworth House, they let me store costumes, they have let me use big spaces for rehearsal and in most ways they are very helpful to me. And I am very thankful for it.

MS HILL: Eileen, what do you think that we can learn from you as to how one can live a positive and healthy life at the age of 105 and a half?

MS KRAMER: That reminds me of some old men in North Russia, were asked their secret and they said, "We don't smoke, we don't drink and we don't chase women." I don't smoke and I don't drink and I don't chase women. And I really don't chase men either. I've given up a lot of things to go on working. I've never owned a car, I've never owned a refrigerator, I've never owned a house. I have hardly ever owned anything. And that's left me free to stay young and do my work.

I think, when I said people need educating, I think there should be --- if they could pay less attention to owning all those things, their spirit would stay young forever.

MS HILL: And what are you currently working on, Eileen? You have described an installation.

MS KRAMER: Sue Healey has made a film with my choreography, that's based on the dance work Isis and Osiris. From that film I'm going to extend the characters into an installation, as like a second movement of the film, and we are hoping to give

the impression that the live action emerges from the film. And Sue says we can do it, she's the film maker. I also understand film making because I learnt that in America. But in this case Sue is the director of this film, with my choreography, and together we will make the second part of it with live action. And it's all to do with --- anyway, it's a little bit to do with what happens after lockup. I expect and everybody expects there will be new --- there will be a lot of new things after lockup.

Every calamity stimulates creativity, so it is stimulating us to make this film, which we hope to show at the Art Gallery of New South Wales. We hope to do that. So I'm just going ahead as well as I can and while we're locked up and making costumes, writing the script and making my colleagues aware of what we want to do when lockup is over. So we are quite busy. We're not sitting around looking bored.

MS HILL: And --- pardon me.

MS KRAMER: Hm?

MS HILL: I was going to ask the operator to display a further and a second photograph of Sue Healey, which you have referred to in your answers today. I'll ask Maggie, do you see a copy of a photograph on the screen before you?

MS HAERTSCH: Yes, I do. It's a very beautiful photograph of Eileen. It was a photograph --- well, it's a still from the film that Sue Healey has made and it's a --- it was a finalist in the National Digit Portrait Prize in the National Gallery in Canberra and also a finalist in the 65th Blake Prize. And yes, it's Eileen. That would have been in 2017.

MS KRAMER: By the way, that picture is on the cover of the little book that Allie and I produced. Allie was the girl who was coming here with my therapy and we made this book together. So that's on the cover of that book.

MS HILL: Thank you, Eileen.

Returning to you, Maggie, ahead of the interview today I asked you to turn your mind to what your response would be to a question that I asked you: what you have learnt from Eileen and your relationship and friendship with Eileen? Would you like to respond to that question now?

MS KRAMER: I think it's grown slowly.

MS HAERTSCH: Eileen, I think the question --- we can come to you next, if you like. I think the question is directed to me to talk about you.

MS HILL: I will give you a right of reply, it's okay, Eileen.

MS KRAMER: I'll have a little sleep while you're doing it.

MS HAERTSCH: Okay. I took the liberty of talking to a few of the group of people that have been supporting Eileen and I counted them. Basically there's a group of nine people. So it's not just me, although I play a very important coordination role with a lot of Eileen's activities. And, you know, the words are that she's inspiring, that, you know, Eileen symbolises joy and it is this extraordinary creative spirit. And for me, I am absolutely in awe of Eileen. She has changed my life. Eileen is more or less twice my age and people when they turn 50, they kind of worry that they're halfway, halfway to 100 or whatever and there is this sense of fear about age. And I think it's a terrible, terrible thing for our society.

Age is truly a number. What's most important is that we continue to have purpose and meaning and Eileen absolutely embodies that.

I work a lot in residential aged care homes so I have a fairly strong background around aged care specifically and I can see this inherent kind of people giving up, you know, because they continue to have birthdays and then not look forward to them. You know, we seem to earmark that because you turn a certain age, your life is done, like it's over; like this concept of retirement, it can also be something we really need to reconsider. It's about how you live a full life, a vibrant life, what it is that matters to you, and Eileen just embodies that in every single way.

I have been with Eileen in many, many different situations. We have travelled together to the centre of Australia. There's a way of being with Eileen that has taught me so much about really listening, really taking time to slow down and to really be with her, to not --- you know, to fully appreciate that Eileen is who she is.

For some reason, when we go out in public sometimes --- it happens more often than not --- people talk to me instead of to Eileen and ask me questions about Eileen, when she's actually there. And this has got to stop. And I think that there's a bigger problem with the way in which we think about ageing, that goes very deep culturally and it's that that I think we need to truly understand and change.

But Eileen, for me, has transformed the way I think and is an incredible example to all of us around really rethinking what the whole concept of age really means. And in a way I think we create a whole lot of self-limiting aspects to our lives when we keep focusing on age rather than really, you know, a joyful life.

MS HILL: Would you like to respond to that, Eileen?

MS KRAMER: I heard a lot about Eileen. What about Maggie? She has affected my life too. Because in a way she works with the other side of aged care and she's more --- not practical but she knows how to do things that I wouldn't know. And I have learned that from her, I've learned a few things I didn't know how to do before, so I've learned from Maggie that there's a way to do things, as far as managing my life. You have helped me manage my life.

MS HAERTSCH: Oh, that's good. And it's fun to do. You keep us very, very busy.

And in many ways I think this is a very important model. We tend to focus on chronic ill health, you know, chronic diseases. I'm a nurse by background. There's too much emphasis on being frail. And if we can in fact start to look at the potential and just adjust a person's life, so that it's all back of house, you know, the care, the dressings, the medications, all of that, but get on with actually having a really good life with the time that you have, and I think residential care in particular still has a bit of a way to go there and that's partly --- there's a system problem which, you know, I'm very, very glad that the Royal Commission can really look into. Because the emphasis is all wrong. The perversive funding incentives, everything about it is focused on ill health and thinking about it like a hospital. And to some extent I think that families, to some degree too, think of it a bit like that.

If we can really understand what it is that actually makes that person have a good and satisfying life then I think we look after mental wellbeing, the creativity and the sense of purpose that people still have.

MS HILL: Eileen, why was it important for you to be able to share your and Maggie's story with the Royal Commission?

MS KRAMER: Well, I never heard of Royal Commissions until I came here. But I see that that's a way to make progress towards good things. I'm going to sneeze, I think.

MS HILL: Bless you.

MS KRAMER: So I think it's important to be here doing this because the Royal Commission can have some effect upon the world or the country or the city or the time and the place. And I didn't quite comprehend that when I was asked to do this, but I do comprehend it now, and so thank you, both of you, for letting me know things about myself.

MS HILL: Maggie, I'm drawing to the end of the questions that I have for both yourself and Eileen. Were there any other matters that you would like to share at this stage or would you like to respond to that question that I posed to Eileen about why it was important to share your and Eileen's story with the Aged Care Royal Commission?

MS HAERTSCH: Yes, I think that that's a very important question. I was working in the World Health Organisation in Geneva for a period of time, just before the Royal Commission was announced. I was over there when it was announced and I was working in the global dementia strategy there. And I thought --- I felt compelled to come back. I felt that we needed to really help fix the system. I was more interested in Australia's issues than I was around the global issues at that point.

And here I feel it's a real privilege, it's my second appearance before the Royal Commission and it is a real privilege to be able to present, you know, another experience, and this is Eileen's lived experience, of having been in a system of home

care and then into residential care, and it's a good story. It's a very good story of support and appropriate collaboration and so on.

I believe that we need to understand that there are fabulous stories out there, that aged care --- as much as the system needs to be overhauled, we need to take faith and hope in what we can now redesign and do. And I really hope that Eileen's experience makes an impact in amongst, of course, all the other witnesses and all the hard work that the Commission has been doing. And I think that if there was just something about quality of life, focusing on quality of life rather than just quality care, and we really think about what it means to have a meaningful and purposeful life, then we've got the basis of moving forward into a much better system, I believe, that's good for Australia.

So I want to say thank you. I want to say thank you very much for having this opportunity and to also thank Eileen because we worked on all of this together.

MS HILL: Eileen, may I turn to you and give you the final word in our interview today. Do you have a parting message or observation you would like to share?

MS KRAMER: Yes, keep on doing what you're doing. I think, when I was first asked, I didn't want to have anything to do with talking about age. In fact, until I actually came back to Australia I was living in my own house --- not my house but I was living in a house --- looking after myself, at 90. You know how old I was; I forget.

Since I came here, I've heard a lot about age. And I didn't want to be involved. But now that I'm involved, I see it's important and I'm quite enjoying it. So long as I'm not expected to behave old. I don't feel old, I don't want to behave old. But I realise that the spirit has a house to live in and that house is our body, so we have to look after that. And that's what aged care is about, in a way. We have to look after that house so that our spirit can enjoy life. Mine does. Is yours, Maggie?

MS HAERTSCH: Yes, mine does.

MS KRAMER: Is yours?

MS HILL: Yes. Thank you. We are in heated agreement there at the conclusion of our recording of this interview. Thank you both and I'll indicate now that the formal recording will conclude at this point.

VIDEO OF MS EILEEN KRAMER AND MS MARGUERITE HAERTSCH CONCLUDES

MATTER ADJOURNED AT 3.09 PM UNTIL WEDNESDAY, 2 SEPTEMBER 2020

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