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TRANSCRIPT OF PROCEEDINGS

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

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

SYDNEY

9.38 AM, FRIDAY, 18 SEPTEMBER 2020

DAY 95

MR P. GRAY QC appears with MR P. BOLSTER and MS E. BERGIN as counsel assisting
MR S. FREE SC with MR B. DIGHTON appears for the Commonwealth of Australia
MS V. HOLT appears for the State of Victoria

COMMISSIONER PAGONE: Yes Mr Gray.

MR GRAY QC: Thank you, Commissioner. I call Dr Steven Kennedy PSM and Ms Jenny Wilkinson.

DR STEVEN KENNEDY, AFFIRMED

MS JENNY WILKINSON, AFFIRMED

EXAMINATION-IN-CHIEF BY MR GRAY QC

MR GRAY QC: Dr Kennedy, you are the Secretary of the Australian Treasury; correct?

DR KENNEDY: I am.

MR GRAY QC: Ms Wilkinson, you are Deputy Secretary, Fiscal Group, of the Treasury; is that right?

MS WILKINSON: That's correct.

MR GRAY QC: The Treasury has prepared a response to a notice to give information or statement in writing from the Royal Commission. The response is dated 31 August 2020. I will ask that it be displayed on the screen in front of you. It's Tab 118 of the tender bundle, CTH.9300.0001.0001, and if we go past the first page please, operator, so Dr Kennedy and Ms Wilkinson can see the text. Is that the response prepared by Treasury?

DR KENNEDY: It is.

MR GRAY QC: Have you satisfied to yourselves that to the best of your knowledge and belief, the facts in it are correct?

DR KENNEDY: I am.

MS WILKINSON: Yes, we are. I am.

MR GRAY QC: There are various opinions stated in it. Are you satisfied that they represent the positions adopted on the particular points mentioned on the part of the Treasury?

DR KENNEDY: We are.

MR GRAY QC: Thank you. Now, can I just make a few introductory remarks by way of context, forming the backdrop to the questions that I'm going to be asking you predominantly about financing of the future needs of the aged care system. Please assume ---

DR KENNEDY: Yes.

MR GRAY QC: Thank you. Please assume that Counsel assisting the Royal Commissioners will be submitting that in the future there needs to be a process for the independent calibration of funding levels to be made available to aged care providers to provide aged care services based on some sort of benchmark efficient estimate of the costs of providing those services. Please make that assumption.

DR KENNEDY: Yes.

MR GRAY QC: And please also make an assumption that there will be proposals concerning a thorough assessment of individuals as to their needs for aged care services, and that that will be the trigger for eligibility for individuals to receive services from providers. Please assume also there will be proposals about clearing existing waiting lists that seem to have arisen as a result of planning controls or supply rationing or limitations and that in these ways there will be a transition to moving away from supply controls all together to a needs-driven or demand-driven system which provides services in accordance with need funded to the level reflecting the cost inputs of those services. Please also assume this will be rigorous reporting by the providers of their income and expenditure to some independent body so that that independent body can consider that information for the purposes of recalibrating on an iterative basis the appropriate benchmarks for future funding levels.

Now, all of this will present, I suggest, a significant financing challenge for the future and that's the context in which I wish to ask you questions about financing. But before I go to that, if Treasury has formed any view about the appropriateness of a scheme of the kind that I've just outlined involving independent cost-informed subsidy level setting or price setting, please do share that with the Royal Commissioners now. Has Treasury considered that basic point of principle? Do you have a view on it?

DR KENNEDY: Well, I have a view on it. I will pass to my colleague in a moment. But my view is those sound principles for designing an aged care system, Counsel, and they would be the type of principles we expect to be applied in a system that gave the Government confidence that the funding that came with such a system was appropriate. And as you said, there are iterative processes here. It would be absolutely crucial that the Government trusted that the system was being applied effectively. That, Counsel, the type of system you outlined, the independent price setting, independent assessment mechanisms to review, they would all contribute to a Government, from my perspective, being able to have trust in such a system and fund such a system.

MR GRAY QC: Thank you. And, Ms Wilkinson, did you have any digs al points to make in addition to Dr Kennedy's points?

MS WILKINSON: No. I agree with Dr Kennedy's points and don't have anything to add.

MR GRAY QC: Thank you. Dr Kennedy, I'll direct my questions to you in the first instance but if you feel you wish to bring Ms Wilkinson in on any particular point, please feel free to do so. But I would ask that you, in effect, exhaust your knowledge first and attempt to answer the question I put.

DR KENNEDY: It may be the point that Ms Wilkinson disagrees with me so I'm happy to do that.

MR GRAY QC: We will cross that bridge when we come to it. But in the first instance I'll direct my questions to you.

DR KENNEDY: Okay.

MR GRAY QC: The Royal Commissioners have received evidence that generally speaking, Treasury officials and perhaps executive governments are not all that in favour of the concept of hypothecation, and that proposition has put in different words but there has been a strong suggestion in the evidence that Treasury officials don't like hypothecation. Why is that so or, if you agree with that, why would that be so?

DR KENNEDY: Look, I want to be clear at the outset that I'm not against hypothecation in all circumstances. In some ways, Counsel, it's not a question of me like it or not like it. It's a question of in what circumstances would hypothecation work well. We had an example in our submission of where we thought hypothecation worked well. Another example I often use is hypothecation works well when government do things like congestion charges and they set those fees where they charge, for example, a person entering a city, where there's congestion, it has been done in a number of cities, again services provided by the city, they may be public transport or those types of things. So where the levy goes on to the people who then can see the flow of their money back to the activity --- back to the benefit, I guess, from applying the levy, where there is very much a one-to-one, and also where it helps in getting the policy through. There is definitely a political economy aspect to it.

Where we become less sort of - less sure that hypothecation will be helpful is when you're trying to fund something as wide and complex as a health system, a disability system like NDIS, or in this case an aged care system or, frankly, a childcare system, an education system, there is a lot of very important services to be delivered across Government, and once the service is large and wide and there is not that direct link, our general preference is that we focus on high quality systems, the type of system

you outlined, for example, on the aged care side, delivering those services equitably and efficiently with people having reasonable access to all of them, and then we raise the funds to pay for them in the most efficient way possible. That doesn't rule out --- Counsel, I will just finish on this point --- we don't look for transparency mechanisms to show how money is being raised in general revenue are funding a high quality system, and in some ways the Government's commitments around the National Disability Insurance Scheme and the Government's broad commitments around the health system are examples of that around where there is budget transparency. Effectively, though, against general revenue, there is not a one-to-one levy matched to this exercise. So, Counsel, if you are looking for, you know, my suggestion here is a one-to-one levy to fund this system is something I think removes flexibility from the Government. I really feel the financing piece comes after the design or the quality system piece. If you're looking for transparency, there are ways to do that or commitment, if you like, from the Government that such a scheme is inundated on an ongoing basis without necessarily raising a levy. If it's okay, I will just address one more issue. The other issue that sometimes arises is, if we're going to expand the scope of the of government, raise the size of the tax base is sometimes an argument we might put a levy over and above the existing taxes we raise to pay for new services, in this case aged care services, over and above the services we provide. I just feel that that's a leap before a lot of considerations need to be made about is there the opportunity to fund this within the existing revenue base, how do I put a levy on that isn't inequitable for those people who I'm going to raise this money off to pay for these services.

Lastly --- apologies for going on a bit --- which is a point we raised in our submission, is a reasonable amount of private contribution being made to this scheme? So, yes, apologies. That look a little longer than I wanted it to, but I would just suggest that it's not a question of us ruling out hypothecation under all regimes, it's where it works and what mechanism works well to make sure a system is sustainably funded.

MR GRAY QC: I want to ask you about what you said concerning flexibility and the desire of governments to have flexibility, that's my interpolation. But you mentioned one of the disadvantages of hypothecation might be a lack of flexibility. And an aspect of that surely, Dr Kennedy, is that the government of the day wants to be able to have flexibility to meet the fiscal imperatives or purposes that it perceives arising from circumstances as they unfold from year to year, and it doesn't like having money locked away and inaccessible for general fiscal purposes. Is that an aspect of the flexibility point that you made a little earlier?

DR KENNEDY: Yeah, look. Yes. It's an aspect of that flexibility point. It partly goes to having an optimally designed tax system as well though Counsel. A levy has to be raised off somebody, and so it also wants flexibility over time to be able to change the manner in which it raises revenue from the public to make that as efficient and as equitable and as reasonable as possible. But, yes, yes. There's no doubt there's flexibility. Let's say, for example, there was a single levy, a portion raised off people who were employed, and at the moment that levy would be falling

dramatically because of the outcomes around COVID and the Government would be going into deficit, of course it wouldn't be sensible at all to begin to reduce the services to which that levy was set against. Now, there are means to solve that through rolling funds over and a range of other exercises, but really, what I would like to see out of the service side of Government is a trusted system that people believe delivers quality care, that the Government funds, commits to fund on an ongoing basis, and then rather than a financing tool somehow or other giving you that confidence. I really feel it's about the system itself.

MR GRAY QC: Yes. I understand that. Thank you. I'm just wishing to explore the financing aspect as well, though.

DR KENNEDY: Yeah, okay.

MR GRAY QC: And further to that, just taking this flexibility point and the fiscal imperatives perceived by the government of the day a little further. If you had a situation where there had been a history of instability and mistrust, to the extent that it was impeding proper investment and threatening continuity of essential service provision, that might be a case, mightn't it, for a measure to, in effect, remove flexibility from Government by hypothecating funds as a gesture to the sector in the community to instil confidence in the continuity of services in the future? What do you think?

DR KENNEDY: It's a possibility. As I said, my assessment in this case is it's not needed. I raise that issue of transparency, a manner of - I guess, Counsel, what you're seeking is a commitment from government that it will fund something on an ongoing basis and that the levy provides that commitment, if I understood the question correctly.

MR GRAY QC: Yes. Yes. And I would add to that by saying it needn't necessarily exactly meet the entire financing commitment of the program of services in a given year. But the gesture is important. Just like the Medicare levy is important because Australians have confidence in the Medicare system partly as a result, I suggest, of the Medicare levy and the indication that gives that part of their taxes will go towards continuity of Medicare services.

DR KENNEDY: Yes.

MR GRAY QC: I just wanted to augment my question. Please do respond.

DR KENNEDY: Yes, sorry. In some ways to push it further, you could make the same argument with the way the Medicare levy was changed for NDIS from memory, and is set against the funding for NDIS. Look, it's sort of a political economy question, really. It's not an economic policy question. It's a - I mean, at best it's a suggestion that the providers of the system become more confident because they're, say, partially funded by some form of an ongoing levy, or that you've given the community some confidence that inside the tax system, there's a part of the tax

system that is specifically set against this activity. So we take this activity seriously because we said - look, I don't think - I don't think that solves - the primary way to solve the problem is to solve the problem of the system. And then, frankly, once you solve the problem of the system, and this is what we have in my view largely in healthcare and elsewhere, the commitment follows easily and stays in place. I don't - in my view, Counsel, you've sort of got - we can sort of get it back the front if we focus solely on the funding thing. If the Government from a transparency perspective wanted to state --- it doesn't even need to put a levy in place, if it wanted to say I'm going to allocate this portion of the consolidated revenue against the aged care system on an ongoing basis, there is no levy, it's just that i'm going to allocate this because I want to show my commitment to this scheme on an ongoing basis, it may not fully fund it or not, that's effectively what happens, as I understand it, Ms Wilkinson, with health funding, as I understand it, in the Budget papers, Counsel. So once again you don't require me to go and put a levy in the tax system to do that. A portion of consolidated revenue can be set and allocated against this activity and, as you said, if you thought it was an important gesture it may not need to cover even the full cost. But it's a consideration about, I guess, how to build confidence. At best it's a secondary consideration from my perspective after I trust this system, it delivers high quality outcomes and then lastly, which we will no doubt come back to, that people reasonably contribute to the system from their own means. Because all of those funds that I'm setting this against are in competition against very other important essential services. As I said, childcare, other health systems, education system, every part of our --- our community values all those services deeply, and they all have to be funded and delivered appropriately. So, look, it's a possibility but as you can hear from my answer, it's not where my focus would be.

MR GRAY QC: I understand. I think the Commissioners have got the message pretty clearly. I will move on to another topic, social insurance.

In the Treasury response document, Treasury seems to have treated the proposal or the possible option of social insurance-based financing in the Financing Options Paper published by the Royal Commission as a pre-funded social insurance proposition, and only as a pre-funded social insurance proposition. That, in fact, is not the only basis on which social insurance was raised as a possible financing option. It is also raised on a pay-as-you-go basis. That is, one possibility is that a social insurance scheme could be managed on a pay-as-you-go basis where the incoming revenue in respect of a particular period closely matches the outgoing expenditure of the fund constituted by the premiums received under the social insurance scheme.

Now, having made that clear, does that alter the Treasury analysis in the response document somewhat? Is there more to be said for a pay-as-you-go social insurance scheme than a pre-funded one?

DR KENNEDY: Look, Jenny knows more about this than me so I will pass to her in a moment, you will quickly exhaust my knowledge.

We did talk about third party insurance, motor vehicle third party insurance as an example, from memory, in the submission. And the point we were trying to make is that that's a social insurance scheme that we all contribute to on an ongoing basis, but a very small number of us will draw on it, Counsel. It manages that type of risk. And there are similar versions of those type of social arrangements - insurance schemes, for example New Zealand runs one, from memory, for public liability. Yes, so we did take a specific example and talk our way through it. Would sort of the motor vehicle third party insurance type of approach work here as a social insurance scheme? I don't think it would change ---

MR GRAY QC: I will just stop you there, if I may. That is one category of examples of compulsory insurance you could describe for the social insurance scheme but that's not the emphasis here. The emphasis in the financing options paper is on human services financing.

DR KENNEDY: Yes.

MR GRAY QC: And it's far more relevant to consider pay-as-you-go insurance schemes in other countries such as Japan and the Netherlands and so forth.

DR KENNEDY: Yes.

MR GRAY QC: Thank you for raising that, but it's a long way from this context. In the context of human services social insurance, the question is, putting aside the straw man of a pre-funded social insurance scheme --- because in fact no purely pre-funded social insurance scheme for human services exist, to the best of our knowledge --- what about a pay-as-you-go social insurance scheme? That's really the question.

DR KENNEDY: Look, I will pass to Jenny, but I mean, a pay-as-you-go social insurance, it all depends on who you are levying, I suppose, and how the risks are being shared across that population and then who it applies to. In some ways it can become not that different, I think this is right, from basically raising - from paying for the system as you go as we do today through tax revenue and with contributions on the side. So - and in terms of - sorry, I'm doing this a bit on the fly, but why would you introduce this insurance system, it's to get some benefit from the risk pooling, and I'm not sure how the risk pooling benefit helps here, because in design terms you would want a system where people are drawing on the system for need that's paid for, you're looking for a way of risk pooling somehow or other that I guess the whole population has contributed on some basis for this premium. That - in some ways that's no different from depending on how you apply the premiums from using general revenue --- but you are getting at the edge of my thinking here. I'll pass to Jenny if you don't mind, briefly, to elaborate.

MR GRAY QC: Thank you, Dr Kennedy.

MS WILKINSON: So just to be clear upfront, I'm not an expert in the Japanese or

the Netherlands schemes. But Dr Kennedy is right, when we thought about a pay-as-you-go social insurance scheme I guess we thought about the fact that that felt in this context, given the fact that it's not clear how this is dealing with a risk pooling issue, it actually just felt like it's another form of a hypothecated levy.

DR KENNEDY: That's right.

MS WILKINSON: I'm not sure. So we couldn't understand how we should think about that as having different attributes to a hypothecated levy.

MR GRAY QC: Yes. Thank you. And you may be right, Ms Wilkinson, in that the similarities probably outweigh the differences. But there may be differences in actuarial approaches and things of that kind. I mean, is the NDIS a social insurance scheme or is it, in effect, a scheme that has adopted that name. But it's in fact a pay-as-you-go scheme funded from general revenue. These are the sorts of questions I think that your response is raising. But my question to you was the paper, the response from Treasury seemed to assume that we were only proposing a fully pre-funded social insurance scheme, and to the extent that I'm now clarifying that we're also considering a pay-as-you-go social insurance scheme, would the analysis or conclusions of Treasury in the response document be different in that regard?

DR KENNEDY: I might, if you don't mind Jenny, very quickly and then go back to you, because you raised a good point, Counsel. National Disability Insurance Scheme is not an insurance scheme. It's a national disability scheme. You just addressed that in a sense very clearly. So I just associate myself and I will pass back to Ms Wilkinson, with the comment around, if this does start to feel and look like a hypothecated levy, would we revise - just off the top of my head - would we revise our advice around is there something in that type of risk pooling or actuarial treatment as you said that would lower the cost of funding or improve the quality of services on the other side. I would be very surprised. I'm happy to think about it more deeply after the hearing, but I would be surprised.

Jenny, don't know if you have the same view?

MS WILKINSON: There were issues we had in a pre-funded scheme which obviously don't apply like a pay-as-you-go scheme, like the issues around intergenerational equity, don't apply so much. But I think, if you like, if we are talking about a pay-as-you-go scheme, then our advice around hypothecated levies would flow directly back - would apply to how we would think about a pay-as-you-go scheme. I agree with Dr Kennedy in terms of thinking about the risk pooling element of it. I just still don't see how it addresses in a more efficient way how you pool the risk of ageing and of needing aged care. We're happy to think about that some more, but I don't think it materially changes the advice that we provided --- and we did try to be quite clear in our advice around the model that we were providing advice on, because with any of these things, it is the details of the model which are important to a range of different conclusions that you draw.

DR KENNEDY: To give you to give us the opportunity to ask us these questions to clarify.

MR GRAY QC: Yes. Now, I want to turn from the public financing piece of the debate to potentially available private sources of financing and, Dr Kennedy, I think earlier you were keen on getting to this point, you said, "No doubt we will get to it later." Let's open that topic now.

Can I start with an idea floated by Paul Keating on Monday, and I'll ask that a precis of evidence just be displayed on the screen by the operator, RCD.9999.0517.0001.

Dr Kennedy and Ms Wilkinson, did you get any word that I would be raising Mr Keating's evidence with you and were you able to familiarize yourself with his proposition for a post-funded private contribution to aged care via something resembling a Higher Education Contribution Scheme but adapted to aged care?

DR KENNEDY: I wasn't aware we were going to get questions. I'm very happy to take them because I did read the - perhaps I was. There's a bit on at the moment, but I did read ---

MR GRAY QC: I don't want to ask about communications you might have had with legal representatives or anything, but I hope you've reflected on ---

DR KENNEDY: Happy to ---

MR GRAY QC: --- Mr Keating's proposal, and if you need time to read this precis, that's fine, please take some time to quickly read it, but it's along the lines, I just summarise --- his proposal, if I can very briefly summarise it, is that for any older person receiving Commonwealth subsidised aged care, there will in effect be an account opened recording a debt to the Commonwealth in respect of the amounts of subsidies paid for that person to receive those services. And it's not intended that during that person's life, that the debt would be collected. It would, in effect, accrue until that person's death. And indeed you could extend it and say that it wouldn't accrue until the death of, say, a partner living in the same home. And then at that point there would be, and no doubt there would be a lot of detail needed here including anti- avoidance rules, at that point there would be a process of accrediting the account from the estate of the person or in other words the Commonwealth recovering the loan from the person's estate. Now, have you had - I hope you've had an opportunity to reflect on that.

DR KENNEDY: Yes.

MR GRAY QC: I don't know, if you want to defer to Ms Wilkinson that's fine too. Can I seek Treasury's response on Mr Keating's proposal?

DR KENNEDY: We're happy to respond. She always knows more about these things than me, but we're happy to respond.

MR GRAY QC: Dr Kennedy, I will start with you.

DR KENNEDY: It's an interesting idea. It's not an idea I would go to at the outset. I think it's worth examination, but there's a few things I would do before I got to such a circumstance and how a policy unfolded. The first thing is, Counsel, we need to put in place an expectation that there would be a reasonable ongoing co-payment, probably beyond what's currently required in the system through the income testing and assets testing that's already applied. Because I guess this is trying to solve a problem of - it's taken as given that there should be a reasonable - for those who have the ability to pay, tapered appropriately against their income and assets they should make that contribution to their aged care services. Until we have that fully in place, this is sort of a model that is kind of addressing, you know, that issue, and I think in a sense the demand for that additional private contribution is the thing that needs to be sorted out first. What Paul Keating is proposing then is a model to say "Okay, once we've sorted that out, here is a model for people to make that private contribution".

So my second part on that is that I don't think that we have, in our current policy, arrangements --- have fully, by any means actually, fully exploited the opportunity for our superannuation system which is maturing and will be mature in the next couple of decades, to be providing a set of products that could make that contribution on an ongoing basis rather than a settling-up basis at death or also death of the household or the partners. And also there are other mechanisms such as reverse mortgages and the Pension Loan Scheme, I think it's called. And those types of mechanisms which, yes, and I think we are about come to this, people may be uncomfortable to use. But in the current juncture, with caps on how much people contribute on an ongoing basis, they're hardly likely to be very much exploited, Counsel, I would put. So I think, you know - and just think about superannuation assets and I'll just finish here --- we see people holding substantial superannuation assets at death. I would be much more inclined, rather than that money sitting with superannuation funds to death and then we tidy it up with the sort of estate piece, I would be much more inclined to be putting - and it may require Government intervention to encourage it - I would be more inclined to be saying how do we get the superannuation system and the aged care system working more effectively such that there are simple, straightforward products that allow people with the means to make a reasonable contribution to their aged care. It's an idea worthy of consideration but it is not where I would start. I would start with the co-payment piece first, and then I would look at exploiting the existing set of policy arrangements before I then --- and tested whether they met the system - before I moved to a system such as this.

Jenny, do you have anything to add?

MS WILKINSON: So if you don't mind me adding, the only other thing I would add is that Mr Keating's comparison with the Higher Education Contribution Scheme is - so I can see why he has drawn that parallel. I think that when I think about why that scheme has been successful, it has been because it has integrated with the

existing income tax system, and has been able to use income taxes over the life of someone's earning career to gradually, over time, repay a debt that has been accumulated. This would be a very different and a very new system that would have to be developed, which would involve the Government being much more involved at the time at which estates are resolved.

So I think that while I completely agree that the Higher Education Contribution Scheme has been a very effective income-contingent loan system that has enabled a large number of people to attend university who may not otherwise have been able to, I think - and it's - it operates in a pretty seamless way, I think I just wouldn't underestimate the significance of this sort of system to implement and including, as you mentioned, Counsel, the integrity challenges.

But as Dr Kennedy says, this is one way in which a decision to raise greater contributions on behalf of participants in the sector could potentially be designed. There is probably other ways within the existing system that you could deliver that outcome without such a significant structural change.

MR GRAY QC: Thank you, Ms Wilkinson.

Dr Kennedy, just going back to something you mentioned in the course of your answer, I don't think you used the expression annuity, but you seem to be mentioning a suite of possible ways of augmenting a user contribution avenues for financing aged care. You mentioned reverse mortgage, you mentioned Pension Loan Scheme. What did you have in mind that they would be supporting? What, the purchase of annuity products or the compulsory purchase of annuity products effectively for people who, in effect, don't pass a means test for Government subsidisation of a particular component of the costs of their care? Can you elaborate?

DR KENNEDY: Yes. They don't have to support directly the purchase of the annuity. They can be a mechanism to just generate a flow of payments themselves that come directly - that can then be set against a flow of aged care payments that are subsequently going to be required. When I was thinking about the superannuation products, I was thinking more of - it does appear to us that there aren't a wide range of products available in the retirement phase of superannuation, and even those limited products that are available, such as annuities, I understand to be reasonably expensive. And so I think there is opportunity there, Counsel, for, frankly, that sector, but if so required, with encouragement from Government at some point, particularly if we were moving down a path of requiring greater co-payments, to provide simple, straightforward products, and have managed risk appropriately. It's hard to do justice to exactly how you would design that in these couple of minute answers, but I will just draw the Commissioners' attention to the fact that over the next couple of decades and then on an ongoing basis many Australians, and particularly the more wealthy Australians, will carry large amounts of assets in their superannuation and I think, you know, the ability for people to pay or to contribute to their services they receive from the Government doesn't stop at age 65. The community has an expectation that those of us who are in a position to contribute

more should contribute more to the full range of services we get, and it's trying to integrate these policies more effectively.

I do acknowledge, Counsel, we've only considered this at a general level and you would have to do significantly more work to pin it down.

MR GRAY QC: I will ask that the Operator put up CTH.9300.0001.0015 of the Treasury response document, Tab 118 and that's, I think, a page that's very relevant to what you've just been saying, Dr Kennedy, and perhaps we can explore some of the points you make or that Treasury makes on this page in a little more detail.

Ms Wilkinson, I include you in the questions, of course.

Firstly, you refer to the point about there being a cap on that portion of the value of the family home that is included in means test arrangements to determine a residents' contribution to their accommodation and care costs, and you give an approximate value of that cap of around $170,000. And then you say a resident's family home is excluded from the means test if it remains occupied by a protected person such as a partner or dependent child. And then you make the point about the effect of that. Do you want to elaborate on how, in Treasury's view, attention should be given to the redesign of that cap arrangement? I note that there was a legislated review of aged care by Mr David Tune and Mr Tune concluded that in fact the caps should be removed. What's Treasury's view on this? Should the cap be redesigned, removed altogether, and what of the position of the protected person provision?

DR KENNEDY: Jenny, do you want to start off on this one?

Counsel, would you mind if Ms Wilkinson started the answer on this one?

MR GRAY QC: That's absolutely fine.

MS WILKINSON: So I think as we've outlined in our submission, our view is that consideration should be given to potentially including a higher value of the family home in the means test. We have highlighted the potential - sort of, what are the anomalies in the current system which is really that individuals with some wealth but not a significant amount of wealth have a greater proportion of their wealth which is effectively captured in the means test. And there's an arguable case that that's not an equitable outcome.

We certainly have acknowledged that when a partner or a dependent child is occupying a residence, you do need to think about whether or not - whether it's appropriate for the family home to be counted and acknowledge the need for, you know, consideration being given to carve-outs in special circumstances but we also just note as soon as you - in any of these sorts of arrangements when you've carve-outs in special circumstances, you've to be acutely aware of what the incentives are and what the incentives are for how people might then, you know, adjust their affairs in light of those rules. So that's what I would like to say. Would

you like to add anything?

DR KENNEDY: I would just say, Counsel, I guess clearly seek an opinion to all of this, my inclination would definitely be towards redesign, and I had a lot of sympathy for Mr Tune's --- David Tune's recommendations but you would start with redesign and I would be quite open-minded about the caps going altogether. I think one also, as Ms Wilkinson said, should think very carefully about the treatment of different assets. We don't want to be treating the home - this issue about treating the home differently from someone who holds financial assets but doesn't want to hold the home. That is something I would want to look at the redesign and assets test.

MS WILKINSON: If you don't mind me adding, I think you've outlined in Funding Proposition 20, you've highlighted a number. So I think this is one issue but there's a range of issues around means testing, and I think in that most recent proposition that we received, we would agree with many of the issues that you outlined in terms of what some of the anomalies of the current system are that you would want to be thinking about in the redesign of a system.

DR KENNEDY: Actually that's a very good point. I thought that proposition outlined very effectively, Counsel, the issues, and yes, I would happily associate myself with the direction you were taking in that proposition.

MR GRAY QC: For the public, that is Tab 111, proposition FF20.

Can I take this point about protected persons a little further. Isn't there an argument that there's a differential impact as a result of the protected persons exclusion whereby a single person is, in effect, disadvantaged by the operation of the means test by comparison to people who have a partner or dependants in the home? But there's a potential solution which is, to pick up on a point you made a few pages earlier, if the Operator could kindly go to page CTH.9300.0001.0013, the foot of the page:

> *Reverse mortgages could help finance consumer contributions to aged care*

And there's a description of reverse mortgages over the break of the page and continuing really to paragraph 87. We could just make the point, as you do at paragraph 85, that:

> *Being a reverse mortgage scheme repayment of the loan principal and compound interest is only required when the secured property is sold or the borrower dies.*

One could extend that protection to make sure that the property would only be sold, in effect, for security interest, would only trigger recovery of the loan at the time the partner dies, if there's a partner sharing the home.

Now, with design features such that, wouldn't there be a way of imputing a share of

equity to the particular person receiving aged care service and accruing a debt through a mechanism like this in a way that wouldn't jeopardise the continued residence of a home by a partner but would meet the financing goals that you seem to favour?

DR KENNEDY: I think that's right, Counsel, I think that proposition is right. The only thing I suggest is, we just want to have some empathy for the particular circumstances that people might be facing because, you know, if a partner is going into some form of aged care, it's obviously a highly stressful time, and the circumstances that might persist for the person occupying the home, continuing to occupy the home may only be for a limited period, so I guess - I think a lot of thought, Counsel, would need to go into, you know, how quickly one saw this applied in those circumstances, whether people were given a grace period because of the, you know, I think we've all gone through this, it's a very stressful period for people, particularly there would be a range of circumstances I think in which we just want to be empathetic before we turned up with a requirement that one must now quickly move to a reverse mortgage. I know that's not what you are suggesting, but I just want to draw out sometimes these optimal design arrangements can look great in theory, in practice they can raise complexity and be a real difficulty for people in a difficult time. So as long as that was sorted out, I think it's a highly prospective proposition.

MR GRAY QC: So, Dr Kennedy, are you saying there that it would be absolutely essential that certainly a partner and possibly other dependants who were living in the home not be prejudiced in their occupation of the home, and that they must be able to continue to live in the home? And that much can be accepted, but in the end it's a matter of whether the Commonwealth is able to, in effect, accrue a secured interest in the home to be collected at some time in the future when it's fair to all occupants of the home, probably some distant point in the future? How does that stand to you?

DR KENNEDY: Yes, that sounds right. But I'm also thinking about the transition point itself. So in this circumstance where someone was rapidly going into aged care, it wasn't predicted, you know, there's going to be a lot of moving parts in people's lives as they think about these issues. Tests are being applied. I was just thinking of, you know, when we're trying to design systems to work, we have to acknowledge that it is a going to be a kind of conflict, stressful set of arrangements when that transition is made, and even a grace period for people to sort their circumstances out or something along those lines. That's all I was thinking about. Or what you've raised, Counsel, is also consistent with what I was thinking.

MR GRAY QC: Thanks, Dr Kennedy. It's the case, isn't it, that previous reviews have raised mechanisms of this kind, reverse mortgages and the like; Government hasn't taken them up. Why the aversion, why the apparent aversion to this? And I'm instructed to say that these recommendations go back to at least 2004. Recommendations go back to at least swore.

MS WILKINSON: So, the Pension Loan Scheme is a reverse mortgage scheme, so the Government has ---

MR GRAY QC: Sorry, let me clarify. I mean as an adjunct to compulsory user contributions in aged care, not simply as a voluntary mechanism for a person to purchase a right to an annuity through the Pension Loan Scheme, but as a compulsory user contribution element to provide private financing contributing to the costs of aged care.

DR KENNEDY: Look, so that's right. And my observation would be that successive governments have found it very difficult to ask for these types of contributions and change these income tests or assets tests. And I will just go back to an earlier point. Until one does that, one can't really expect these products to be fully exploited or working because the demand to use the products, Counsel, hasn't really been created on the other side when we cap off how much income will be contributed after, I think it's a couple of years, isn't it, or the extent of the assets test.

Look, I can only make the observation that no doubt you are, that it has been a very difficult political judgment for Government to make and policy judgment, and they've chosen not to do it. They have been advised this by economic policy advisers such as myself. We will continue to advise what we think is the ideal outcome, but we absolutely respect that democratic process delivers a different policy outcome.

MS WILKINSON: Can I add, I think there's two separable issues, so one is whether individuals should make additional contributions and how those means testing arrangements should work across all of the different aged care payments. So that's one set of contributions. The other is, how do you then support people in making those contributions? And I guess the point that we were trying to make in our submission was that one of the things that the maturing of the superannuation system is potentially enabling is its meaning that there are many more people who are going to retire with a significant value of superannuation assets. They can be used through a range of different mechanisms to help make these contributions, and at least at the moment the evidence is that people are actually dying at the end of their lives with a significant proportion of their superannuation which hasn't been spent.

So sometimes I think these discussions have been challenging because particular products like reverse mortgages or annuities are complex financial products which are hard for people to understand. And this is why we think that one of the ways to help progress the discussion around contributions to your aged care involve --- it would benefit from pulling together thinking about all of the aspects of someone's retirement. So the retirement income aspect with the retirement care aspect.

DR KENNEDY: To put it more sharply to finish off, Counsel, as I see it, superannuation wasn't designed as a mechanism for you to, you know, tax prefer, raise assets to bequest or leave to your family. It was designed to assist you in the retirement period and raise your quality of life in that retirement period, and that, Ms Wilkinson, is absolutely right, that is an issue that we are focused on, and we see

it as integrating with the issues that you're talking about, about how to get a sustainably funded system and a reasonable proportionate contribution. But there are two issues being solved, if you like, at the same time. But we do see this opportunity to bring them together. I think Dr Henry made a point about this about people dying with substantial super assets in place, and how - you know, that wouldn't appear to us on face value to be an ideal arrangement. It's certainly not what the super system was designed to do.

MR GRAY QC: I will ask the operator to put up page CTH.9300.0001.0018, paragraph 110. I think this is the point you are making at the end of the Treasury response. You haven't developed the linkages you are hinting at in that paragraph. Are you essentially handing the baton to the Royal Commission on that point or have you done more detailed thinking about linkages between superannuation assets, retirement income and aged care funding, including through user contributions? Have you got any more detail you can share with the Royal Commissioners?

MS WILKINSON: So we haven't got any more detail that we can share other than, I guess, what we thought it was important to do was just to point out to the Royal Commission that there are these streams of work which are operating in parallel but are clearly related to each other.

DR KENNEDY: I think, Counsel, I would say that if the Commissioners in their recommendations were focused on developing what they felt were a reasonable co-contributions for people in different means, it's a point, I guess, we've made a couple of times, that really puts - and should the Government be minded to go down that route - that then really helps put that impetus back into those of us who are trying to develop higher quality superannuation policy to fund - to assist people make those payments. Because at the moment, as I said, those products aren't there because the system - you know, is just maturing, is not fully mature. So obviously there has been a very big focus on the accumulation phase, and more and more focus now comes on the retirement face. I think it's just opportune if a reasonable approach is taken on the aged care side, and obviously the Commissioners are thinking about it and they make a set of recommendations to suggest that contribution comes, it will accelerate that integration.

At the moment, when your contribution is capped off or your overall treatment of assets is capped off, there isn't much demand on the other side for those products, even though those products in and of themselves would be useful in people's retirement, so we will be working on that matter regardless of the outcome on the aged care side, but these could be highly complementary developments.

MR GRAY QC: Ms Wilkinson, just a moment. Just while Dr Kennedy has referred to the other caps. Can I just make it clear, and I should have set it up in the questioning into led into this topic, but we're not only talking about a cap on the value of the home included in the means tests. We are also talking here, are we not, Dr Kennedy, about annual caps and lifetime caps on the level of contributions to care --- which were also the subject of consideration by Mr Tune and indeed he made a

similar recommendation about removal of those. I want to make that clear for those listening.

That's so, isn't it, Dr Kennedy, you've been considering that?

DR KENNEDY: We are.

MR GRAY QC: You've been considering those in the course of giving that evidence?

DR KENNEDY: Yes, I have been considering both in the course of this. Absolutely.

MS WILKINSON: And the application of the means test across all of the different payments, so it's not just the current design of the means testing arrangements.

MR GRAY QC: Ms Wilkinson, I think you I interrupted you. You were going to add to something Dr Kennedy had said.

MS WILKINSON: The only point -

COMMISSIONER BRIGGS: Counsel, if I ---

MS WILKINSON: No, sorry, go ahead.

COMMISSIONER BRIGGS: I was going to ask --- this is the problem of Zoom conferences, so I do apologise, Ms Wilkinson.

What I wanted to ask was, in thinking this issue through, if you blow the caps, what can happen is that older people would be paying in fact more than either their care or their accommodation and cross-subsidizing others. So there's an issue about how you would see, whether you would see the need for any controls around the lifting of the caps.

DR KENNEDY: I think, Commissioner, that's an excellent point. If you want to lift caps and expect people to make this contribution, they have to be very confident about how they're being - how charges are being raised on the other side about - and, you know, you're in areas that get well beyond our expertise, but these natures of case mix funding in residential care and elsewhere, particularly in-home care, and, frankly, the operation of the providers in these areas, you know, this is a highly regulated sector, so reasonable and proportionate profits, for example, those types of things. I think that's an excellent point. This has to come as package. In asking people to make that private contribution, just like government that must have in the public funding of the scheme, they must have confidence in the private funding of the scheme that assists that care or whatever aspect of the service being provided is reasonably charged, the price is reasonably set, and that they're not sort of, you know, paying for others or paying for inefficiencies. Yes, so I would definitely

associate myself with that point. I think it's a very good point.

COMMISSIONER BRIGGS: Thank you.

MR GRAY QC: Dr Kennedy, would the independent pricing mechanism that I outlined in the contextual remarks at the start, and with which you associated yourself, play a very important role in instilling that necessary confidence?

DR KENNEDY: Yes, it would.

MR GRAY QC: Ms Wilkinson, I am sorry I interrupted you before. Was there something you wished to add?

MS WILKINSON: So I think one thing that I just wanted to add was that I just wanted to make sure that the commission was cognisant of the fact that when we made this point about linking superannuation and aged care funding, part of what we were trying to do was just remind everyone that the superannuation system is about 20 years in to having, you know, more than 9 per cent compulsory contributions being made by individuals. Superannuation balances have been, you can see that they've been increasing in recent years. They are likely to increase substantially over the next 20 years, and that is going to be the period in which the baby boomer generation is going to be putting increasing demand on aged care services. And so when thinking about designing these arrangements, I guess it's just worthwhile being mindful of the fact that the distribution of wealth for that cohort who will be using these services may well look very different from the distribution of the last 10 or 20 years. So that's the reason why we think almost - so, yes, there needs to be some development of products, but even putting that to one side, just the actual quantum of assets which would potentially be available if Government wished to make additional contributions, the quantum of assets will be much greater over the next 20 years than it has been in the past. That was the only point I was going to make.

MR GRAY QC: Thanks, Ms Wilkinson.

COMMISSIONER PAGONE: Ms Wilkinson, I think what Counsel was trying to ask you about earlier on was what would that link look like. I imagine there is a lot of people out there watching this evidence, thinking, "Oh dear, what are they going to do to my superannuation tomorrow?" What do you have in mind as "the link"?

MS WILKINSON: So the link is simply that there doesn't have to be a direct link from superannuation. The link is that when thinking about any means testing arrangement that involves additional co-contributions from individuals, superannuation assets are going to be a set of assets which future generations of retirees are going to have available to assist with their contributions to their aged care services.

COMMISSIONER PAGONE: So you would be thinking of some form of levy on the superannuation assets? Is that the kind of link that you've got in mind there?

MS WILKINSON: No, not a levy on assets. So once someone is retired, most people currently, they have an account-based pension which means that they drawdown a certain amount of income, when in fact there's a compulsory drawdown of a certain amount of income from their superannuation every year. That is a stream of income which is available to individuals just like the age pension is a stream of income and other sources of income are a stream of income available to individuals to defray their living costs, whether they are in aged care or whether they are pre-aged care. This is just a stream of income which should be taken into account when one is thinking about what the design of these means testing arrangements could look like.

COMMISSIONER PAGONE: I see.

MR GRAY QC: Just to finish off on means testing, can I just ask you, Dr Kennedy and Ms Wilkinson, to the extent you want to join in on this point, when we've been talking about redesign of the means testing arrangements for user contributions in aged care, it's not all one way, is it? It's not all about endeavouring to simply extract more money from people receiving aged care services? There are significant inequities in the way people of quite modest means are affected by the current means testing arrangements. And we've analysed certain ways in which there are quite inequitable effects in that relatively modest space in the wealth spectrum under the current means testing arrangements, and we've observed in the commentary under proposition FF20 on pages 12 and following of Tab 111 that reform is needed to, in effect, smooth out the way, or make more progressive the way in which the means test tapers, as it's called. Are those also remarks with which you associate yourself, Dr Kennedy? And we've concluded with a submission I can read:

> *We submit that the settings should be adjusted to commence means testing at a higher level ....*

Of wealth, that is the threshold at which the means testing begins should be later in the wealth spectrum, towards the higher end of the wealth spectrum, and when that happens:

> *.... for the reduction rate to be more gradual, and more consistent in its effects in requiring contributions to both accommodation and care charges, so as to avoid the sorts of arbitrary impacts ....*

That I've just mentioned. Dr Kennedy, your thoughts?

DR KENNEDY: That sounds quite likely, Counsel. I haven't given consideration to those precise numbers that you've just popped up, but the proposition I think would well be worth testing. And if I can make two quick points because Commissioner Pagone has raised an issue for me that I think it might be worth making clear in our own evidence here around co-payments.

What we are encouraging consideration of is just a reasonable - what the community would regard as a reasonable contribution from people who have, you know, higher means than others and as you're just now pointing out, Counsel, that that is tapered in in a reasonable way. Ideally, the Royal Commission may wish to look at how it intersects with access to the aged care pension and other means tests and tests that are applied elsewhere in the current system, because ---

MR GRAY QC: Age pension.

MS WILKINSON: Age pension.

DR KENNEDY: I beg your pardon, the age pension. Because one of the things that we would all like to avoid as much as we can is a complex array of arrangement of different tests applying in different parts of the system. We don't want to get caught in a tidy mind syndrome, but just thinking carefully about how those things integrate. Because, you know, in those circumstances we can see perhaps means tests applying in a way that is already considered proportionate in the way they apply to the age pension.

And the last point on this is, this is not an issue for us just say about older people in this phase of their life and their contribution. What we're trying to do in all public policy, be it through in the raising of taxes and the delivery of services, and I think Australia generally has had --- done very well at this, is just consider that people of all ages make reasonable contributions based on their means, and receive services at a level that reflects those means. So I just want to be clear it's not a question of us thinking this is a group that somehow or other should pay more than any other group. We're looking to apply just that principle, proportionate principle more generally. I hope that helps.

COMMISSIONER PAGONE: And in relation to caps that were being referred to earlier on, the caps would always need to be at the level, limited to the level of the Government's contribution because otherwise it would become an additional tax, wouldn't it?

DR KENNEDY: Yes. That's correct, Commissioner. Yes.

MR GRAY QC: I have no further questions.

DR KENNEDY: There is one piece because my colleague has screwed her face up. It does depend a little on the Government's contribution, I think, Jenny, reflecting that the case mix or the charge was designed effectively on the other side. So --- but yes, Commissioner, if you satisfy that test that Commissioner Briggs raised earlier, that the system is well designed and it's charged appropriately and the prices are clear, then you are right, than if you were beginning to charge people for more than what that reasonable cost was, it would look like you were either cross-subsidizing someone else in the form of a tax. Yes. Just to make that clear.

Thank you, Jenny.

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

COMMISSIONER PAGONE: I would like to go back to something very briefly that was raised earlier on in the examination by Mr Gray, and which I think probably was left on the basis that it had not been engaged in by the Treasury response, and I think I would just like to ask, that there is an engagement with the issue. I don't say that critically and I'm not expecting an engagement on the spot. But there will be some people out in the community who will think that it would be a really good idea if there were a pot of money that is going to be allocated to aged care system being ringfenced in some way so that it has about it some degree of security and certainty and stability. And some of the questions about hypothecation and the difficulties about hypothecation, I think we understand, but we would, I think, be keen to receive your views, not just whether you think it's a good idea or a bad idea, but why it might be a good idea or bad idea and how it might be made to work if it was thought to work. Is that a helpful enough broad description of where some of the questioning and some of our thinking might be going?

DR KENNEDY: Yes, Commissioner. We gave some thought in our response to that transparency aspect which is a version of hypothecation, how one might report this from a Budget point of view, and how one might use this in a special account perspective. So that might mean, Commissioner, that there isn't a new levy, but that the portion of existing revenue is allocated to this purpose, which I think is what you're talking about and that that's ringfenced. We did draw that out a little in how one could do that from a budgeting perspective.

So we could elaborate, I think, Jenny, on that. I have more sympathy, Commissioner, for that type of approach than a new levy going in, finding a way for me to design a new levy to put inside the existing tax system and then hypothecating or associating that with the expenditure on the aged care side, because as I said in my earlier remarks, there are already a couple of commitment mechanisms the Government is using around NDIS and health, and you are really seeking the same type of commitment mechanism, as I understand it, for aged care funding, as to the public side of healthcare ---

MR GRAY QC: Operator, please display page 0010 under the heading "Hypothecation can be managed in a number of ways". You might want to point out whether this is the passage you are intending to refer to?

DR KENNEDY: Counsel, can I just clarify with Commissioner Pagone that the way I represented that was where he was headed?

COMMISSIONER PAGONE: That's certainly one way that one might be headed. I'm really putting it very broadly because it would be useful to get an engagement at all sorts of levels. So the broad proposition really is this. We're talking about a group of people who have worked all their lives, presumably, and are getting to a

stage where they are increasingly vulnerable and to some extent losing some degree of control about their own resources and what they can do. So we're talking about groups of people or people who are going through a stage where certainty, predictability, security become really key features of their life. They don't want to go worrying about stuff. What's more, they don't want to worry about whether the rules are going to be changed on them because somebody has decided that it's a better use of money in one year to do one thing rather than another thing. So that one way in which some of those features might begin to be provided might be to show that there is a pot of money in a place that you can't, the Government can't get access to it quickly. It's restricted in availability because it provides security, predictability and certainty, comfort, et cetera.

DR KENNEDY: Look, Commissioner, it may be of some help but I don't think it will be of much help if the system keeps changing, if it's complex, if people are demanding a service but finding that it's quantity rationed, that providers are not viable. So I'm not - as I said, I'm not sort of ruling it out as part of a way of giving people confidence that this system will be there. But I think the points you just raised in the proposition you put to me are the ones that are crucial, is having the Government trusting, and the community trusting, and particularly older Australians trusting, that this is a well-run, sustainable system with all the transparency mechanisms that's needed.

If we solve that problem --- and that problem has to be solved, the funding problem will not solve that problem. If that problem is solved and there was an additional need for confidence that there was a commitment mechanism of some form and it could be in a more - a less flexible arrangement, the one you raised, or it could simply be in a Budget reporting arrangement, I'm open minded about that. The only thing I would encourage the Commissioners to consider is that first issue is the primary issue that has to be solved first. I think we're all in agreement on that, I suppose. But that's where my efforts would be.

COMMISSIONER PAGONE: Well, we are all in agreement to a certain extent, although I must say that some of the answer does sound a little bit like what Mr Keating referred to in rather critical terms. But, of course, we need to make sure that the other parts of the problems are also dealt with. But there is a bit of a chicken and egg here, isn't there, that to some extent the certainty of the funding might in part might make some of the other parts difficult to deal with? Anyway, I ---

DR KENNEDY: Commissioner, all I would say in response to that, that isn't how we've got certainty around the healthcare system, more broadly, nor around NDIS. The certainty that has developed around NDIS has come about because it's regarded as a scheme the Productivity Commission examined carefully, it was well designed, it will need to be monitored and iterated on, but the scheme design is what came first and what gave people confidence, and what gives people confidence in Australia's health system today has been the introduction of things like case mix funding, those types of issues. The fact that there's a Medicare levy that partially contributes to that scheme, as Counsel outlined, may be helpful, but I appreciate - as I said, I appreciate

Paul Keating's comments, I don't rule out by any means this prospect. As I said, it's just not where I would be focused and I think - and I'm not sure it is chicken and egg. I think my efforts go squarely in one direction before the other.

COMMISSIONER PAGONE: And assuming we will be dealing with the former, I hope that I'm not hearing your answer to be that you won't engage in the latter?

DR KENNEDY: No. Absolutely. No, Commissioner, I'm very open-minded to that and --- no, you've made some very good points.

COMMISSIONER PAGONE: Thank you. Thank you both very much for the work that you've put into this. These are obviously really critical issues for the entire Australian community both present and future, and we are really grateful for the work you've done and for being open, available and robust and helpful with your answers. We do thank both of you very sincerely for that. I think I now need formally excuse you from further attendance and thanks again.

DR KENNEDY: Thank you, Commissioners. Appreciate it.

THE WITNESSES WITHDREW

MR GRAY QC: Would 11.15 be appropriate?

COMMISSIONER PAGONE: Certainly. A short adjournment until 11.15.

ADJOURNED **[11.01 AM]**

RESUMED **[11.15 AM]**

COMMISSIONER PAGONE: Mr Gray.

MR GRAY QC: Thank you, Commissioner. I call Dr Brendan Murphy, Dr Nick Hartland and Mr Nigel Murray.

DR BRENDAN MURPHY, AFFIRMED

DR NICK HARTLAND, SWORN

MR NIGEL MURRAY, AFFIRMED

EXAMINATION-IN-CHIEF BY MR GRAY QC

MR GRAY QC: Dr Murphy, you are the Secretary of the Department of Health of the Commonwealth?

DR MURPHY: I am, Counsel.

MR GRAY QC: Dr Hartland, you are the First Assistant Secretary in the Department of Health?

DR HARTLAND: Yes. That's right, Mr Gray.

MR GRAY QC: Mr Murray, you are an Assistant Secretary in the Department of Health?

MR MURRAY: Yes. That's correct.

MR GRAY QC: You've all given evidence to the Royal Commissioners before, and thank you for your attendance today, and we will proceed with a session on predominantly funding arrangements in aged care services for the future.

The Department has prepared a response to a notice to give information or a statement in relation to these matters. It's available already in the tendered set of documents at tab 117. I will ask it be displayed, CTH.1000.0004.9191.

Dr Murphy, I will address my questions to you in the first instance and if you wish to defer to the other officers on the panel because you don't know the answer or you've exhausted your knowledge, that's fine. But can I just ask you, did you satisfy yourself that the contents of this response are, to the extent that the response contains facts, that those facts are to the best of your knowledge true and correct?

DR MURPHY: I have, counsel, yes.

MR GRAY QC: And to the extent that there are positions on policy points, are they the positions that are currently adopted by the Department of Health?

DR MURPHY: They are, Counsel, yes.

MR GRAY QC: Yes. Thank you. Now, can I ask you first about rationing, and I'll address these questions to you, Dr Murphy.

When Ms Beauchamp your predecessor first appeared before the Royal Commission in February 2019, Ms Beauchamp's statement explained the aged care provision ratio, sometimes called the aged care target provision ratio. Does that ratio still

apply?

DR MURPHY: I might direct that to Mr Murray to answer as it applies at the moment. Yes.

MR MURRAY: Yes, counsel, there are planning ratios in place. The Government has made a number of measures to increase home care places in particular recently, which has adjusted how we would be meeting those ratios. But the ratios do exist, yes.

MR GRAY QC: And Ms Beauchamp spoke of the aged care provision ratio at the time being a plan to move to 125 places per 1000 people in the cohort of Australians aged 70 years or over by a certain point by the end of 2021/22? Is that the case?

MR MURRAY: Yes. That is still the case. As I mentioned, the Government has increased more Home Care Packages recently, which meant the target for hitting that ratio has altered, but the ratio still broadly exists, yes.

MR GRAY QC: As a result or in connection with the release of the Home Care Packages you've mentioned, has that resulted in a shifting of the sub-ratios within the overall target ratio of 125 places per 1000 people aged 70 or over, but hasn't changed the figure of 125?

MR MURRAY: The figure itself hasn't been changed as a planning tool, but what was happened with the release of the Home Care Packages is that we've actually hit those ratios quicker than would otherwise have been the case.

MR GRAY QC: Okay. Now, what are the reasons for having the aged care target provision ratio or the aged care provision ratio, whatever I should call it? Are they fiscally driven? Are they imposed by the Executive Government of Australia as a means of fiscal constraint over the program of aged care services overall?

MR MURRAY: I think they serve two broad two purposes. One was the intent that we should have some mechanism in place to help us release residential and home care places, and ensure that is meeting the general sort of growth in demand over the future.

As you have pointed out, yes, they also do have the impact of, in effect, if that is the target, then that would be the limit, and hence that would have an impact on other budgetary considerations as well. From time to time, as we have seen in recent years, Government can release more packages if it so chooses.

MR GRAY QC: Thank you. Let's remember that point you've made about meeting demand and I will ask you some questions about that in a minute.

In contrast perhaps to the existence of the ratio at present, which you've clarified, what's the policy position going forward, as they say? What's the policy position

about future reform of the aged care system? Does the Department have a position on whether the aged care provision ratio should remain in place? Dr Murphy?

DR MURPHY: I think we are obviously aligned with the Royal Commission belief that the system does need a fundamental reset and at the moment the focus, Government's focus has been very much on meeting the demand for Home Care Packages and releasing significant numbers of Home Care Packages, but I think we clearly accept that the system does need significant redesign and including in the costing and funding and transparency of that system. And in doing that, I think all of these approaches need to be looked at. And, clearly one of the very significant things that has happened at the moment is that there is actually spare capacity in residential care at the moment, there is no - you know, the demand for residential care has been essentially met. But there is clearly demand for Home Care Packages and I think the Commission and we are strongly of the view that we should support people to stay in the home, that's why our approach has been to very significantly expand the existing home care system, but it does need a fundamental redesign so I think all of those things are up for consideration in the redesign of the system.

MR GRAY QC: Thank you, and thanks for indicating that the Department is aligned with the Royal Commission, however, the Royal Commissioners haven't said what they think about this. I've made a submission on 4 March that the system should move to a position where it is, in effect, demand-driven. That doesn't mean if somebody says I want a service, they necessarily get it. They have to be assessed, and if they have a need for aged care, that need should be met by services that are subsidised by the Commonwealth and with some reasonable user contribution applying.

Now, what's your position on the submission I made on 4 March that the system should move to a demand-driven system of that nature as compared to one where per capita subsidies are rationed, that is there is a process for limiting the number of people who can benefit from a subsidy? What's your position on that?

DR HARTLAND: In our statement to you that you pulled up earlier, we've said we acknowledge that the future level of investment into aged care will need to increase to meet demand for services. Currently we are supportive of the move to a needs-based aged care system.

MR GRAY QC: I will ask it one more time. Thank you, Dr Hartland, for that, and I think that's helpful. But, Professor Murphy, the question is, and if it's just impossible to answer, please just say so: does the Department say that the aged care provision ratio should be scrapped and the Program should eventually move to an uncapped program?

DR MURPHY: I think we would agree with the contention, counsel, that it should move to a demand-driven system, as you say a system where people are appropriately assessed for need by a rigorous assessment process, and the system is transparently funded. But I think we would agree it should move to an essentially

demand-driven system. In fact it is demand-driven in residential care at the moment, and we are endeavouring, with frequent releases of Home Care Packages, to meet the demand for home care. So essentially, Government is supporting that general direction.

DR HARTLAND: Whether that means the ratio has to be scrapped, I think is a separate question. The ratio, in a needs-driven world, would have to be a way of showing transparently how aged care is going to drive increase in the future, because population and demography is still a major determinant of it, so you might not scrap a ratio in the future, you might still have it as a planning tool --

DR MURPHY: A planning tool, yes.

DR HARTLAND: --- or a transparency tool. That is not to detract from what Dr Murphy just said. A needs-based system should be the objective in the future.

MR GRAY QC: Thanks, Dr Hartland. The purpose of it would change rapidly, though, wouldn't it? That would operate as a cap, whereas you're saying it could be retained as a forecasting tool, and indeed a helpful one at that, but it wouldn't be a cap. Is that what you're saying?

DR MURPHY: That's right. Correct.

MR GRAY QC: And indeed, it's irresistible that the system should move to being demand-driven in the sense I've described, isn't it? Because at present, we've got a situation playing out in home care where there are people who have been assessed as having the same level of need as others, but some are receiving subsidised services and others are not simply because of the rationing of per capita subsidies provided to people assessed as needing home care. That's right, isn't it?

DR MURPHY: I think, counsel, the Government has recognised that there is significant demand in home care. I mean, many of those people waiting for high level packages are getting lower level packages, but it's not --- the system - the Home Care Package has been very substantially expanded in each Budget cycle. There is only a certain amount of capacity for the system to expand to do that. Government has essentially committed to major and consistent and continued expansion in Home Care Packages. Now, how that plays out in the redesigned system and Home Care Packages may well look very different after we reset the system, but I think there is no question that there is a strong commitment from the Department and Government to keep people at home where possible, and to expand as fast as possible the Home Care Package environment, and that has been the evidence that has happened over the last sort of 18 months with very substantial increases in Home Care Packages in each Budget cycle.

MR GRAY QC: Thanks, Dr Murphy. I asked Mr Lye and Dr Hartland about this two weeks ago, and the position we got to was that Mr Lye acknowledged, and I think you did too, Dr Hartland, is what has happened there is that packages that were

forecast in the forward estimate model to be released in future years in a forward estimate model up to 2024 have been released earlier, but at least at present there isn't a gross increase of any material amount in the packages forecast to be available in 2024. Has that position changed since evidence in the home care hearing two weeks ago? Perhaps I will direct that to you, Dr Hartland.

DR HARTLAND: I think reviewed the tables. The once you had before you were created prior to one of the Government announcements. So the end year figure has changed since then. But, you know, as --- going back to your first question about the ratio, you know, it's important to say that the packages that have been released are helping people, people are getting services now, and there are more people getting services now than would have been the case if those measures hadn't been taken, but where we got to --- seems like a while ago --- was that the Government decision so far hadn't changed the ratio beyond the forward estimates period, and that will therefore drive home care provision absent any other changes past these positions. So we haven't changed the ratio. It's worth noting too that David Tune recommended that the ratio be changed or, sorry, reconsidered.

MR GRAY QC: Dr Hartland, you can leave it there. If we just stay focused on the particular questions, we will get to other relevant points in due course. Can I just ask now, though, that those assisting you, Dr Hartland, provide the updated table you just referred to. We were basing that exchange on a response to a notice to give information of a particular date, and if there has been a change to that information, please provide it to the Royal Commission as soon as you can.

Now, can I just ask about CHSP, Commonwealth Home Support Program, that is not governed by the aged care provision ratio; correct?

DR MURPHY: That's correct.

MR GRAY QC: I will keep directing these questions to you, Dr Hartland, because you've got that responsibility in the community and home space, haven't you.

DR HARTLAND: Yes, Counsel.

MR GRAY QC: In the Home Care Package, we know what is in place because it has been in place since 2017. That's correct, isn't it, Dr Hartland?

DR HARTLAND: That's right.

MR GRAY QC: With respect to CHSP, does the department know what waiting lists exist either in certain regions or across the country for certain service categories are that are funded by CHSP? My understanding is there isn't a national prioritisation system, so it must be a more difficult thing to try to ascertain ---

DR HARTLAND: You will be delighted to know the answer is quite complex. We can tell from data analysis the time between assessment and getting a service in

CHSP. So it's on average about 21 days. It's higher for some other - there is difference across the service categories. We don't have an NPS-style waiting list or GSP where we can record all of the characteristics of people that have not got all of the services they might be eligible for. So typically with CHSP, a customer assessor might tick a number of service types. A person will present one --- we know when they get it, but we don't know where they are or whether they need that service until they present to the service. And I saw some discussion about this in some of your evidence, and I'm actually not convinced that an NPS-style waitlist would be possible for CHSP because there is so much complexity in the types of things people get approved for and --- they may be approved for nine things and you've got one thing, you might actually not want the other eight, right, because that is what you needed.

I don't think it would be possible to actually create an NPS-style system in CHSP as exists at the moment. If you did I'm not sure what it would be telling you about that need.

MR GRAY QC: Are you able to give any impression to the Royal Commissioners as to whether there are, in effect, areas where certain service lines are full to capacity and people are being turned away even though they've been assessed by a regional assessment service as eligible for a particular service? Are there any at all?

DR HARTLAND: Yes, we've done that in an analysis in a report that --- I think has been called for and is being finalised for you, a Deloitte study of CHSP. So we can use what we can to help figure out where we think that CHSP might need additional funding every year or so that there is a growth around CHSP so to expand the program, we can use that information to target it. The service lines that jump out as (inaudible) call it waitlists --- are things like home modifications and age and equipment and possibly allied health. So we can also tell inequity across regions, and can use that to target growth around the CHSP program.

MR GRAY QC: What about nursing? Are there any regions in where there are capacity limits on CHSP grant agreements that have been reached for nursing?

DR HARTLAND: I don't recall that as coming out of the analysis, Mr Gray.

MR GRAY QC: Thank you. That's all right. I won't press you. We will await that report.

Although there isn't an aged care provision ratio influence over CHSP, nevertheless there's intrinsically a limit placed on the number of services funded at particular prices via the grant agreements that constitute the funding mechanism in CHSP, isn't there? But CHSP services are rationed, albeit in a different way from Home Care Packages and residential care places. Is that a fair summary?

DR HARTLAND: I think broadly that's fair. As you know we have grant agreements with a number of organisations, both specifying what we're prepared to

fund. I think it's worth noting that CHSP grows by an index of price and population so it grows by a factor of the estimated increase in the over-65 population. So it does grow as a reflex of population as well as price.

MR GRAY QC: What is the average age of commencement of CHSP services? Is it around 80?

DR HARTLAND: I'm sorry, I don't have that figure. It's a bit lower than Home Care Packages, and there are a lot of people coming in at 65 but I don't think it's far off 80. I just don't have that particular figure in my head, I apologise.

COMMISSIONER BRIGGS: Before you move on, Counsel, might I ask Dr Hartland, when you provide that material, could you specifically look at people with disabilities who have had pre-existing disabled conditions and where they fall in those numbers, please? I'm led to believe that they're disproportionately represented in the 65 to 75-year old category. Thank you.

DR HARTLAND: Yes, I think it's worth noting that, you know ---

MR GRAY QC: Dr Hartland, we will keep moving. If there's a chance to come back to you, please make a note.

Operator, please display graphs from Background Paper 2, page 3 at the foot of the page which are three snapshots in time of demographic projections of the various age cohorts of Australia. I want to come back to Mr Murray and just ask you a little bit more about a point you made at the outset concerning the purpose of the planning ratio, Mr Murray; you said it was one of the two reasons for the ratio is to release packages and places to meet demand in the future, and I just want to understand more about that and elicit some evidence from you about that.

And, in particular, is it the case that the aged care provision ratio is pegged to the cohort of people 70 years and over, as I said in my summary of what it is? That is, it's a ratio at the point of time at the end of 2021 that's intended to permit 125 places or packages to be available per 1000 people in the cohort of Australians aged 70 and over?

MR MURRAY: That's correct, yes.

MR GRAY QC: And if we look at these demographic profiles, you're familiar with these sorts of charts, I take it, Mr Murray?

MR MURRAY: Yes.

MR GRAY QC: And have you seen these specific charts before?

MR MURRAY: I'm not sure I've seen these ones specifically, but I'm familiar with the general.

MR GRAY QC: Yes. And what they are describing is the numbers of people, in particular age cohorts that are listed in the Y-axis of each of these graphs on the left-hand side of each of the images that appear in blue and pink in the middle of the graph.

So in 1978 there's an image that looks a little bit like a triangle and it's showing men and women, and it's showing people of the ages described in the axis at the left-hand side going up the page from zero through to 100, and there are very few people in 1978, at the far left, who live too much past, about 90, very few reaching 100. And there's quite a regular profile all the way down to virtually zero years of age or very young year of age.

And then the profile is markedly different in 2018. There's a bulge in the middle of the shape for the demographic profile of Australia, and it is being extended at the top because more people are living longer, and then in the projection between, '58, that trend has become more pronounced and there is more people in the top part of the profile.

So, Mr Murray, this is a graphical depiction of the demographic profile of Australia at those three points in time, and you are familiar with the way these diagrams operate?

MR MURRAY: Yes.

MR GRAY QC: Now, if you peg the aged care provision ratio to the profile - I beg your pardon, to the cohort of people age 70 and over, I'm going to suggest to you that there are good reasons to think that it's going to be unlikely to be able to provide for the needs of people who actually use aged care as accurately as the ratio might work if you pegged it to a higher age cohort. The rate of change between the size of the overall cohort of people age 70 and over, compared with the rate of change of the sub-cohort of people aged 80 and over, is different, isn't it?

MR MURRAY: Yes.

MR GRAY QC: And we know, don't we, that the average needs of the sub-cohort of people age 80 and over is greater than the needs of the overall cohort of people age 70 and over, and we know that because the rate of use of aged care for the cohort age 85 and over is about three times the rate of the use of home care for the cohort age 75 and over, and that is in an ACFA, the ACFA report chart 3.15, but you are probably familiar with that fact, aren't you, Mr Murray?

MR MURRAY: Yes. So what would need to be done if the ratio were to be retained, even as a useful forecasting form along the lines that Dr Hartland is suggesting, it would need to be re-pegged to the cohort of people using aged care, the average age which is more like about 80 for CHSP and 84 for Home Care Package and 85 for residential care, that's the average age of commencement for Australians

using those services, isn't it?

MR MURRAY: Yes.

MR GRAY QC: What do you say to my proposition that --- I included two questions in that one question and that was unfair of me. What do you say to my proposition that it would be more accurate to peg the ratio to the cohort of people aged at least 80 and over?

MR MURRAY: I would agree with that, and that was recommended by David Tune in his review a few years ago, to use the higher ratio. So we would support that.

MR GRAY QC: Yes. Thanks. Mr Tune said 75, but it really should be 80, shouldn't it?

MR MURRAY: Yes, Mr Tune modelled two different variants, yes. He did 80 and 75 and thought 75 would be a reasonable first step.

MR GRAY QC: Mr Tune recommended that a while ago, and you agreed it should be done. Is it being done?

DR HARTLAND: Mr Tune recommended that it be done, when we got to the full provision ratio in 2021/22, that it be reviewed at that point. So we are not at the point where it would need to have been done.

MR GRAY QC: That's true. I will repeat my question in a different way. You've agreed it should be done. Is it being done?

DR HARTLAND: It is due to be done but it hasn't been done. We haven't got to the point where the ratio - we haven't got to the point where we are at the 125.

MR GRAY QC: You are going to retain the ratio of 125 per 1000 people aged 70 and over up to the end of 2021/22, that is June 2022, even though you know that it isn't as accurate as it would be compared with ---

DR HARTLAND: The confounding thing in all that is the numbers of places per 70 year old is increasing to get to the ratio. So Mr Tune's logic was, there looks like there is a need to review the ratio and how it's pegged, and the time to do it is when you've actually got to the full 125.

MR MURRAY: Baby boomers hit from the late 20s rather than earlier.

MR GRAY QC: Well, it looks like there are increasingly more people in the cohort of people aged 80 and over than there were even 20 years ago. Mr Keating was referring to some figures on that topic a little while ago. So isn't it already appropriate to start making the plans that would be necessary to forecast the needs of that age cohort rather than sticking with the needs of this broader cohort of age 70

and over?

DR MURPHY: I think, Counsel, the point the officers are making is that we are continually expanding Home Care Packages to meet the current demand, and I don't think it would change the pace at which we can rapidly increase Home Care Packages. So I think we would accept that there is a need to revisit that planning tool and we will do that.

MR GRAY QC: Okay. Thanks, Dr Murphy. Can I just ask a bit about what impact this might have had in the past in constraining limiting expenditure that might actually have been called for to meet the needs of the increasing numbers of older Australians, particularly in that cohort of 80 and over. I will just go to another document, it's Tab 114. And we will go, please, Operator, to Figure 3 where we have expenditure on aged care expressed in a particular way to control for the size of the economy. It's expressed as a share of GDP per person. And have you had a chance to reflect ---

DR MURPHY: We have. Yes, we have, Counsel.

MR GRAY QC: Thank you. And do you accept that expressed as a percentage of GDP per person or per capita, that's at the Y-axis at the left-hand side of the figure, that this graph is accurately depicting expenditure on aged care for the particular age cohorts of 70-plus and 80-plus, that's the blue and red lines? And have you received any advice that this is accurate?

DR MURPHY: We don't have any advice that it isn't accurate, but it also obviously expresses the growth for GDP for the whole population as well, which has increased over time.

DR HARTLAND: I think there are difficulties with interpretation but I think they will come out with your next set of questions, Mr Gray.

MR GRAY QC: Yes. So if we just look at - Dr Murphy, you were making a point that as a share of GDP in its entirety, that's not on a per person basis, but just overall expenditure on aged care as a share of GDP as depicted on the right Y-axis, expenditure on aged care has been increasing over time?

DR MURPHY: Correct.

MR GRAY QC: It's been increasing over time, but it has flatlined in 2015. Can you see that, that's the green line?

DR MURPHY: We acknowledge that there have been the last sort of five years or so, there have been a lot of very significant impacts in aged care. We had the ACFI system which we know caused significant problems. There have been a lot of changes and we do accept, and I think I might pre-empt some of your later questions, we accept that the system is under financial pressure at the moment, and definitely

does need some financial resetting. I think to pre-empt, perhaps, where you're going to, we don't accept some of the contentions of this document that defines a large gap of what could have been spent for a range of reasons we can go into. But we will be very happy to accept that the system at the moment is under financial pressure. We've had to put supports in this year for COVID measures and others, we know we'll have to put more supports in, despite providers providing good care, the system in general is under pressure and we accept that.

MR GRAY QC: And is your impression that those providers that are managing to provide good care under all the circumstances to maintain staffing levels and so forth are eating into their surpluses to do that?

DR MURPHY: Not all of them, counsel. Some of them are very much more efficient than others, they might have economies of scale and the like, but we don't -- - we do not dispute that as at overall, the financial performance of the sector has deteriorated in recent years and it needs some addressing. And many of the $1.5 million of COVID measures put in this year in fact have gone to supporting the viability of the sector.

MR GRAY QC: Look, thank you, Dr Murphy, for making that clear, and indeed the response to the notice at a general level expressed a similar sentiment. But that doesn't regrettably relieve me from the obligation of having to make some inquiry as to the reasons why the system is, as you say, under pressure. It's relevant for the Royal Commissioners to know how this has come about, so I'll persist and I will ask you a few more questions about this.

Now, we've got, under the green line, the red line and the blue line, and they are referable to the left Y-axis, not the right Y-axis.

Let's take the blue line first. Expressed as a share of GDP per person, therefore controlling for the changes in the sizes in the economy. Expenditure per person in the cohort of people aged 70 and over has gently increased over time, back from the 50s, to --- up to recent times. And in a way one might expect that, mightn't one, given that the planning tool used to release subsidies on a per capita basis, at least in recent times, is pegged to the needs of the cohort of Australians aged 70 and over?

Mr Murray, should I be directing questions to you on this?

MR MURRAY: Yes.

MR GRAY QC: That's a conclusion that is consistent with the character of the aged care provision ratio planning tool; is that right?

MR MURRAY: Well, in terms of general growth and that measure, I think it is worth noting that the use of how the comparison point is relevant, even for the red line there is 80-plus, if that was done, for example, on an increase in funding per resident in that category, that line would generally progress upwards always. This

analysis uses a percentage of GDP comparison, that is the economy has grown and hence that has been an impact on the shape of that line. So I think that is worth noting, that the actual real expenditure per person in the 80-plus group, if you had mapped that line, would have shown an increase similar to the blue line in fact, possibly a little bit higher. So yes, that is worth noting.

Having said that, yes, certainly the ratio is at 70-plus, the 70-plus finding is growing. The 70 and 80-plus groups are different, as you would expect, and hence we can get slightly different outcomes.

DR HARTLAND: To add to Mr Murray's comments, there is a different interpretation of those long-term graphs. If you look at your Figure 2 in that paper, if you take 85 as the benchmark, you've got no equivalents to Home Care Packages in the system, and you've got a very small CHSP system. Since the mid-1980s, the aged care system has massively rebalanced towards in-home care, and so the mix of services is very different in order to meet demand. So taking a snapshot of aged care as it was in the mid-80s, and then using that to derive conclusions about an aged care system that is fundamentally different, doesn't I think give you very useful information about what you would be wanting to fund and finance now into the future.

MR GRAY QC: All right. Thanks, Dr Hartland. Nevertheless, just in trying to understand how it has come to be there are pressures on the system, it might be worth persisting in just this further point. The red line has been declining. That might have been different, I suggest, that is declining as a share of GDP per capita, that might be different, I might suggest, Mr Murray, if the planning ratio had been pegged to that cohort of Australians because their needs are evidently more acute. There would have been a more generous provision of places had the ratio been pegged to the needs of that cohort of Australians of 80-plus. Is that a fair summary?

MR MURRAY: Again, a lot of these sort of modelling relies on various assumptions. For example, if you had used that higher planning ratio in residential care, you would be over-planning for residential care, and we currently have demand well met in residential care, I understand.

It is a difficulty, I guess, in sort of going backwards and trying to project from different planning ratios that won't necessarily reflect the practice of what has happened and the reality of demand at the moment and obviously the rebalance towards home care more recently as well. So home care has increased lately, and it is obviously is a lower value funding amount, so relative to a system where it was more residential care focused, you have a higher average funding as well. Again, those type of considerations would affect the gradient of that line if they were done slightly differently.

DR HARTLAND: I think our judgment would be that the change in mix is a bigger driver than the population ratio. You would have to recut the figures fundamentally to get some conclusions. I think really, we would say, taking a snapshot where a

system was, as I said, in the mid-80s and projecting it forward on simple populations and GDP is not telling you very much about where you need to go in the future.

MR GRAY QC: All right. I want to ask you about indexation. Now, it's the case, isn't it, that the various levels of subsidy that are made available for care and residential care under the Act, the instrument, have never been calibrated by a study of the actual costs of high quality care. Firstly, is that a fair comment?

DR MURPHY: We would agree with that. We would agree that as we move to a new system we strongly support an independent pricing mechanism. Indexation, we accept, has not kept pace with some of the cost of care but it's complicated in ACFI as you know, because ACFI has been an instrument that has not been always properly used and has in fact been misused and there were lots of complications with over-claiming in ACFI, and we accept that indexation needs to be determined in a much more evidence-based way in the future.

MR GRAY QC: Okay. Thanks, Dr Murphy. Now, in a way the question is, well, what are we indexing, and we are indexing something that we don't know. We don't know what price things we are indexing because there has never been a cost study. There is a real difficulty there, I suggest.

DR MURPHY: Not a comprehensive cost study. There have been many studies over the time. But I think we accept your contention that a much more robust and transparent and regularly revised approach to costing is part of our reset of the system in the future. Absolutely.

MR GRAY QC: Yes. And the level of the subsidy that is provided - and there is a little bit of confusion in terminology here but I'll have a go and see if you agree with it. What results from the ACFI is in fact called the care subsidy, residential aged care. But sometimes not the entire amount of the so-called care subsidy is actually paid by way of a subsidy from the Commonwealth. There's --- for people who go through a particular means test and are deemed liable to contribute to a certain degree, there's a top-up by a user contribution to get to the point of what is called the care subsidy. Do you agree with that?

MR MURRAY: I might take that, if you like. The care subsidy is set at a particular level, for example $180 a day. If the means test determines that individual A should pay $10, then the Government will pay $170 and the individual will pay $10, which comes to 180.

MR GRAY QC: And the figure of 180 is, in effect, the price that the residential care provider is charging, if you like, and receives for a day of care for that person, and it's the cost to a combination of the Commonwealth and the user for the provision of that care for that day. Is that a fair summary, Mr Murray?

MR MURRAY: Yes, that's right. Yes.

MR GRAY QC: And the fact that it's called the care subsidy, even though there might be a user contribution, is perhaps neither here nor there, we just need to focus on the fact sometimes it's not 100 per cent subsidy, sometimes it's partly user contribution. Very well.

Now, it's very important that that price be accurate, that is, be at least sufficient to cover the costs of providing high quality care, isn't it? And that's no easy thing to determine, but it's a very important goal because if that price is insufficient, then over time the pressure that will be put on providers by reason of them being unable to cover the costs of high quality care will tend to put pressure on quality and even safety of the services they provide. Do you agree with that, Mr Murray?

MR MURRAY: Yes. Price is obviously fundamental to allowing them to provide care. And obviously the providers also have to take every effort they can to ensure they provide care in the most effective and efficient manner.

MR GRAY QC: Yes. And there's a regulatory regime involving monitoring of quality and safety, accreditation and so forth. But in the end, if the price being paid, that is the combination of subsidy and user contributions for care is insufficient to meet the costs, then the provider will be squeezed between the regulatory outcomes that are required on the quality and safety, and inability to cover their own costs. Agreed?

DR MURPHY: We accept absolutely that the price has to be paid to meet the cost of efficient care. At the moment there are some elements, some providers are probably cross-subsidizing the daily cost of care. The combination of those fees in a global sense, a price has to be adequate to meet the efficient costs of providing good quality care and associated services. We accept that contention.

MR GRAY QC: Thank you. Thanks. And thanks for mentioning daily living costs. So the Commonwealth is generally not paying those, they are actually fully comprised of user contributions that are required by the system but the system imposes a price cap, doesn't it?

DR MURPHY: It does.

MR GRAY QC: 85 per cent of the single basic aged care?

DR MURPHY: And it's not necessarily a clear distinction between the cost of daily living and the costs of care. There's a lot of crossover in that space and so, you know, we think the system is currently overly complicated in dividing you amongst sort of various care costs and the various cost elements.

MR GRAY QC: Now, can I ask you about indexation of the care subsidy, and I'll go back to the document we were discussing earlier. And I know that you've made the acknowledgement you have about generally speaking the system being under pressure because of inadequate funding, but I want to ask you about indexation as

what appears to be a contributor to that.

On pages 8 and 9 of Tab 114, there's an analysis culminating perhaps in figure 8, which is a comparison of the rates of growth subsidy levels compared with provider input costs, and generally speaking the rates of growth of input costs have been quite a lot higher than the rates of growth of subsidy levels in the graph as shown since the year 2000. Have you been able to obtain advice about that? Are you satisfied that that graph is accurate?

DR MURRAY: Generally speaking, if we're comparing indexation to the rates of growth in wage cost indices and the like, then yes, the wage cost indices have exceeded the indexation based on WC09. The thing you have to also consider in those issues is the growth in ACFI funding, and for a significant period the growth in ACFI funding has been high as well. The total price paid to the provider has been a combination is the growth of ACFI plus the indexation provided.

MR GRAY QC: Yes, thank you. I know there is in effect a difference of perception on what I will loosely call the sector on one hand, and Government on the other, I won't ask yet what drove that, and I think, Dr Murphy, you were saying something about those indexation pauses a little earlier, we will come to that.

But in the analysis on pages 8 and 9, and this is also reflected in the Department's own response to the notice to give information at paragraph 90, that is at Tab 117 paragraph 90, it's a description of the indexation method. I don't think you've called it by any particular name, but the paper calls it a particular form of --- I withdraw that, the name of it doesn't appear. But I understand there's a name, COPE, which is used to describe this form of indexation, and what it involves is a 25 per cent CPI component and a 75 per cent wage component. Let's just talk about the wage component.

For the wage component, the indexation methodology involves taking the annual dollar increase in the national minimum wage, as determined by the (unclear) Commission, but you're not just using that rate of change in the minimum wage from year to year, but dividing that number by the average weekly ordinary time earnings figure.

Now, the average weekly time earnings figure - sorry, average weekly ordinary time earnings figure is always going to be greater than the minimum wage figure. So you've got a denominator that is always going to be larger than the numerator, so what you're doing is diluting the effect of increases in the minimum wage through this method of dividing it by the average weekly ordinary time earnings figure. What this produces is an indexation method that is 75 per cent heavily weighted to a very much lower scale of indexation than would be dictated by just movement in the minimum wage.

Is that a fair summary, Mr Murray?

MR MURRAY: Yes, the method does apply a discount to the movement in the minimum wage. The normal rationale for a client discount is based on recommendations from the Productivity Commission and in years gone by in terms of indexing many things, there should be an expectation of some level of productivity or efficiency dividend. This formula uses the method that you've described to achieve that outcome.

MR GRAY QC: All right. And the effect of that has been that in fact, the indexation has been inadequate to match the rate of growth in costs for providing care over a very long period. Do you agree with that?

MR MURRAY: Certainly the indexation has not matched the rate of growth in wages, for example, and costs in that period. As I mentioned before, you do need to overlay that with the growth in ACFI claiming funding as well, because that provides the whole outcome to the provider.

MR GRAY QC: Well, let's think about that for a moment. The increase in ACFI claiming. It's the case, isn't it, that over this period, the cohort of Australians aged 80 and over has been --- that is the rate --- or the proportion of people aged 80 and over has been increasing by comparison with earlier years. In short, the Australian population has been ageing, and that trend has been quite a marked trend, and it's a continuing trend. Do you agree with that?

DR MURPHY: That's true. I will get Mr Murray to comment. But whilst the population has been ageing and there is increased frailty, it is inconceivable what the rate of growth in ACFI claiming over a short period of time reflected an increase in real frailty and need. In fact, I used to run a health service which had an aged care facility, and there were consultants who were offering their services to maximise ACFI claiming. It was a natural behaviour of the sector when you have a system which is self-assessment and you can claim to maximise revenue. There is no doubt in my mind that there was very creative claiming practices by some providers, I don't blame them for doing that, they were doing what they saw a system allowed them to do because the system wasn't fit for purpose. But I ask Mr Murray to comment further.

MR MURRAY: Yes. That reflects what our analysis show that the rate of growth we saw in provider claiming in certain periods were well above as to what you could expect to see as in a normal growth in frailty. Normal growth in frailty would happen gradually over time, for example, whereas it was seen that there were some quite sharp upward trends, and frailty would just naturally sharply increase overnight, for example.

MR GRAY QC: Have you done a study of the rate of increase in frailty over time? Are you able to actually furnish evidence to the Royal Commission that supports the allegations that you've made that the claiming on ACFI was out of step with increases in frailty?

DR MURPHY: I don't know, counsel, that would be necessary to somehow disprove the fact that a particular cohort might have had something like a 25, 30 per cent increase in frailty over a period of a month or something when --- some of these claims were very, very significant and very sudden. And, you know, we have studied the ageing population, you know, collectively as clinicians for years. And I think frankly anybody looking at the evidence would suggest that it's inconceivable it would match the normal frailty process. I mean, we looked at that evidence in great detail. And, as I said, I had personal experience of the sector ---

MR GRAY QC: Dr Murphy, thank you, you told us that. And can I just ask you this; you said some of the cases and I didn't get the impression that there was a general allegation being made that all providers were doing this. We will come to the response in a minute, but the response, which has actually happened in two periods, 2012-2013 and 2016 for 2016-17 and 17-18, the response was a global one, wasn't it, to pause indexation all together or ---

DR MURPHY: Correct, counsel.

MR GRAY QC: Two periods had a 50 per cent pause, and for another year to have a 100 per cent pause in the indexation for the entire sector. Was that a proportionate response - -

DR MURPHY: It was ---

MR GRAY QC: Dr Murphy, I will finish the question. Was that a proportionate response to some instances of what you perceived to be over-claiming? Why wasn't enforcement or audit activity a more proportionate response? Thank you, that's my question.

DR MURPHY: Well, what we're moving to say is that the ACFI instrument is not fit for purpose. We have been developing AN-ACC to move to a system which involves independent assessment. We absolutely accept that the ACFI instrument, and that was the only tool available at the time to deal with the massive growth in costs. I accept that in that there was a lot of providers were over-claiming. I don't blame them for it. The tool was not an appropriate - is not an appropriate tool. We have to move to something better and I think we've acknowledged that and we accept that.

MR GRAY QC: Operator please bring up paragraph 103 of the department's response at tab 117. In this paragraph, Dr Murphy I will direct the question to you but if you wish to rely on the officers beside you, that's fine, just say so. In this paragraph you, that is the department, has referred to reasons outlined in the Aged Care Financing Authority submission, that is a submission to the Royal Commission in April 2019 and in the Corderoy statement, that's a statement of Mr Grant Corderoy who gave evidence to the royal commission earlier in the week.

..... the Department recognises that the level of indexation has not been

sufficient to cover the increasing cost of service delivery inputs. If this is not addressed then, over time, it will result in pressure being put on service delivery.

Now, my question is this. The last sentence refers to the future if this is not addressed then over time it will result in pressure being put on service delivery. My first question is; hasn't it already resulted in pressure being put on service delivery?

DR MURPHY: I think our evidence would suggest that there are certainly financial pressures put on the sector and their financial performance has deteriorated. I'm not sure that we have clear evidence that there is pressure put on service delivery but I think that the point of that statement is that we acknowledge that the level of indexation needs to be addressed.

MR GRAY QC: The next question is this. Pressure put on service delivery - I repeat the question I asked Mr Murray a little while ago - couldn't it have over time, wouldn't it have an inevitable impact on quality and even safety? Is that what service delivery means in this context?

DR MURPHY: It is part of quality and safety. Obviously a major input to quality and safety and service delivery much we don't have any evidence at the moment that there is an impact on quality and safety from financial performance. Our concern more is that the global financial performance of a sector and that's why we've had to support the sector and why we absolutely accept we need to do further to support the sector financially in the future.

MR GRAY QC: There was a big uptick in regulatory outcomes, adverse regulatory outcomes in 2017-18, wasn't there?

DR MURPHY: I think you cannot conclude that increased action by the regulator and increased outcomes necessarily reflect the deterioration in quality of care. Often that can just be a reflection of improved regulatory oversight and improved regulatory action. I don't think there is evidence to support that.

DR HARTLAND: That period was brought in post the Hopetoun experience where there was much greater focus on regulation as a result of the awful events in that facility in South Australia.

MR GRAY QC: There seem to be two explanations available, neither of which is particularly attractive. One is the regulator wasn't doing a proper job until that uptick in adverse regulatory outcomes and the other is that the system was under financial pressure as a result of the indexation matters that we've been discussing including the freezes just before that period and that that had an impact. Has the department done any analysis to try to understand what is the true cause or is it a combination of both?

DR MURPHY: We've no evidence to suggest that there has been a global deterioration in quality of care in that time. I think what Mr Hartland is saying - I think

it's very important in the whole and the same applies in healthcare, when you do increase oversight audit and quality activity and report this publicly, it should not be seen as evidence of deterioration in quality of care. It can often - the converse is often true. It just shows the regulator is doing a much more thorough job. So I don't think we've got any evidence to support the contention that care quality has declined because of financial pressures. We have evidence that prudentially that there have been pressures across the sector but we don't have evidence that there has been a decline in quality of care.

MR GRAY QC: Thank you. Now, paragraph 103 mentions the Corderoy statement but you've actually as a department worked with StewartBrown and in particular with Mr Corderoy on many occasions in the past. Is that right? I mean, he is a reliable skilled analyst of the financial performance of the sector. Do you agree with that?

DR MURPHY: We do.

MR GRAY QC: Now, have you been monitoring the aged care financial performance survey reports in respect of rolling nine-month periods that are released quarterly by StewartBrown under the leadership, that is the leadership of that survey project by Mr Corderoy?

DR MURPHY: Mr Murray will answer that.

MR MURRAY: Yes. We regularly receive those reports.

MR GRAY QC: They would be very important pieces of information, Mr Murray, that I would suggest you keep a close eye on in.

MR MURRAY: Yes, they are.

MR GRAY QC: They've been coming out since the 90s.

MR MURRAY: The two key pieces of information are the ACFA report and the StewartBrown report which are more regular quarterly surveys.

MR GRAY QC: Thank you. Now, if we just bring up the most recent one that we have available which is tab 61. And I in particular would just ask you to focus, Mr Murray, perhaps, on figure 10 on native page 15 please, Operator. While that's coming up I'll just tell you, Mr Murray, this is the chart on ACFI revenue growth v ACFI service cost growth. And I understand the proviso you've made about claiming under ACFI but in terms of in effect the price, that is available under ACFI and the costs that are available - I beg your pardon, the costs that are required to provide the service that attracts the price, it seems that Mr Corderoy's report has, using a base of 2016, tracked a point in early 2018 where ACFI service costs, changes in ACFI service costs overtook changes in ACFI revenue. Actually, I withdraw that. I will just ask you this. Does this graph take into account cumulative increase including claims or is this simply a depiction of price? Do you know?

MR MURRAY: My reasonable expectation from this graph would be that the actual total ACFI price, so it would include both indexation and claims growth.

MR GRAY QC: Yes. Sorry, I withdraw the question I put to begin with. Even taking into account claims, claims and price and describing those matters as ACFI revenue, at a certain point in early 2018 by the looks of it, ACFI costs overtook increases in ACFI revenue. Were you monitoring that at the time?

MR MURRAY: As I said, we do get these reports and observe these changes. I think the points made in relation to this which I think is in another part of Mr Corderoy's report, is he also finds that total ACFI funding exceeds ACFI costs. So what you are seeing there is a change in the percentage growth over time. In terms of the ultimate numbers he finds ACFI revenue exceeds ACFI costs.

MR GRAY QC: Yes. That's a fair point but that presupposes that we know that high quality care is being delivered and it also raises the question whether other costs are adequately met by other revenue streams. And do you accept Mr Corderoy's analysis that overall the costs required to provide aged care are not met by the available revenue streams because there's no revenue stream covering administration costs adequately and because daily living costs are quite largely under-funded?

MR MURRAY: Certainly that latter point, yes. The funding source for those costs in terms of the basic daily fees, the revenue for that is not meeting the cost which is what the StewartBrown analysis shows. As Dr Murphy said, a number of times, we accept that that it would be desirable to have additional funding come into the sector.

MR GRAY QC: Yes. All right.

DR MURPHY: We have, counsel, put in significant short-term support. The COVID measures we put in this year, which fortunately other than Victoria have hardly needed to be used, have been a significant uplift across the system. We were very concerned about this latest --- this March StewartBrown Report and we are very closely monitoring the sector and obviously as we move to a reset, which we hope a Royal Commission will help us with, we will need to look very seriously at those issues.

MR GRAY QC: All right. Now, I understand you might not be able to tell me much about this but I do need to ask the question. On that point about COVID impact, there's an obvious concern --- and it's raised in the material of Mr Ansell --- about the replenishment rate of refundable accommodation deposits, particularly perhaps in Victoria. And I think you probably understand what I mean by that but just for the sake of explaining it to the public, residential accommodation deposits are deposited by people when they are admitted to residential aged care at their option; they can choose to pay a daily accommodation payment instead. But if they lodge or deposit a refundable accommodation deposit then that becomes, in effect, an important source of capital which is interest free which is available to the residential aged care

provider to use.

Now, the point is that when the person leaves residential aged care, whether by death or other discharge, that refundable accommodation deposit has to be returned and the theory must be that new admissions will tend to replenish that source of capital. There's a concern if the occupancy rate drops or if the replenishment rate of refundable accommodation deposits drop that there might be a liquidity problem, at least for some providers, and one might speculate that Victoria would be an area of concern in this regard.

Firstly, are you able to comment on what I've just summarised and whether that's an area for concern?

DR MURPHY: It's an area we're closely watching. I think the same consultant predicted earlier this year this might happen broadly across the sector and it hasn't happened. But in Victoria clearly there has been, for some particular small number of facilities, a significant outflow. We're watching that very closely. Mr Murray can comment further. But the banks are certainly generally happy to support the situation in the short-term but it's something we're very closely watching. We haven't seen, at this stage, any crisis in financial viability because of it but I will get Mr Murray to comment further.

MR MURRAY: Yes, that's correct. It is something we are closely monitoring and have been since the start of COVID outbreak. There have been some impacts but they have not been so widespread that they have required anything to date, other than we are constantly actively monitoring, we are getting regular reports from the sector of what is happening and also using our own intelligence and data collection to monitor the situation.

MR GRAY QC: Now, I'm not going to insist if you can't answer, but what in broad terms are the measures that are being put in place to address any liquidity concerns? And if you can't answer then say so.

MR MURRAY: We haven't --- (overspeaking)

DR MURPHY: We have to --- (overspeaking). We obviously have --- would consider measures if required but we haven't had to put any measures in at the moment.

MR MURRAY: No, not specifically addressed at that issue. There have been a number of measures in the COVID situation, there's been additional funding provided in general to providers, to address concerns with additional costs coming through there.

MR GRAY QC: So you haven't, for example, set up any sort of contingency plan ---

DR MURPHY: No.

MR GRAY QC: --- for dealing with potential plans for collapses?

DR MURPHY: We have the preparedness to do things if necessary but there hasn't been a need at the moment there.

MR GRAY QC: Are you seeking more regular reports of the financial performance, the liquidity position of providers in Victoria, for example?

DR MURPHY: Yes. We are monitoring it very closely.

MR GRAY QC: All right. And what form do those reports take? Are they monthly financials?

DR MURPHY: Well, I think we're working very closely with the major affected providers. We have a very extensive aged care response centre set up in Victoria. We're working with --- the Quality and Safety Commission is working closely with providers. We are looking at all aspects of their operation as we are now trying to bring residents back into those providers and we are looking very closely at them. I don't know whether Mr Murray can say anything more?

MR MURRAY: No. It's part of our general sort of overall management of the issues going on in Victoria. It has been broadly considered in that context.

MR GRAY QC: There is another bit of analysis in the document, page 114 --- I beg your pardon at tab 114. It's an analysis of the ways in which ACFI may no longer be suitable for its intended purposes. In your response to the notice to give information at paragraph 18, the department acknowledges a number of reasons why ACFI is no longer suitable for its intended purpose. And I acknowledge that --

DR MURPHY: Yes.

MR GRAY QC: --- but I just want to ask you about an additional point that is made in the paper at page 11. And the point is made that in effect ACFI is no longer capturing and reflecting in an appropriate level of subsidy the high levels of acuity in the cohort of people in residential aged care. For example, the largest eight categories used to in 2008 account for 38 per cent of residents. There are 64 categories overall, aren't there? So even then there was quite a bias in the way ACFI captured acuity towards those large state categories.

Now, well as at 2018, the largest eight categories account for 70 per cent of residents. So there seems to have been a very large movement in the more acute direction and the largest of the --- sorry, the highest of the 64 categories in ACFI now has 31.1 per cent of residents in it. This seems to suggest there are bound to be people that are, in effect, off the scale, whose acuity has not been reflected in an appropriate subsidy level by ACFI. What do you say to that?

MR MURRAY: You've to be careful in using ACFI as a guide to what is the real frailty situations occurring. ACFI, as we have mentioned, is driven in part by provider claiming, so you can't really - and that is one of the reasons why we are proposing to move away from ACFI to a new AN-ACC model, is that it is subjective. It is open to the provider decisions about claiming patterns, and you could assume that means frailty, but the reality is that you wouldn't expect claiming to go from 2 per cent in one year to 5 per cent the next purely because of frailty, which is the type of thing we were observing. So you need to treat ACFI with a bit of caution in assuming that it is a pure guide to frailty.

MR GRAY QC: Now, in the response document that the Department has furnished at tab 117, at paragraphs 98 and 99 there is a version of the matter concerning the indexation freezes and their causes set out in those paragraphs and, Dr Murphy, you are in effect referring to these points a little earlier and I was asking you questions about them. And there is, in effect, two perspectives on these events. One is the perspective you've been advancing in the evidence of this panel today and, Mr Murray, you just put a position consistent with what Dr Murphy had said on that, that it was about claiming activity.

Dr Murphy, you referred to the indexation pauses that are identified in paragraph 99 as being driven by claiming activity, and you itemise the pauses to indexation that were the Department's response to that perception.

The sector, according to ACFA in its submission to the Royal Commission at tab 108 at page 20, we don't need to bring it up, I don't think, but it, in effect, recited the position of the Department on those matters and then recited the position of the sector on those matters, which there had been an inappropriate response by the Department and that ACFI had been keeping up with frailty and in any event this was a sort of collective response.

ACFA has, I suggest, been the meat in the sandwich to some degree and has attempted to broker a position, to use Mr Callaghan's words the other day, in an atmosphere of mistrust between the Government and the sector over these matters. Is that a fair summary of what has occurred in relation to these indexation clauses?

DR MURPHY: I will get the others to comment, but I think there are points --- clearly points of disagreement about these issues, and I'm not sure that there's a global mistrust. But I think all of us, all parties agree that the way out of this is to get a proper independent transparent pricing system and a new case mix funding model. And so we are at one on that approach going forward, the sector and the department, so rather than continually re-prosecute the past on ACFI and what has or has not happened, we would prefer to look forward and move to something that is trusted and transparent and agreed by all as the way forward.

MR GRAY QC: Thanks, Dr Murphy. I will leave it there. I want to go to home care.

The HealthConsult Report that has been furnished to the Royal Commission by the Department is at Tab 106, it is a report on steps that have been taken by the Department in particular on the assessment element that would be needed in a uniform or an integrated home community and support program. What has been the outcome of HealthConsult's work so far? I see they've recommended a model known as ACF.

DR MURPHY: ACF.

MR GRAY QC: Yes, ACF. And if we go to Tab 106 there were three options shortlisted at page 8093. So this is CTH.1000.0004.8045 at 8093 which is native page 45. And could you just explain which option was adopted, and what progress is now being made towards ---

DR MURPHY: I will get Dr Hartland to respond to this. He is the expert.

MR GRAY QC: We are at pages 46 of the report.

DR HARTLAND: Thank you, counsel. So HealthConsult, in a way, stripped back to an atomised level all the elements that you would want in a new home care system, and did a structured thought process to find the best option. So rather than starting with Home Care Packages or CHSP, we asked the questions: if you had a clean sheet of paper, what would you want a home care system to be?

The result of their recommendation is that you have effectively two streams, and I say at the start, noting your interactions with Professor Eagar yesterday, they are actually very close to some of the proposals that the Royal Commission Secretariat has put and they are actually very close as well Professor Eagar's primary and secondary care model.

So where they landed, and I think page 37, Figure 4.5, shows --- actually unfortunately it's quite a complex figure --- how it would work. In a nutshell what they are showing at the end point is that there are a group of people in an in-home care system that are likely to use, say, one or two services, say, once or twice a week. And you need a funding system that gets service to them quickly and directly. They call that service events. It's close to Professor Eagar's primary aged care proposal.

Then there is a group of people that, in effect, have more complex needs, and need a service response that looks at the totality of their needs and the mixture of services that they need, and they call that episode-based funding. It's similar in concept to Professor Eagar's secondary aged care and it's similar to some of the proposals you've put on individualised funding. So that is the kind of system they want to get to.

The next step of the work is to actually design the categories and that's considerable piece of work. We are sort of at a stage we were around about 2017. When did we get the RUCS study model, 2016? So if you think about this as a similar journey to

the AN-ACC work, we are at a stage where we looked at how a better classification for residential care would work, and the next step is to actually go away and analyse what would the service needs be in each of those classes and to look at more detail, how would the system work and how would you fund these. It's substantial work.

MR GRAY QC: I see from page 5 that on the matrix of evaluations of the the short list of models, option 3 came up, it seems to have case mix style features to it. Is that a fair summary?

DR HARTLAND: Yes, that's right. So - I'm trying to use language that doesn't assume an outcome, there's a group of people that need to get a bundle of services, if you like, and you need some flexibility in how you do that, but that is one of the ways of doing this case mix style --- and so yes, that's right.

MR GRAY QC: We've just got a few minutes before lunch and then I'm afraid we are going to have to resume time after lunch and take time out of the next panel because I haven't completed the questions I wanted to ask but this will be the last question before lunch. Dr Hartland, in that evidence you just mentioned, Professor Eagar has proposed as an alternative to the program designed submissions and the proposition advanced in the home care hearing the following proposal, a proposal by which a person assessed for care in the home should be given a choice as to whether they wish to receive the subsidy that the Commonwealth make available to assist them to receive care in the home by way of a package, bundle or budget on the one hand or by way of an entitlement akin to the sort of entitlement that results from random assessment for the CHSP program at present.

And Professor Eagar makes the following points. She says there are huge challenges involved in migrating a very large number of people currently receiving services under the CHSP, essentially from the CHSP to an individualised package form of service delivery under the current proposal that counsel have been advancing. Secondly, that there haven't been any real problems with the way the CHSP operates and it has a lot of advantages including stability of workforce, flexibility in the availability of funding for one service line being able to apply to others and flexibility at the individual level in being able to give individuals who need more help, more services and those who needless help, less services without having to acquit expenditures on an individual level.

And she queries whether the Home Care Package program would be a suitable model or a suitable template for the provision of services to so many - literally hundreds of thousands of people currently receiving services under the CHSP. And she points in a cautionary matter to certain aspects of challenges that have been encountered in the NDIS sphere relating to the preparation of support plans and the like. Has the department been giving consideration to those challenges and does it see any merit in Professor Eagar's suggestion that there, in effect, be an option offered to people to receive grant-funded services rather than packaged services?

DR HARTLAND: Look, I like Professor Eagar's first submission to you better than

the second one. I think the second one, as you found yesterday, has been influenced by some assumptions about what people mean when they use particular words and fencing around what the system would look like without thinking through what has actually been proposed. So depends how much time we've got before lunch but let me put it to you this way.

I don't think the department has ever said that everyone on CHSP should be funded on the way that Home Care Packages should be funded. I don't believe anyone has ever said that. If you go back to the HealthConsult work, as I said before, they're proposing effectively that you start your thinking with the types of needs of people. And I think all of us, the department, Professor Eagar and with respect to some of the propositions you put forward in the home care, we think about service providers and service events rather than people.

So to sort of unravel a bit where Professor Eagar got to, think of what a new system might be in these terms. You might have, as HealthConsult propose, a group of customers who need one or two simple services and you fund them in a way, a bit like NDIS at the moment. If you look at CHSP, that is probably about 70 per cent of the customer group get one or two services and you want to fund them simply. You wouldn't want a lot of artificial paraphernalia around monitoring their total package.

They should still get - I think it's useful when talking about these things, about package funds, talking about client control that you go back to what is intended. It's important to think when we talk about individualisation what was going on and it's useful to think about people having a choice of provider and some control over what they do. Think about two different aspects of choice.

So for that service event for people who have one or two levels of service, it makes sense to have a system where they have a choice of provider. Apart from market failure where that should not be possible that should be available to them as a citizen. I think they should have control over what services they get but in such a simple environment, that can be no one is going to force you to have gardening, right. You've got a right not to have that service.

When you get to the episode level funding which we currently understand is Home Care Packages but could look quite different in a new world, or how Professor Eagar has talked about secondary aged care services in dealing with people with complex needs, again, you know, people should have a choice of provider unless it's a market failure and it's simply not possible.

Control thought for this person with much more complex needs is going to mean something different. So I think the debate about this has become a bit ideological and I would be advocating stripping that away a bit and saying what is a practical way of allowing people to have some choice over and control over what happens to them. Because we know that increases welfare and frankly it's a ridiculous proposition to say that someone in aged care actually doesn't get to influence what service is provided to them in what manner.

Now, when you do that, I think you run around the bush and where you and Professor Eagar got to at the end of the evidence is some practical way of letting people control what happens to them. That could be in a number of forms. If they wanted to, they could choose one provider and then the choice and control aspects would come out with proper case care planning, right. So you would sit down with a provider and talk about what suited you within the kind of niche services that were appropriate for the needs that have been identified.

For some people the proposition that the secretariat and you have put around having a leave provider makes a lot of sense. So you might work with a provider that does a lot of your services but you might want a Latvian care worker to come in who speaks your language and they might not have that person on the book and they might use a broker to find and source that worker.

Now, it seems to me to be it would be really odd if we thought that shouldn't happen in a new reform system. It's about the flexibility that would improve people's benefits. And, you know, there is probably a third category about people who want to manage their own plans. The issue here is that people assume that package care, that's the only option. Frankly, I agree with Professor Eagar, it is never going to be the major option.

But, you know, you wouldn't want a system where you said to someone if you wanted to commission your own workers and manage them yourselves with appropriate safeguards that you couldn't do it. That would have to be an element of your system. I think, you know, that won't be the major element but it's a valuable source of innovation for the system as a whole. And I can't see why you would not want people to have that option.

But when you've stepped through it that way, Mr Gray, it's not a black and white choice between self-management and provider management. You know, there's a whole different range of different ways in which to reform the system or to provide people with the ability to choose providers and have control over what happens with them. And I think the parallel actually was very instructive but most people don't want to manage themselves but it's an option they've got. And they - -

MR GRAY QC: Thank you very much. We will leave it there. I will just ask you a follow-up question after lunch which is nevertheless would it be a sensible transition mechanism at the very least to retain a very strong and healthy grant-funded safety net, if you like, while the capacity is built up, which will be necessary for a reliable scheme along the lines that HealthConsult is envisaging. We will leave it there. Could we resume at 2.15, please.

COMMISSIONER PAGONE: I think we were planning to resume at 2.00, weren't we? I think that might be better in the circumstances?

MR GRAY QC: My apologies for overrunning.

COMMISSIONER PAGONE: These things happen. 2 o'clock.

MR GRAY QC: Thank you.

ADJOURNED **[12.51 PM]**

RESUMED **[2.00 PM]**

COMMISSIONER PAGONE: Mr Gray.

MR GRAY QC: Thank you, Commissioner.

Dr Hartland, following on from from the question I left you with over lunch, what is the position whether Professor's Eagar's alternate proposal might be a useful transition mechanism at the very least?

DR HARTLAND: I think the alternative proposal is actually a big bang approach to reform. Because it really puts, with the exception of people self-managing, everybody into one funding system at once. You know, I would favour a transition path that built off the strength of CHSP. I think CHSP does need to reform and if the changes in motion from the Royal Commission hadn't been a prospect, I think the Department would have wanted to work with CHSP providers to get some reform as well. So I can run through it, but I did give some thought overnight to a transition path that might work for CHSP. I think you are right to ask this question, counsel, it's a really good question. Many large-scale reforms can foul up the transition. I think of the last time we tried to integrate the last two sectors, it was actually transitioned in a way that meant it failed because no one could see a path for their providers. I would favour, and I think the CHSP capacity is an absolute strength of aged care. It's a ring of somewhat small providers, it's a ring of low-intensity services before you get to very intense stages, it's a real value to the stage of the system so you wouldn't want to lose it.

What I would advocate is a kind of a bit like what we are doing with the approved payment arrangements approach to Home Care Packages, which is a phased approach. As you might know, that works in two stages, the first stage is the move to arrears payment, and the second stage is we ask providers to build just on what they've provided and that has been intended to deal with aspects of the unspent funds.

If you took that thought process and you added a third stage, which was for them to tell us not only service-to-provider but service-to-provider against service lines, if you like, that would have moved home care providers into a system that's very much like the system that has been initially sketched by HealthConsult for episode-based

care. It would be almost identical.

And I think you can see a similar approach with CHSP providers, that you can move them gradually to a world where they were in a reformed system. I'm anticipating that many of them will concentrate on the service event stream, now low intensity, but I actually wouldn't rule out some of them would actually look for --- would be able to and want to deal with people that need package care, people you've described as needing an individualised service like a CHSP secondary age care and HealthConsult episode care.

The other thing, just before I outline the transition path that I was thinking about over lunch. The other thing is note about this is the CHSP providers are actually quite large organisations. Some of them are very sophisticated, they work in NDIS and home packages and CHSP. So not all, but some, there are a number of very small providers you would want to protect, but some of them are very big sophisticated organisations and quite innovative.

So the path, I think in these things you do need a staged path. What I would advocate just quickly, and I will let you follow it up and anything you kind of think about, so I think the first step would be, within the current ground structure, to give them additional flexibility across product lines, that's something we've been playing with, it makes no sense for a big organization that is funded for a whole different series of product lines not to have capacity to move across those lines to better meet clients' needs.

I think the second stage - and doing that would allow them to start understanding the business, understanding their clients, understand how to control their business without just digitally allocating dollars across lines.

The second thing I think you do is that you would want to get what they provide to a person to be much more closely related to the next assessment of that person. So at the moment people join CHSP on the basis of a needs assessment, through rounds, but the providers can progressively allocate more resources to them as their needs change. I think we would want to change that aspect of the system to get them more thinking if a rate is set, this person needs three hours, that's what this person should get. There is no problem in our system of getting reassessments, which a lot of the assessments are very quick, and that would bring them closer to the system you are proposing about needs assessment, and the one we're working on.

The third stage would be within the existing grant structure to tighten reconciliation of grants. So providers directly file their grants. But if they spend their money, we won't police brutally if their price or volumes are expected, and there is good reason of that. Like you don't want to penalise people without good reason, but you would want to get a tighter line of sight between the price and volume and more consistency in the price. You would be in a world where possibly an aged care pricing authority would be in existence, so you would set prices that would be reasonable. That would be similar to the price volume contracting which Kathy Eagar proposes, or an

activity-based funding model.

The fourth step would be to stay to pay an arrears as you propose in FF12. Once you've gone through those four steps, they would be effectively in the new world that HealthConsult are proposing. The final version of HealthConsult's work is not known. If you did those four steps and then you looked the process flows, the block flows that help --- what we're proposing for on pages 28 and 29, it would be nearly identical. You know, it's a bit like airbags. Airbag safety is like drawing out the impact of the crash, right. So drawing out the time of the transition allows the organisations to adjust. It allows them to review the business processes and gives them time to understand the new world.

All of that would be predicated on you would need block funding in areas of market failure which would be regional or the very small specialist groups, so the Lithuanian sub-group. You would need to fund capacity there.

The final thing, I was thinking about this from your comments about trust in ACFI. It's not only ACFI where there's issues of trust. I think you'd want a co-designed process with the sector. I go to talk to a ACFA conference, which was a really refreshing thing to do, because frankly, not getting out of Canberra much at the moment, and one of --- there is a really great to get people's questions, no one was rude, so that was an improvement on my previous efforts.

The way the question was, when are you going to consult the CHSP sector? And I think to myself, there is actually a culture piece there as well because thinking of yourself as a sector means that every time someone changes the program you can only see it as a loss. So there is a bit of a culture piece there, and it might be that because they've always assumed that we've only ever cared about Home Care Packages, that's all we talk about, that's all I get asked about, that they're a bit forgotten about. I think we would want better closer connections with the sector and to work with more patients --

MR GRAY QC: Thank you very much Dr Hartland. That is very comprehensive. I can leave it there unless the Commissioners have any questions.

It's a good segue into the propositions. Some of the propositions pick up concepts you've mentioned. If the Operator kindly brings up tab 111, we will go through them in order and I will just, beginning by directing questions to Dr Murphy, seek the Department's position, if you like, by exception.

As we go through clusters of these propositions, if the Department has a real difficulty, a substantive concern about the appropriateness in principle or the workability in practice of any of these propositions, we would be very grateful to hear about that. And let's start with FF1 and FF2. In a way FF3 and 4 are integral, but let's start with FF1 and FF2 which are very closely connected and define the independent pricing role.

I heard what you said earlier, Dr Murphy, and you were clearly supportive of independent pricing. Do these propositions do the job, in your view?

DR MURPHY: I think yes, in general terms, Counsel. I think we were not - we might have some potential concerns with a price, that Government have been locked into delivering a price, I think that price needs to be transparently determined and recommended to Government, but whether Government should have the fiscal right to determine how that's manifested is a matter for debate.

We don't, you know, feel very strongly about it but I think the general principle of an independent transparent evidence-based price determination, we support. Yes.

MR GRAY QC: Thank you. Just on that point about recommendation or binding determination, of course the argument for binding determination is that you really are removing the process from the risk of expedient decision-making due to the fiscal pressures of the day, and to that extent you're enhancing the confidence in the overall process. Do you have any thoughts about the benefits?

DR MURPHY: That's certainly an interpretation. But I think in general that the approach to funding policy is that Government has to look at the overall picture, but I think in a transparent, well-publicized price model it would be hard for Government not to implement a recommended price. But I think generally speaking, governments usually have the right to interpret price recommendations. But it's not a major issue, it's just that that's something we wouldn't want to have Government locked into that position.

MR GRAY QC: Okay. Let's go to FF3 and FF4. FF3, in effect, poses precautionary principle to the test for when there should be some form of economic regulation. That form of economic regulation might not necessarily be a price gap but it could include a price gap. It might be something of a lighter touch, such as a monitoring role, a provisional cap that can be waived, of the nature of the function of the aged care pricing commission under the present system with regard to RADs that are higher than $350,000 for example. It's a broad proposition about economic regulation because of all of the vulnerabilities and the market power issues that have been identified in evidence over the week, unless it's clear that there's workable competition for the particular service line or in the particular area. What are the Department's views about this?

DR MURPHY: In the main we would support that contention. Yes. We support that clearly there are situations in home care where there is workable competition where price setting wouldn't be necessary. But I think in general, in the residential care sector, as you've outlined in the proposition, the pricing authority would be likely to determine those prices. So yes, we support that proposition. Yes.

MR GRAY QC: Yes. Thank you. And we will just pick up an element, if you like, of what might happen specifically with respect to places or in respect of product lines where there is no workably competitive market mechanism, FF4. Have you reflected

on the principles set out in FF4? We've mentioned two potential functions and potentially two different entities there: a system manager, and we've been agnostic about who would exercise the function of system manager; and the pricing body that we've been talking about, or let's say the independent pricing function we've been talking about. Do you wish to comment on that aspect, the potential separation of those two functions or any other aspect of FF4? Is it appropriate in your view, FF4, and is it workable?

DR MURPHY: So I think we again support thin market arrangements, we have them already in a number of aspects of the aged care system. And I think the pricing authority certainly could do that in any event in the residential care setting. I think when you're talking about commissioning services, you know, I think we already do that. And Dr Hartland might want to comment on that further.

DR HARTLAND: Look, I think, absolutely, it needs to be part of the future. You know, it's clear, we've already talked about it being needed in rural and remote. There are mechanisms that can be expanded on. As I said, there are other thin markets in metropolitan areas, specialist groups, there are some wonderful organisations that [indistinct] people that we fund, and they need a certainty of funding and standard capacity. Absolutely it should be a commission.

MR GRAY QC: Dr Hartland, just while we're on it, can I ask about what commissioning should involve, and can I ask whether the Department is conducting commissioning with an appropriate regional or even local focus, and to what extent, for example, CHSP involves good commissioning practices, and does the capability of the Department have to be enhanced in this regard.

My understanding of commissioning is that it isn't simply a matter of granting a funding agreement, but it involves iterative communication, feedback about improvement in services delivery, improvement in the conditions of the grant, that it should involve at least two-way communication, and it should communication with policymakers. And these are the sorts of things that one reads in the literature about good Public Service commissioning practice.

It seems to require a regional or even a local capability. Is this what the Department is doing at the moment or are there plans for the department to conduct commissioning with a local focus of that kind?

DR HARTLAND: Well, we do - in CHSP programs, there are grants managers that actually assess but they do work with grant organisations, if there's a problem on performance, they'll go and talk to them. Part of their role is to understand the situation of the organization and have a regular point of contact with them.

You know, it tends to get exercised most if an organization is in trouble or there's a crisis in the area in which case they can become intensively involved in the organization. I think that that, it certainly should be a part of the armoury and you're right, good commissioning is a two-way process. It needs to have a local

understanding. I don't know that you necessarily have to have grant managers in each country town to achieve that, but you certainly do need to have people that understand the circumstances of the provider they're talking to.

I think, though, that it does need to be seen in an area where there's a discernible failure for a normal activity-based approach. So, I think, you know, one of the problems with the grants process is you can end up being spread a bit thin, there is 1400 organisations to be funded through CHSP, so you can't have the same intensity through all of them. I'm recommending the services would not be all of the broadly what CHSP is now. You would have a more activity-based approach to the large sophisticated organisations that are a fully functioning market.

MR GRAY QC: We will move to the next proposition, FF5. FF5 really requires a little bit of reading into the narrative that appears underneath, and one can see there that our primary thinking is that this is predominantly, at least at present --- and you might have seen this in our home care outline of proposed new service arrangements --- that this is the funding model under consideration by those assisting the Royal Commission at present called Social Supports, Assistive Technology in Home Modifications and Respite Care.

On that footing, what are your thoughts about the appropriateness and workability of FF5? Should I direct this to Dr Hartland?

DR MURPHY: Yes, please.

DR HARTLAND: We covered this before lunch. The proposition is driving at the right idea that you absolutely need a set of services that are able to deal efficiently and well with people with low service needs, like one or two service needs. So as I said, we are broadly in agreement with this, it's very similar to HealthConsult's service event proposition and Kathy Eagar's primary aged care. I have a slight hesitation, which I'm not sure that --- obviously you need block grants for market failure. We would anticipate that the other services should be on activity basis, and I'm not sure that FF5b quite hits the mark in the way you would think about these services. I would suggest that you think about them in terms of the people who need one or two service events rather than the product lines.

One way of illustrating this --- so I think it needs some development. One way of illustrating this, if you thought it was only about uniform high volume services, as implied by (b), you think about assistive technology and home modifications and respite, they don't fit that criteria. They are likely to be different for different people, so they are not uniform, and home modifications certainly are not high volume.

So I think you absolutely need something like this in the system, but you probably need to think about it in relation to the people that need that type of service rather than service lines.

MR GRAY QC: Thank you very much. I think I will stay with you, Dr Hartland, on

FF6.

DR MURPHY: I think so.

MR GRAY QC: Perhaps in large measure you've already covered this and I don't want you to repeat yourself with respect to the thoughts you've conveyed to the Royal Commissioners already both before and after lunch. But looking at FF6 as a proposal predominantly, it's our intention that this would be the approach to the care at home category referred to in the home care outline of service arrangements.

What are your thoughts, Dr Hartland?

DR HARTLAND: Look, this is really close to what we think where HealthConsult are proposing episode-based care, what Kathy is proposing in relation to secondary aged care, so I think the idea that there is a group of people that need a bundle of services that you contemplate as a whole is absolutely agreed.

I'm not sure what you've in mind there, and it might be yesterday you were talking about before you have a classification system you needed an NDIS-like system. But if you juts took (c) on the face of it, we would suggest to you actually that this is a bit wrong way around, that if you've a system that funds people with a package that's around their needs, you actually need a classification system to sit underneath it so you can understand whether you got the funding right, and we are working on that with HealthConsult.

The current version of it, Home Care Packages, does need at least fundamental reform because it's too broad and doesn't really understand people's needs, but you do need a funding classification system. I think Professor Eagar made this point when she said you needed an a AN-ACC approach.

MR GRAY QC: Yes. And what I'm hearing, and what I heard when you explained the HealthConsult trajectory, if I can put it that way, is that there may be a possibility of skipping any step of having to generate individualised budgets from particular line items referable to a schedule of unit rates of services and moving straight to, in effect, what resembles a case mix classification style of funding eligibility for home care. Is that right, Dr Hartland?

DR HARTLAND: I think that's right. Look, even NDIS has a classification system that sits behind it, it's just not in the foreground. Apart from that, it's a technical ---

MR GRAY QC: Professor Eagar also raises another point, and that is that it may be unnecessary at least for some people who don't wish to have this, to have a dollar value budget, just unnecessary. But effectively back in that territory of discussing the alternative model. Do I take it that the Department's current plans would be that there will be a dollar value generated by the plan, albeit through a case mix approach?

DR HARTLAND: I think you want a bit of both, you want a dollar value but also a better understanding about what you are expecting to buy with that while allowing people's flexibility in the way we talked about before lunch to make some decisions about what was best for them.

MR GRAY QC: Any other comments on FF6 or shall we leave it there?

DR HARTLAND: Steam on.

DR MURPHY: No more.

MR GRAY QC: FF7. You will see we were agnostic about whether FF7 may be applicable to home care, later if not sooner, and we haven't actually stipulated under either FF6 or FF7 that they're necessarily restricted to one particular modality or the other. But our predominant - our thinking was predominantly was that FF7 would be the apposite funding mechanism for residential care, and we weren't sure how soon it would be available for home care, but focusing on residential care, we have, of course, the resources led by the team of Professor Eagar in the terms of AN-ACC. That seems like a good starting point and a reasonably obvious candidate to give consideration to in this context. What are your thoughts about FF7? Does that go without saying it's all right or do you have any problems with it?

DR MURPHY: No, it's good. It's good. It's consistent with our approach with AN-ACC and that is the point we want to make.

MR GRAY QC: This is the point between home care and residential care, both in terms of the relationship between the maximum amount of funding that will be allowed in-home care under our propositions in this document and perhaps far more importantly, in terms of the life decisions that a particular person might have to make at a particular point in time when it seems they might, in spite of their best wishes, no longer be able to live at home safely and to receive appropriate care there.

Now, we have proposed that the tax amount of funding that should be available to a person for care at home should have a connection with the care component of the funding they would have been assessed to receive in a residential setting. What is the Department's position on this? There is some detail that has to be worked through, for example what is the position of formal carers and so forth, but in principle what is your position?

DR MURPHY: In principle we strongly support the idea that Home Care Packages should be able to be much more generous and should enable people to stay in their home with increasing levels of frailty. The general contention, we support. The idea you would somehow link a dollar amount to what would be otherwise a residential aged care assessment process, it might have some technical complexities in it, but I think the general approach we are perfectly happy looking at a much broader range of Home Care Packages that would allow people to stay in their home. So whether you would need to then do a full residential style of assessment for someone in home

care to determine their dollar amount might be a bit tricky. Mr Murray might want to comment, but I think in general the direction is something we support.

MR GRAY QC: I think I will leave it there because I'm just about out of time, but thank you for that indication. Now, I don't want to spend any real time on 9, 10 and 11 unless you think there's a major difficulty with any of those propositions. They are the supplements that one might expect, some immediate funding to address staffing levels and the general principles for assessment of need.

DR MURPHY: The only issue I would say in those is that we'd support them in general, but to have --- for a transitional funding mechanism to have a burdensome equivalent process on staffing needs might be disproportionate if we are talking about a short-term thing. I understand the desire to increase staffing needs, but we wouldn't want to --- we are very concerned about not having an overly burdensome acquittal process in our future. Yes.

MR GRAY QC: That's FF10. That leads me to the last one I really wanted to address with you, which was, we've heard about arrears; what about acquittal of care expenditure in residential care?

Now, that would be acquittal to the system manager indicating what staffing levels have been employed and what care expenditure has been incurred. What is the position on that.

DR MURPHY: I think the system manager has a right to know that funds have been spent appropriately. What we are a little concerned about, and the same would apply in-home care, we are concerned about having an overly burdensome acquittal process as a supposed means to improve quality of care. We strongly think that the most important thing in our new re-envisaged system is we should be measuring outputs, consumer outputs and quality of care. Absolutely, money needs --- we need to have good financial reporting, but having micro-level reporting down to hours of particular care types for particular residents could be unnecessarily burdensome and there's not necessarily evidence to support that would improve the quality of care. So definitely good financial reporting, good accountability, but we wouldn't want it to be thought that some sort of burdensome micro-acquittal process is the pathway to improving quality of care.

MR GRAY QC: Would it be a reasonable corollary, and I'm not necessarily suggesting at the individual resident level, but to know what had been spent at a particular facility on direct care costs. After all, that's what the ACFI funding stream is for, isn't it?

DR MURPHY: At that level, absolutely, there's no problem. But I'm just worried about a micro, burdensome system that might be envisaged.

MR GRAY QC: Thank you. Look, finally, Dr Murphy, I do need to just go back to something you said a little earlier. It has been raised with me and I'm not saying that

it matters that it was raised with me, but I'm interested in clarifying something you said.

When I was asking you about the steps that had been taken, particularly in 2016 on the index freezes but I understand there was an earlier event that was similar in 2012, in any event with reference to 2016, I think, you were saying:

> *We have been developing AN-ACC to move to a system which involves independent assessment. We absolutely accept that the ACFI instrument, and that was the only tool available at the time to deal with the massive growth in costs. I accept that in that there was a lot of providers were over-claiming. I don't blame them for it. The tool was not an appropriate --- is not an appropriate tool. We have to move to something better and I think we've acknowledged that and we accept that.*

Then we moved on. I just need to ask you about the tension between your point about not blaming these procedures for the supposed overclaiming.

DR MURPHY: Sure.

MR GRAY QC: --- and how you reconcile that with what happened as a result. Overclaiming would be a form of fraud, wouldn't it?

DR MURPHY: Look, it's an interesting contention, counsel. When you've a funding system, this has been seen in the healthcare system with case mix. When case mix was first introduced, every hospital set up little units to maximise the claims and use the weaknesses in the system. And they're doing it legally. You know and so not saying illegally but I'm saying the intent of the tool was being distorted the way it was used. People and when I say I don't blame them, I'm saying it's a natural thing, in a tight market when you've a Government funding system, for people to maximise it. The same happens in the tax system. Systems need to be calibrated to control for those unintended consequences. The problem with this tool is it is provider-generated and not independently determined.

MR GRAY QC: All right. So it was perfectly legal what they were doing, even on your characterisation, it's just it was causing a problem.

DR MURPHY: Yes, yes.

MR GRAY QC: Now, the nature of this problem was this, wasn't it? The expenditure on ACFI was tracking above the forecast in the forward estimate model? So there was fiscal pressure then created by the claiming on ACFI? Is that the reason?

DR MURPHY: There were, but the claiming pattern was completely inconsistent with any natural progression of frailty. It was clearly - the tool was meant to accurately reflect the frailty and it was clearly being used in a way that

over-estimated the frailty assessment.

MR GRAY QC: Now, the reason for some providers doing this was because of the pressure that you mentioned. Wouldn't taking a collective measure like that just create more pressure in incentivising more and more providers to do the same? Surely the reason here must have simply been the fiscal imperative to keep within the forecast.

DR MURPHY: I'm not sure that those fiscal imperatives were the same then as they are now. I think that was a different circumstance. I'm acknowledging fiscal pressure now. Back then --- I wasn't in the role then, I had nothing to do with aged care, but my advice is that the system was not under the same sort of fiscal pressure. And, as I said, when you introduce an activity-based system, people will tend to - if they're responsible for the claiming, in is a natural tendency to maximise it, and I think that's why we think we need an independently assessed assessment service.

MR GRAY QC: I was talking about fiscal pressure on the Government of Australia, not pressure on providers. When I said fiscal imperatives, I was talking about the Government's desire to stick within budgetary forecasts. Does that change your answer?

DR MURPHY: I think the huge increase in costs at that time were certainly - would certainly have placed an unpredicted fiscal pressure on Government.

MR GRAY QC: Thank you. That was the point I wished to clarify, Dr Murphy. I have no further questions.

COMMISSIONER PAGONE: Yes. Thank you, Mr Gray.

Gentlemen, I think I need to excuse two of you from further attendance, Dr Murphy and Dr Hartland. I think Mr Murray is remaining on the panel for the next one. But can I take the opportunity to thank you yet again. You've been very good at making yourselves available to fit with our timetable, and we really are grateful for the efforts that you've made in making yourselves available, responding to all the questions and so on.

Thank you very much for your assistance. Two of you are now excused. The other one needs to remain.

THE WITNESSES WITHDREW

MR GRAY QC: Mr Bolster will take the next one.

COMMISSIONER PAGONE: Do we need to take a break for the next one?

MR BOLSTER: Yes, Commissioner.

COMMISSIONER PAGONE: We might take a break for five minutes.

ADJOURNED **[2.36 PM]**

RESUMED **[2.44 PM]**

MR BOLSTER: Can I call Mr Jaye Smith and Commissioner Janet Anderson. If they could be affirmed.

MR JAYE SMITH, AFFIRMED

COMMISSIONER JANET ANDERSON, AFFIRMED

EXAMINATION-IN-CHIEF BY MR BOLSTER

MR BOLSTER: Mr Smith, I'm not sure whether you've given evidence to the Royal Commission before. Have you?

MR SMITH: Yes, I have.

MR BOLSTER: Given that all three of you have given evidence, I will skip the introductions because we know who you are. Can I ask whether each of you have had a look at the Department of Health and Aged Care QSC statement from 2 March this year, which is at Tab 116 of the General Tender Bundle, which is Exhibit 21-1?

MR SMITH: Yes.

COMMISSIONER ANDERSON: Yes.

MR MURRAY: Yes.

MR BOLSTER: Is there anything that needs to be updated or corrected?

MR SMITH: No.

MR BOLSTER: I think there was a response to a notice to produce documents dated 2 September 2020, which is at Tab 104 of the Exhibit. Are you each familiar with the material contained in that?

MS ANDERSON: Yes.

MR SMITH: Yes.

MR BOLSTER: Is there anything you wish to correct about that material?

MR SMITH: No.

COMMISSIONER ANDERSON: No.

MR BOLSTER: If we can begin with general propositions that seem to flow from the material that has been provided to this Commission by both the Department and the Safety Commission, there is a general recognition, I take it, that there is a need to strengthen the existing prudential regulatory framework?

Commissioner Anderson, perhaps you can answer that first since you are the regulator.

COMMISSIONER ANDERSON: Yes. That is the general proposition, yes.

MR BOLSTER: And from the Department of Health's perspective, Mr Smith, you would agree with that?

MR SMITH: Yes. I agree with that.

MR BOLSTER: And since 2017 there have been a succession of reviews that have been asked to address various elements of the prudential regulatory framework; correct? Commissioner Anderson?

COMMISSIONER ANDERSON: Yes, counsel. Those are questions more properly for the Department, but certainly I agree with that, yes.

MR BOLSTER: All right. So we started off with Ernst & Young. Deloitte did a report. The Department issued a discussion paper, and then finally we had a review by Mr Barnier. Correct, Mr Smith?

MR SMITH: That's largely correct. Mr Barnier's report was less about the strengthening of the prudential standard as such whereas those earlier documents were about strengthening prudential standards. Mr Barnier's report was part of a broader project around the Department's capability from a provider viability perspective in particular. There was, though, a StewartBrown report that went directly to that matter of strengthening prudential standards as well as part of those series of documents.

MR BOLSTER: Do I take it, just to cut to the chase, that the Government is considering all of those reports but is yet to finalise a package of concrete measures

to address the various recommendations?

MR SMITH: Those reports, and I will ask Mr Murray to sort of add anything to my answer, but those reports follow each other, I suppose, in the sense the delete report was building on the propositions in the EY report which was used by David Tune in his review. Government announced in May 2018 that it in principle supported a review of the - rather a strengthening of the prudential framework, and it put in place action in relation to a series of measures that would achieve that. The follow-up to that was the Deloitte report and the Australian Government consultation, and then leading on to that was the StewartBrown report which was to put the implementation details together.

MR BOLSTER: Thank you for that. The ACFA, the Aged Care Funding Authority is on the record as saying that the current prudential regulatory system is intended to protect and even sure the return of RADs to RAD-paying residents to aged care providers. If you assume RADs extends to bonds, do you accept that as a an accurate statement of where the regulatory balance lies at the moment?

MR SMITH: Yes, I accept that.

COMMISSIONER ANDERSON: Yes.

MR BOLSTER: Does the Commonwealth agree, though, that there's probably a more fundamental and significant purpose to prudential regulation at the end of the day and that's about preventing quality of care issues arising that impinge or have the ability to impinge upon the care that is provided to residents?

MR SMITH: Yes. I accept that there is a connection between prudential oversight and financial performance and the ability of providers to, over time, be able to provide that quality care and to remain in business to provide quality care.

MR BOLSTER: Is it a flaw in the current regulatory system that that purpose is not expressly stated anywhere?

MR SMITH: I would say that - sorry.

MR BOLSTER: No, please continue.

MR SMITH: I would say that the Australian Government and then the Department has absolutely accepted that the prudential framework is not currently fit for purpose, that it requires fundamental reform to make sure that it can meet contemporary needs in the system.

MR BOLSTER: All right. If we go to your joint statement which is at Tab 116 and we go to paragraph 7, there's a marking out of the areas of responsibility between the Department and the Quality and Safety Commission beginning at paragraph 7, as you can see there. It's the fact, isn't it, Commissioner Anderson, since 1 January this

year, your organization has had responsibility for the regulation of the prudential situation in aged care; correct?

COMMISSIONER ANDERSON: Yes, Counsel. We are responsible for prudential compliance.

MR BOLSTER: And you have a prudential compliance section which has a number of tasks which are set out in paragraph 7 which you can see in front of you; correct?

COMMISSIONER ANDERSON: Yes.

MR BOLSTER: Can you give us a sense of how significant that branch is within the overall context of the Quality and Safety Commission?

COMMISSIONER ANDERSON: We received 6.9 full-time equivalents in the transfer of the function from the department to the commission. It has now grown to 10 staff. And it is a high-performing, relatively small team within a much larger Commission. I have over 600 full-time equivalents across the totality of the Commission.

MR BOLSTER: And the general qualifications of that equivalent of around 10 or 11 full-time equivalents, are we talking about people with accounting backgrounds and investigative backgrounds? What's the skillset that you've deployed to this role?

COMMISSIONER ANDERSON: A number of the staff have accounting and financing qualifications.

MR BOLSTER: A lot has happened in 2020 and as we will see, there have been a lot of pressures brought to bear on the industry. What is the current feeling that you have about the adequacy of the staff that you have allocated to this particular role?

COMMISSIONER ANDERSON: The staff are highly competent, but there aren't enough of them. We are currently recruiting across most operational areas in the Commission, and I expect that I will be building a larger complement of staff over the coming months.

MR BOLSTER: And have you mapped out the number of staff that you think is an appropriate level to deal with the responsibilities of the Commission?

COMMISSIONER ANDERSON: That's a fair question, Counsel. The answer is no, it's a work in progress, but I expect I will be in a place to answer that in as soon as two to three weeks' time.

MR BOLSTER: Now, there's a parallel responsibility on the part of the Department which is indicated in paragraph 9 of the statement, Mr Smith and Mr Murray. You're familiar with the Prudential and Financial Analysis Section known as PFAS; correct?

MR SMITH: Yes.

MR BOLSTER: And what's the equivalent staffing of PFAS with the prudential regulation aspect of aged care?

MR SMITH: So I should say that since this statement was issued the Department has, or my Division, Residential and Flexible Aged Care Division has undertaken some restructuring. That section has moved and has changed names and has also expanded in responsibility. Unfortunately I can't give you the exact number working on the particular functions that were previously held by that section, but it is part of a broader sector support taskforce that currently has 25 staff in it. It is responsible for prudential risk analysis, which is what this PFAS section was doing, as well as broader sector viability analysis and outreach to providers at risk.

I would be happy to provide details of that new section structure, I just don't have it in front of me --- with the numbers I mean.

MR BOLSTER: We might list that down as homework, thank you for that.

The task of PFAS would seem to me from the statement, and correct me if I'm wrong, involve receiving the three reports of a financial nature that providers are required to file by 31 October each year; correct?

MR SMITH: Yes, that's right.

MR BOLSTER: You put that in a format that is capable of being analysed by people in your division. Correct?

MR SMITH: It is received in a format --- and this is where Mr Murray might need to provide more technical detail, but --- the information is received in a format that is digitised, that can then be put through an automated risk assessment system.

MR BOLSTER: Mr Murray?

MR MURRAY: I'm just confirming that most of it, the main part of the information comes in digitally now and we can therefore run that through our system. There are some other more hard copy sort of versions of information which the team also analyses to support that.

MR BOLSTER: By February of this year you had produced a first pass report which summarised effectively the prudential and liquidity position and a whole range of other risk issues for all of the providers in residential age care; correct?

MR SMITH: That's correct.

MR BOLSTER: And that was based on the material that was lodged by the end of October 2019?

MR SMITH: Yes. That's correct.

MR BOLSTER: And there are about 35 or so providers who hadn't given you complete information? Correct?

MR MURRAY: Yes, there is always --- normally some follow-up on some providers.

MR BOLSTER: Is it your branch, Mr Murray, that carries out the first pass analysis?

MR MURRAY: It was until recently, until a few months ago it was.

MR BOLSTER: All right. Let's just talk about the last reporting period. And it was not until February of this year that the report of the first pass process was provided to the Quality and Safety Commission; is that right?

MR MURRAY: A complete report, yes. The normal process is if there are individual providers which we feel --- or the Commission are interested in as well, there would be ongoing communications back and forth between the Departments.

MR BOLSTER: All right. And that process would be similar to the sorts of processes that we've discussed, for example, in the Brisbane hearing where there is communication about providers of concern that is discussed at fortnightly or monthly meetings. Is that the case, Commissioner Anderson?

COMMISSIONER ANDERSON: Well, in fact there are a whole sequence of meetings, counsel. There are meetings which occur weekly at director level. We have fortnightly meetings, and then there are a couple of monthly meetings with different personnel.

MR BOLSTER: When does risk-related data from the documents that are filed by 31 October first start coming to the Commission to assist it in its regulatory role?

COMMISSIONER ANDERSON: Well, the first set data feed is in fact before the end of the calendar year 2019, obviously before these functions came to Commission. But routinely, when the third party data collected, to whom the data is submitted, does its quality review check, and if there are any omitting prudential statements, that is brought directly to our attention, and that is an early follow-up. If they trigger any additional criteria such as very low liquidity levels, that is also brought to our attention earlier, so we get an early feed from them, and that becomes something that we would move on more quickly. And then the first pass risk assessment comes, as you've observed, in February with the detailed risk assessment following that.

MR BOLSTER: Given that bifurcation, does that bifurcation stand in the way of effective regulation in the context of the prudential role that you have primarily,

Commissioner Anderson, but which seems to be extremely dependent upon what the Department does? Commissioner Anderson, what's your perspective on that?

COMMISSIONER ANDERSON: Counsel, we make it work. I believe the architecture is able to be operationalised and I think we've demonstrated that. But I am also of the view, which is already known to the Royal Commission, that my Advisory Council has, which is that the prudential functions would be better addressed if they were integrated into a single entity, and my Advisory Council's view would be that that would be the Commission.

MR BOLSTER: That is Mr Callaghan from the Aged Care Funding Authority, that's his view and he has given some evidence about that. And I was going to ask you each to comment on that. Do you share his view or is he wrong? Perhaps if I can read to you, he says that:

> *Responsibility for prudential regulation should be with the Department or a specialised agency and it should not be the same agency with responsibility for quality and safety.*

Mr Smith, do you have a view about that?

MR SMITH: My view is that, and I accept the position that prudential regulation could all sit in one organization. That was certainly under consideration when the Commission was established and the prudential functions moved from - the prudential compliance functions moved from the Department to the Commission. There was a question as to whether the prudential risk assessment that you referred to earlier would also move, and there were advantages and disadvantages to both options. So the Department, and indeed it's a proposition in this hearing that there be a single prudential regulator. We don't oppose that. As I say, there are reasons why we retained those functions in the Department in the first place, and that relates to the way in which the data - the Department also uses the data that comes in for prudential risk analysis to inform other policy work. So, no, I guess to summarise that, I don't disagree with Mr Callaghan. As I said, it was carefully considered and advantageous to both options.

MR BOLSTER: Thank you. Perhaps if we can turn then to the first pass analysis that was produced in February of this year. If we can bring up please Tab 123. It's an Excel spreadsheet. Yes. Now, I hope you can recognise this. All the relevant data has been stripped from this copy of the document. But this is the Excel spreadsheet that effectively embodies the first pass assessment from February of this year, and it's produced by the Commonwealth and it's dated 7 February 2020.

So, Mr Murray, that's roughly when you would have completed the first pass assessment; correct?

MR MURRAY: Yes.

MR BOLSTER: And effectively what this document is, is a list of every approved provider and how they rank one against the other on a scale of prudential performance. Correct, Mr Murray?

MR MURRAY: That's correct, yes.

MR BOLSTER: And you give each provider a score. It's a ratio, and I understand we can't go into how you come up with that score, that would reveal some commercial-in-confidence material so we won't do that, but you rank providers by reference to severity. You've severe, risk assessment, you've a high risk assessment, you've a moderate and you've a low risk assessment across all the providers. The document provided to us indicates that as of February 2020, allowing for 35 incomplete providers who hadn't provided all the documentation to enable the assessment to occur, there were roughly 110 providers who were severe in the severe category. Can you give us a sense of what a severe prudential risk means when you have a score above 3.63? Mr Murray, perhaps?

MR MURRAY: The scheme is designed to give a relative rating of each of the providers, and --- so we've rated them severe to high to moderate to low. Now, the intent of that, it does not necessarily mean that provider is breaching prudential standards or that they are necessarily going to fall over tomorrow, for example. But it does give you, when we look at our ratings, an indication that these providers have certainly missed areas which means they are more likely than others to potentially pose a risk in terms of prudential compliance. So we use those risk indicators which are at the top of your table there, we look at the net assets of the entity, whether they've been making losses, the net profit margin, cash, per place, liquidity, all these financial accounting ratios, to give you a feel for the risk for that particular provider. There are also some things directly targeted to the prudential standards themselves, such as how they've used those assets in accordance with the permitted uses requirements in the legislation. Effectively what this does is group the providers into a number of bands, but effectively the aim is just to work out which providers are more likely than others to potentially have some issues and hence would be the ones to focus any sort of regulatory resources on.

MR BOLSTER: Now, if we just turn to the prudential standard regarding liquidity, the liquidity standard, it involves or requires each provider to come up with a number which is an amount of money that they need to hold in order to meet their expected obligations to refund RAD in the ordinary course of business over the next 12 months; correct?

MR MURRAY: Correct.

MR BOLSTER: The first pass assessment doesn't set out, it doesn't seem, from my reading of it, correct me if I'm wrong, it doesn't seem to include each provider's own prudential standard. Is there a reason for that?

MR MURRAY: So the first part risk assessment is based on the information that

comes in to the ACSR financial return. It calculates these accounting ratios in an automated basis using that return. Now, there is then analysis can be further done. All those who are rated severe have a detailed risk assessment done of them. That involves having a greater look in detail at the financial assets and statements of the provider and through that basis that can further, I guess, analyse where those risks are actually higher than others.

MR BOLSTER: Wouldn't it be a prudent thing for the regulator to do, and I will open this up to any of you, to see how the provider measures against its own prudential standard that it is required to come up with under the prudential standards?

MR MURRAY: Part of the report is a compliance statement, a prudential compliance statement whereby the provider is required to attest to their compliance with the relevant prudential standards, and that's an audited statement as well.

MR BOLSTER: Do you look at that and do you measure their performance against their standard?

MR MURRAY: Well, they have to attest in an audited statement as to whether they've complied with the prudential standards. If there's an indication they have not, then yes, it would definitely be followed up as a potential breach of the standards. The other indicators we use in here is to try and use the financial information to, I guess, give a further picture of what the liquidity position is and analyse where there are risks, where a provider might have --- the liquidity ratios, for example, would give an indication that provider is more likely than others to perhaps be breaching their liquidity standard requirements.

MR BOLSTER: So when you carry out your first pass assessment, you apply an objective liquidity measure to see whether there is a risk; correct?

MR MURRAY: Yes, we look at the liquidity ratio which is a basis of assets over debts, and that then determines a weighting.

MR BOLSTER: You would be familiar with the fact that a number of the reviews say that there should be a specific objective liquidity ratio of around 15 per cent, that comes from StewartBrown, that should be in force for all providers; correct?

MR MURRAY: Yes. Yes.

MR BOLSTER: Doesn't it very much suggest that if you are simply rely on the fact that the provider has given you an audited version of their accounts, which says that they meet their prudential obligations, but you run off an objective liquidity ratio, doesn't it suggest that it really is a better use of the taxpayer's dollar to apply that objective standard in the first place?

MR MURRAY: Well, we support going forward that a liquidity standard would be an additional benefit to the system, and if that is then put in place, then of course that

would be easier to assess compliance at. At the moment, however, we can calculate a liquidity ratio ourselves, and that then builds into our risk assessment, and clearly providers who have a very low liquidity ratio would get a high risk rating.

MR BOLSTER: You would have to wait though until you get the accounts in October, do your analysis which you achieve by November, December, January, before you can figure out what the liquidity position was as of 30 June last year; correct?

MR MURRAY: Yes. There is a delay in the reporting. One of the projects we've been working on this year is involving us going out and doing proactive contact with high risk providers and at that point we get more up-to-date financial information. That's almost the first thing we do, to see what the currency of the current situation is.

MR BOLSTER: We will deal with this when we go through the propositions in turn, but wouldn't that suggest, given the time lag and given as we've all found out this year how quickly things can change, may I suggest to you it's too long to wait until February before you can rank everyone on their liquidity?

MR MURRAY: We would actually support ---

MR BOLSTER: An ongoing disclosure situation where there are significant changes that are reported?

MR MURRAY: Yes. Again, some of the recommendations coming out of the review are to go down that path and weep would support that path and support more regular reporting.

MR BOLSTER: All right. Now, we might have a look, given the time, Mr Barnier provided a report in February of this year at about the time this process came to an end. And if we can go please to his report which you will find at tab - sorry, if we can bring up, please, Tab 93. If we can go, please, to page 3504. I take it each of you is familiar with Mr Barnier's report?

MR SMITH: Yes.

COMMISSIONER ANDERSON: Yes.

MR BOLSTER: So he was reporting on 25 February of this year a third of providers were experiencing immediate or imminent financial stress based on data to the end of 30 June 2019; correct?

MR SMITH: Yes.

MR BOLSTER: That was consistent with the analysis you carried out when you looked at the first pass material, Mr Murray?

MR MURRAY: It's broadly consistent. Mr Barnier's hard work slightly refined some of the ratings, in effect, given some of the criteria had a slightly more focus on the immediate sort of cash issues as opposed to some of the broader prudential issues.

MR BOLSTER: And he identified, didn't he, that there were a number of providers who were experiencing immediate or imminent financial stress that required close scrutiny? Correct?

MR MURRAY: Yes. That was his conclusion, yes.

MR BOLSTER: If we go over to 3506 which is two pages along, you will be familiar with what he had to say about all of that, including the fact that there were 89 providers that he predicted would be in severe financial stress within two years. Did that come as any great surprise to the Department?

MR MURRAY: I mean, the Department is aware that the sector has been facing financial stress. That has always been the focus of the work we have been doing to date, and certainly the reason we engaged Mr Barnier to undertake this project, was to take another look at that and to understand what the quantum of those issues are. And that is why we have instigated the project to now go out and actually make proactive contact with the higher risk providers to get a better feel for their situation and, where appropriate, we can push them into other programs we have to help, such as the Business Advisory Service and Business Improvement Fund.

MR BOLSTER: All right. I won't take you to it because we don't have enough time, but Ansell Strategic did some advice work for the dealt throughout 2020 in relation to how COVID may have impacted upon this issue and particularly the repayment of RADs; correct?

MR SMITH: That's right.

MR BOLSTER: And perhaps I think we need to go briefly to the final report of Ansell Strategic at Tab 128. If that can be brought up. If we go to page 4 and to the boxes on that page. If we can bring out the first box, "Occupancy". So this was to the end of or close to the end of August, 23 August 2020, and there was a significant decline in occupancy across the country, but a more pronounced decline in occupancy in Victoria for reasons that will surprise no one. That figure of 89.04, Mr Smith, how unusual is that for residential occupancy in the State of Victoria?

MR SMITH: Sorry, I guess the first point I will make is that Mr Ansell was using a sample of providers. That's not the occupancy rate that applies to all of Victoria. Mr Ansell has provided excellent material to us throughout the course of 2020 as you suggested, and has been an excellent input to Government consideration about the issue on liquidity. Our analysis shows that the decline in occupancy has not been as sharp as he predicted it would be based on his sample. The examples indicate about

a percentage point difference in the actual decline in occupancy, so it's difficult for me to comment on that particular number. We could certainly give you, not right now, I would have to get it done, but an occupancy for Victoria.

MR BOLSTER: Do you then have a figure that's mates the sector exposure, if we go to the last box on page 5, which is really - let's cut to the chase, is the really big number that we need to focus on. His projections based on his sample, which is about a 7 or 8 per cent sample across the country, suggested that there was a net outflow of RADs of around 1.25 billion. Do you agree with that or do you suggest the figure is something else?

MR SMITH: Well, I don't have a number. My view is that number is overstated because of the sample group that was used by Ansell. The point is, I guess, that the occupancy rates - the actual occupancy rates are not declining at the rate as that particular sample group, so I can't give you a specific number, but we don't think it's as high as that.

I should stress, that's not to say we don't take it very seriously, but the fact there are outflows that may have impacts on particular providers, and we are engaged in a provider-to-provider piece of work to understand individual providers, especially relating to RAD outflows.

MR BOLSTER: The RAD outflow is likely to be a lagging indicator after the position on the ground owing to the need for formalities with the State, paperwork and all of that to happen. So it's quite possible, isn't it, that the worst of this outflow is yet to appear in the accounts of providers?

MR SMITH: It is correct, that's right. When a resident exits residential care, it can take some time for the RAD debt to then flow through to the provider.

MR BOLSTER: All right. Given Mr Barnier's warning back in February before COVID that 50 providers were likely to depart the scene in 2020, what's the current figure to the best of the Department's resources? What figure do you suggest?

MR SMITH: Well, Mr Barnier's figure of 50 related directly to his risk assessment that there would be, well, in the order of 50, 46 providers at extreme risk. Each of those providers have been directly contacted by the Department with the exception of three who are in sale or transition processes. So the Department is actively working with all of those providers to offer them supports that might be available through the Business Advisory Service or the Business Improvement Fund. So what --- I guess, to add to that, what we've done is extend that risk analysis to other providers that might be at risk, maybe not as extreme risk but we have a broader list of providers that we're actually going out and working with actively. That's what Mr Murray was referring to earlier.

MR BOLSTER: And to be fair there is a letter at Tab 110 which I won't bring up because we unfortunately don't have the time to do it, but which shows a whole range

of action by the Government in relation to this particular issue. You're familiar with that letter?

MR SMITH: I believe I know which letter you're referring to, yes.

MR BOLSTER: Yes. We may come back to it if we have an opportunity. But I would like to turn now to the prudential regulation propositions which have been circulated. I take it each of you is familiar with them?

COMMISSIONER ANDERSON: Yes.

MR SMITH: Yes.

MR MURRAY: Yes.

MR BOLSTER: Let's start with Proposition 3 which seems to flow naturally from the material that we have been discussing, and that is continuous reporting. Prudential, if we go to PR3 please, not FF3.

If the Operator could bring up PR3 which is on page 21 of the document. Proposition PR3. There we are. Thank you.

It's, can I suggest, consistent with Kate Carnell's recommendation 10 in the Earle Haven set of recommendations. Are you familiar with that, Mr Smith?

MR SMITH: Yes.

MR BOLSTER: And what is the Commonwealth's position about continuous disclosure?

MR SMITH: We support that proposition and the government has accepted all of the recommendations from the Kate Carnell report. The important words here are that, you know, material information, so obviously thinking about the burden of reporting but, yes, absolutely material information should be disclosed as soon as possible to the Department's regulator.

MR BOLSTER: Your joint statement back from March speaks in terms of changes that could address this issue of reporting frequency. Has the Commonwealth actually made a decision to introduce a continuous disclosure regime?

MR SMITH: Well, we support it, and it's part of the reform of prudential standards that's the vehicle through which we would deliver that.

MR BOLSTER: All right. But it hasn't been announced as a formal proposal yet?

MR SMITH: No.

MR MURRAY: Not to say --- not in this context. There is already a requirement for notification of issues which may affect a provider's ability to meet their obligations. So there is a broad obligation already in place.

MR BOLSTER: Commissioner Anderson, would a continuous reporting obligation assist you in your regulatory responsibilities?

COMMISSIONER ANDERSON: The short answer is yes, counsel. I am wary of asking for or receiving information which we would not use. So as my colleagues have said, it would need to be carefully defined as to what would warrant disclosure, and I'm also conscious, in the narrative around this, that would be a duty in relation to the accessorial liability, so we would be clear of the grounds on which disclosure was required, and then what that looked like as a failure.

MR BOLSTER: The StewartBrown proposition that mirrors our Proposition 3 involves a more detailed set of indicia or criteria for reporting. Does the Government support those matters, Mr Smith?

MR SMITH: Look, I'm sorry, I don't actually have that in front of me, Counsel. Sorry, Mr Murray?

MR MURRAY: No. I haven't got those in front of me either. I mean, we do support the general proposition of PR3, and I think the question to be resolved is what is that level of materiality, and how would that actually operate in practice, and that is something I think we would need to work through.

MR BOLSTER: All right. Then flowing on from that, if you have a form of continuous disclosure that picks up problems in liquidity and a range of other markers that might be agreed would be significant or of assistance when it comes to regulation, that may remove some of the pressure when it comes to updating the reporting requirements. But what is your view about the prudential regulation - Prudential Proposition 1, or a form of bespoke aged care reporting regime where the prudential regulator determines what it is that needs to be reported?

MR MURRAY: I think in principle we would support that requirement and support getting better and more regular financial reporting.

MR BOLSTER: Commissioner Anderson, is the fact that you have to wade through three sets of reports, a prudential report, a general purpose report and an aged care financial statement, does that make it more difficult for you to carry out your responsibilities?

COMMISSIONER ANDERSON: Well, we do tend to focus on the prudential compliance statement. But in relation to Proposition 1, I think that the principle of the prudential regulator specifying the required information and having the evidence base, that the information being sought actually is material, is a sound one.

MR BOLSTER: Thank you. We can turn then to Proposition 2 and that's about information gathering.

Commissioner Anderson, I might start with you. How significant is it that you can't demand a provider to allow you to inspect and take away documents that you may want to have access to for purely legitimate regulatory reasons?

COMMISSIONER ANDERSON: Our certain powers do allow us to go on to premises but as you probably are aware, Counsel, it is conditional on the consent of the provider. It's rare, in my understanding, that a provider would deny consent, and we have means of requiring information to be provided by a provider through notices that we serve. So present on the site is not the only way that we use information about that provider.

MR BOLSTER: But are you hamstrung by the current provisions that enable a provider to deny you access?

COMMISSIONER ANDERSON: Not that I'm aware of, counsel.

MR BOLSTER: What do you say then about Proposition 2?

COMMISSIONER ANDERSON: I understand what you're reaching for, and I think judiciously used it would serve a useful purpose.

MR BOLSTER: What is the Department's view, Mr Smith?

MR SMITH: I would agree with Commissioner Anderson in relation to that. The Department's experience, when it has been on its outreach program with providers at risk, have found the providers generally are very willing to, you know, have us in and show us the information we need to be able to make those more detailed assessments about viability, but again used appropriately and having that power could be a useful thing.

MR BOLSTER: Commissioner Anderson, are you familiar with a problem that arose in South Australia in the coming text of the NDIA where a provider simply refused access?

COMMISSIONER ANDERSON: No, I am not.

MR BOLSTER: If we can perhaps bring up tab 104 and go to paragraph 10, please. Paragraph 10, please.

And, Mr Smith, you would be familiar with this. We are dealing now with the liquidity proposition. You would be familiar with this statement from the Department on 2 September in which you updated where the Department was at when it came to a formal liquidity requirement?

MR SMITH: Yes. I'm familiar with the statement, yes.

MR BOLSTER: So you're working on a new methodology, I understand it?

MR SMITH: That's correct.

MR BOLSTER: And will that methodology involve a formal ratio such as what StewartBrown has recommended?

MR SMITH: My understanding, and I really will have to defer to Mr Murray for detail, is that that would still be a matter for a reform set of prudential standards.

MR BOLSTER: Mr Murray? Our proposition says the regulatory, the prudential regulator should be able to determine what a liquidity standard is. StewartBrown say that a rate of --- an objective but clearly defined rate of 15 per cent should be imposed. What's the direction the Commonwealth is moving towards?

MR MURRAY: We support the general principle, having now prescribed the liquidity level. I think it will be appropriate for the regulator to have some discretion perhaps over that to adjust to particular circumstances, but we support the general principle.

MR BOLSTER: Well, I think we will come to the flexibility when we come to proposition PR7. But I think you've answered my question about PR5. I think Kate Carnell made a Recommendation Number 6 on the same issue. Is there anything that flows from that that we need to know about, Mr Murray?

MR MURRAY: Sorry, which recommendation of Carnell?

MR BOLSTER: If you go to the joint statement at Tab 116 and page 3578 you will see Ms Carnell recommended specific liquidity and capital requirements, amongst a number of things.

MR MURRAY: Yes. Those are the requirements still under consideration in the context of the prudential review, and I guess we note that the propositions put forward by counsel broadly support those. As does the Department.

MR BOLSTER: Capital adequacy is a slightly different issue. From the Commonwealth perspective, what is the material difference between liquidity, a liquidity ratio and capital adequacy? Mr Smith?

MR SMITH: I'm sorry, I'll defer to Mr Murray for that.

MR MURRAY: So the liquidity ratio is obviously very much about the short-term ability of the provider to meet its liabilities, so it has a more immediate, I guess, focus. The capital adequacy requirements are generally more about the long-term sustainability of the provider. They provide, in effect, an extra buffer in terms of if

the provider was to have a series of loss-making years, for example, but they have a buffer to sort of deal with that. So both are important. The StewartBrown report had noted in their view that liquidity is probably the primary one to focus on in terms of viability issues for the sector, but the potential for capital adequacy requirements could add some further strength, I guess, more to the soundness of providers.

MR BOLSTER: In fairness to StewartBrown, their position was that if you increased the level of reporting so that you had a much better idea of what was happening at any given time, then you wouldn't need a capital adequacy. Does that proposition find favour with you or not?

MR MURRAY: I certainly understand the proposition and where it's coming from. The liquidity ratio, I think, would be the primary thing to bring in. The capital adequacy requirement probably is something that possibly needs a bit more further reflection. We already take into net asset requirements in our risk ratings, for example, so it's already something we consider. And I guess the question is whether there will be benefit, great benefit from expanding that to perhaps some prescriptive ratio which again, taking in the capital adequacy requirements, would have to vary between different providers.

MR BOLSTER: Commissioner Anderson, as the regulator, do either criteria assist you when it comes to working with providers to come back into compliance? Which do you pay most attention to, the liquidity ratio or capital adequacy ratio?

COMMISSIONER ANDERSON: The liquidity ratio is nested within the prudential standards as part of, you know, the way we would assess compliance with those standards. We do look at adequacy levels, and particularly in the context of a good liquidity management strategy, that each provider is required to produce if they are managing RAD. So --- and we do find from time to time that are low liquidity levels, and indeed there are also self-disclosed breaches of that particular requirement where a provider has not anticipated the number of RADs that would need to be refunded in a particular period and has run short of cash.

When we engage with providers, we often find that they can self-correct quite quickly by extending a line of credit, or in some other way ensuring they can cover that short run difficulty.

MR BOLSTER: I guess my question is this. Which is the most useful thing for the regulator, for you as the regulator, to work with in your operational work?

COMMISSIONER ANDERSON: I will offer you a view rather than evidence-based conclusions, Counsel. My view is that the liquidity ratio is the more valuable of the two.

MR BOLSTER: All right. And why is that?

COMMISSIONER ANDERSON: Because it goes to performance against the

financial obligation that the RAD present. It's not to say that the other is inconsequential, however, and I wouldn't want to suggest that capital adequacy is irrelevant.

MR BOLSTER: Yes. If we could then turn to Proposition 7, which is about the style, "Tools for enforcing the prudential regulations", I think this gets to the proposition that the regulator needs to have flexibility to impose particular obligations on providers once a risk is identified.

What's your view about that approach as reflected in proposition PR7, Mr Smith?

MR SMITH: Look, broadly, we would support that, that the regulator would need the appropriate tools and appropriate kind of range of different response options to be able to effectively manage prudential requirements and oversee prudential requirements.

MR BOLSTER: And Commissioner Anderson, would that proposition assist you?

COMMISSIONER ANDERSON: Yes. I suspect this is the regulator's equivalent of trainspotting. I can appreciate the elements of your list. But if I may, Counsel, and briefly, I think there's a bit missing. The heading is "enforcement", but nowhere in your proposition did you give weight to education, guidance and encouragement of best practice. And I do think - I just wanted to draw that to your attention because I really believe that we do some of our best work, in fact regulators internationally do some of their best work, in raising awareness of what the regulations are, and through behavioural insights activities, nudging providers towards compliance without needing to wield more heavy duty reference that are present in your list.

MR BOLSTER: And I think, to be fair to you, you set out a lot of those steps that you take in the joint statement. Correct me if I'm wrong but I'm sure I read them there.

COMMISSIONER ANDERSON: That's right, Counsel. We do talk about the educational prudential reviews that we undertake, and also our intention to mount a suited campaign.

MR BOLSTER: Thank you very much for that. That moves us along to outsourcing which is sort of the odd one out here but it flows from what happened at Earle Haven and what we investigated in Brisbane last year. The recommendation mirrors Recommendations 13, 14 and 15 of Ms Carnell which can be found at Tab 116, page 3581, which I think for the benefit of those in Canberra is page 32 of their document.

And, Mr Smith, you record that there was implementation at least in March 2020 to give effect to those three recommendations which seem to flow from and mirror our recommendations. Do you agree with that?

MR SMITH: Yes, I agree.

MR BOLSTER: What's happened since March?

MR SMITH: So, look, there have been changes made to, I believe it's the material notification form which requires providers to advise if there has been a change in, particularly in subcontracting arrangements and to clarify that requirement in particular. That has been the main sort of implementation piece so far. The other elements would require legislative change, and I know that planning is underway in relation to that.

MR BOLSTER: All right.

Commissioner Anderson, how common is outsourcing in your experience? I mean, is this a response just to a one-off in Earle Haven or was it something we are going to see more of or that you see more of?

COMMISSIONER ANDERSON: I'm not sure I can make an observation about a trend, Counsel. It does happen. But it happens to different extents as well. There are some subcontract arrangements where an element of residential care offer is provided by another party as in other circumstances --- I'm not sure with Earle Haven, the entirety of the service is --- the management of that service is outsourced. In my understanding, the matter is less often the case.

MR BOLSTER: I don't think we're talking about bringing in contract physiotherapists or bringing in contract allied health, but I would be interested to explore the boundaries with you.

If you bring in a labour hire management team that is separately - completely separate as a corporate entity from the approved provider where there are no links of a corporate nature between the two entities, surely this would apply to that sort of situation or should apply to that sort of situation?

COMMISSIONER ANDERSON: I can consider that there are specific risks which would potentially attach to that arrangement. Each circumstance would have to be considered on its own conditions but I think the general point you're making counsel, is well made. And I think those matters should be more carefully considered for their potential risk.

MR BOLSTER: Mr Smith, what's the sort of boundary that the department has in mind from a policy perspective of this sort of provision?

MR SMITH: Well - I mean, I think Ms Anderson's point is also well made about there are different circumstances that apply. I would say that it relates to this sort of outsourcing, I suppose, or subcontracting of care arrangements. Where you draw the line on that is more difficult to determine, but that's how I would see it.

MR BOLSTER: And finally, if we turn to proposition PR8, and that's building the

capability of the regulator, Commissioner Anderson, we discussed this briefly earlier. Is there anything you wish to add in the context of the form of this particular recommendation about what you need or what any prudential regulator going forward needs to deal with the sorts of issues we've been discussing today?

COMMISSIONER ANDERSON: Engaging with the propositions in totality, counsel, there are threaded through them, I think on at least three occasions, references to concerns about quality and safety of care. And then in Proposition 8, we see in (b) this reference to building a risk profile of aged care providers. The question which came to my mind, if the prudential regulator is to be separate from the quality and safety regulator then there would need to be far greater clarity about the way in which those two entities would work together in order that they didn't cross each other unhelpfully, and that they weren't doing each other's work with inadequate information available to them to draw conclusions. Their remit, if they are distinct, would need to cross-refer in a very constructive way, and so building a risk profile, if that risk profile were to be entirely separate from the risk profile which is available as being further developed for the Commission I lead, I think would introduce more problems than it solves.

MR BOLSTER: Mr Smith, what is the Commonwealth's perspective about PR8?

MR SMITH: We would in principle support that, but support what Ms Anderson said, and the reference to risk profile is an important one, the Department has its own responsibilities which are outside of the prudential compliance framework relating to provider viability, risk assessment, so that we do --- that would have a lot of relevance to prudential compliance arrangements. So the communication and the way in which the different tools are shared or accessible by all parties is important, but the fundamental principle of increasing capacity, having the right skill sets available to undertake risk assessments and to undertake audits and financial analysis is very important, it's something the Department is focused on and is continuing to be.

MR BOLSTER: Yes, thank you very much.

Those are my questions, Commissioners.

COMMISSIONER PAGONE: Thank you, Mr Bolster. Thank you to each of you. I can now formally excuse you from further attendance and want to thank each of you. It has been a long day for Mr Murray, but you've borne up very well. Thank you for the time you've given to this. I know it's time consuming, both in preparing for the matter, the background work that you've done, being on top of all the figures and details. We're very grateful for the assistance you've given us in considering these matters, so thank you very much indeed.

THE WITNESSES WITHDREW

COMMISSIONER PAGONE: Mr Gray.

MR GRAY QC: I will call our last witness for the week. I call Campbell George Ansell.

MR CAMPBELL GEORGE ANSELL, AFFIRMED

EXAMINATION-IN-CHIEF BY MR GRAY QC

MR GRAY QC: Mr Ansell, is your full name Campbell George Ansell?

MR ANSELL: Yes, it is.

MR GRAY QC: Have you prepared a witness statement for the Royal Commission, I'll ask that it be displayed, WIT.1382.0001.0001, dated 7 September 2020, and is that a copy of it? And do you recognise that as being a copy of it?

MR ANSELL: Yes, I do.

MR GRAY QC: It's accompanied by two exhibits, CGA-1 and 2 at Tabs 95 and 96 of the bundle respectively.

Mr Ansell, to the best of your knowledge and belief are the contents of the statement true and correct, and to the extent that you express some opinions in there about certain issues concerning refundable accommodation deposits, are those opinions sincerely held by you?

MR ANSELL: Yes, they are.

MR GRAY QC: Yes. I tender the statement.

COMMISSIONER PAGONE: Yes, the statement of Mr Ansell will be Exhibit 21-13.

EXHIBIT 21-13 - STATEMENT OF CAMPBELL GEORGE ANSELL

MR GRAY QC: Thank you.

Mr Ansell, in your statement you refer to your qualification and your experience, you are a chartered accountant, you are also a real estate and business agents licence holder, and you have various other qualifications and roles. You are the Director ---

or the Managing Director, I should say, Mr Ansell, of Ansell Strategic since 2013, and prior to that you were at Grant Thornton, were you?

MR ANSELL: Yes, that's correct.

MR GRAY QC: And, Mr Ansell, you worked in aged care and retirement living industries for over 25 years, and you have very broad international experience in relation to financial and operational analysis of aged care services. You've led major studies, you've advised Government and industry on matters of policy, financial viability and sustainability. I want to ask you just briefly also about your experience in relation to bank financing of aged care. You make a point about, this is later in your statement at 22, about a connection between lending for capital projects in aged care and in Australia, the use of refundable accommodation deposits. Can you just explain to the Commissioners what's the connection there and what bank lending practices has that led to in Australia?

MR ANSELL: Certainly, Mr Gray. So RADs have a --- resident deposits have an important role in the development of new homes. The major banks are accustomed to providing finance and support for providers as they build new nursing homes, and generally speaking as residents are admitted to the new homes once they're commissioned, they will provide refundable accommodation deposits to the providers, and the banks generally expect to have most of their development funding repaid through those deposits. That's the normal process through which the majority of nursing homes are built.

MR GRAY QC: And has that tended to lead to shorter term lending arrangements than might otherwise be the case?

MR ANSELL: Yes, it does. The majority of the property assets of the industry are funded by refundable accommodation deposits and bank lending sits at around about $2.5 billion, a relatively small portion of the total funding.

MR GRAY QC: You mention at paragraph 22 of your statement that the repayment horizon is somewhat a shorter repayment horizon, turnaround five years than might be the case elsewhere because of this feature of the Australian aged care financing landscape?

MR ANSELL: Yes, so it takes quite a while to go through the planning and execution of a development of a nursing home. Then there is a period of time of ramp-up where the places are advertised and residents will come in over time. That might take, depending on whether or not it's a redevelopment of an existing service but generally speaking that might take anywhere from six months to two years for the home to fill. And during that process, a proportion of residents will pay deposits. That goes down against the borrowings that were forwarded by the banks, and in that way the banks' lending horizons tend to be relatively short for the development debt.

MR GRAY QC: By comparison with perhaps other jurisdictions, a little bit more

pressure on a provider which will have to meet that repayment obligation in a somewhat shorter horizon than might be the case else where around the world; is that what you are saying?

MR ANSELL: That is my experience. To my knowledge, RADs don't exist elsewhere.

MR GRAY QC: Mr Ansell, in a previous session, reports that you have made at the Department of Health were mentioned and RADs have been explained to the Commissioners so I won't ask you to give an explanation of the function of RADs in general, but I will just go to some important points you make in your statement and which you've made in some reports including, I think, the ones that have been mentioned in the previous session that you provided to the Department of Health?

It's the case, isn't it, that you're estimating at present that the aggregate RAD balance in the sector is up above $30 billion?

MR ANSELL: That is my understanding.

MR GRAY QC: And the proposition that you've been concerned about during the course of this year starting in about March because of the COVID crisis is, in broad terms, what, Mr Ansell? What has been concerning you?

MR ANSELL: Prior to COVID we had been concerned that there was a migration away from lump sum deposits towards periodic payments, DAPs.

MR GRAY QC: I will ask paragraph 17 of your statement be brought up while you're talking and we can ask the Operator to track through these points as you address them. Thanks.

MR ANSELL: Sure.

So we had been concerned that there was a migration away from residents electing to pay lump-sum deposits, RADS, in favour of periodic payments, DAPS. And we were concerned that this, over time, could place strain on the liquidity of the sector particularly given that a lot of the RADs were invested in bricks and mortar, the nursing homes themselves, and not a huge amount was necessarily held in cash. We then became more concerned that the onset of COVID might result in people finding it difficult to pay lump sums, difficult to sell their homes, or that they might be unwilling to divest or to liquidate their assets in the middle of a pandemic.

And so our concern was that it would increase the movement away from lump-sum deposits in favour of periodic payments, and at the beginning of the process that was the main area that concerned us, that we might end up in a situation there might be a cash flow crisis while they were trying to deal with the infection.

MR GRAY QC: And what did you do about it? Have you conducted analysis by

reference to a sample of providers?

MR ANSELL: Yes, so we made clear to the Federal Government what our concerns were. We had liaised with our counterparts in London to be able to get an understanding of the impact of resident admissions and departures and then we engaged with providers, a group of for profit and not-for-profit providers, around the country trying to cover all States and Territories. And across 16,000 places we analysed every fortnight the amount of people that were coming in and electing to pay either a RAD or a DAP compared to resident discharges and the fee payment of RADs and then we tracked that over the period up until this month.

MR GRAY QC: Thank you.

And, indeed, you've kindly or very helpfully produced a very up-to-date report right up to, I believe, almost the end of August. I think the data is up-to-date up to 23 August, very recently, even since you submitted your witness statement to the Royal Commission. Should we go to that now? It's at tab 128. And it was mentioned actually, Mr Ansell, in the previous session.

Could you just explain to the Commissioners a point that was raised about a reference here to the occupancy rate. This is the occupancy rate across the sample, is it? I'm looking now at page 4 of the report, 0004 under "key findings" in the box alongside occupancy, a reference to a 91.66 per cent occupancy level as at 23 August 2020 for the entire sample. That's substantially above the average sector occupancy level for residential aged care across the country, isn't it?

MR ANSELL: It is. And part of dealing with an imperfect sample is that we had just under 10 per cent of the sector represented within the group that we were using as a sample. And the starting point, the occupancy among that sample at the starting point, was higher than the industry averages. So they didn't mirror exactly what the remainder of the sector was. And so this was about determining a relativity given where they were at the beginning of the process, what was the impact on COVID, both on their occupancy and also on their RAD/DAP elections.

MR GRAY QC: Thank you. And you've also done a segmented analysis of just Victoria and you've plotted that against the entire sample on a graph on page 0006, haven't you?

MR ANSELL: Yes.

MR GRAY QC: From 22 March to 23 August. Just to pick up the point you first made that the starting occupancy rate was substantially above the industry average, if we go to the far left side of the graph as at about 2 March, we see there, don't we, a figure that is just a shade below 94 per cent occupancy which is what, some 5 per cent higher than the industry average?

MR ANSELL: Yes, that's right. ACFA reported the occupancy closer to 90 per cent

at the end of January 2019.

MR GRAY QC: Around 4 per cent higher and across the entire sample that's the solid line, isn't it?

MR ANSELL: That's right.

MR GRAY QC: There has been a decline to a point at around 11 May, then a pick-up, and then a slight decline again after a peak in about July to the point whereas of 17 August, or near the end of August, the occupancy across the sample is back more or less to the dip that it was in on around 11 May. Is that a fair interpretation of occupancy across the sample?

MR ANSELL: That's correct, Mr Gray.

MR GRAY QC: And what's happening in Victoria, Mr Ansell?

MR ANSELL: So the graph on the screen demonstrates the impact of the heavy lock downs experienced in Victoria at the moment. And, as you can see, difficulty in being able to admit residents has resulted in discharges at normal rates without them being replaced at that normal business practice.

MR GRAY QC: So, firstly, is Victoria plotted with the broken line and overlaid on top of the whole of sample average, and we start with Victoria in fact having a healthier occupancy rate than the sample average, up around 96 - well, between 95 and 96 per cent on 2 March? Am I interpreting the graph correctly?

MR ANSELL: Yes, that's correct.

MR GRAY QC: And getting down very substantially by comparison with the whole of sample average of around the 89 per cent mark by late August. Is that right?

MR ANSELL: That's correct.

MR GRAY QC: And can you explain what connection these data might have, assuming that they're broadly representative of circumstances in Victoria, for the liquidity position of providers in Victoria?

MR ANSELL: Yes. So there's two critical elements. The occupancy one is the one that is relatively obvious from the graph that you have on at the moment, and so at the moment what you can see that from the beginning of our analysis from 2 March we've gone from just under 96 per cent to around about 89 per cent. So every resident that is discharged is not being replaced and that has an obvious cash flow consequence if you're having to repay a lump sum and someone doesn't come in to pay a new lump sum. That's a direct outgoing.

What's not as obvious or not showing on that graph is for the people that are coming

in to the homes, not just in Victoria but around the country, the majority of them are not electing to pay a lump sum.

MR GRAY QC: Shall we go now to some other graphs in the report at page 0008. Would graph 4 be an appropriate place to start?

MR ANSELL: Sure.

MR GRAY QC: Operator, please go to graph 4 on page 0008. Please continue, Mr Ansell.

MR ANSELL: So you can see from graph 4 that the average RADs on a weekly basis that are being required to be repaid, they are RAD-paying residents discharged in the orange line at the top. And the number of ingoing RADs are on the blue line. You can see that gap then becomes the cash, the difference in cash payments and cash receipts that will need to be addressed in the coming months. The sharpest is at the end of the first lockdown which is indicated by the broken vertical lines and then the next one you can see coming as Victoria goes into lockdown.

MR GRAY QC: And just to be clear, are we dealing here with a graph that is across the entire sample nationwide or is this a Victorian segment?

MR ANSELL: This one is the entire sample.

MR GRAY QC: Okay. So we could expect that for Victoria what, the disparity between the orange line and the equivalent of the black line would be even greater?

MR ANSELL: Yes, that's right.

COMMISSIONER BRIGGS: And can I just confirm that the horizontal - no, the vertical axis is in billions of dollars?

MR ANSELL: They are number of RAD-paying residents being discharged.

COMMISSIONER BRIGGS: Thank you. Thank you.

MR GRAY QC: And is that a number per provider?

MR ANSELL: That's the entire sample on a weekly basis.

MR GRAY QC: That's the entire sample. Thank you. It's a fairly small sample but it tells us something. Is that a fair reflection of these data?

MR ANSELL: It's just under 10 per cent of the sector.

MR GRAY QC: Okay. In what period is that? So the orange line is just below 35 so 34 or so residents per what period?

MR ANSELL: So every week on average 35 residents that have paid a RAD are being discharged. And that's the orange line so that's an average across the period. And then the actual amount of RAD-paying residents that are coming in are on the dark line below. So the gap between the orange line and the red line is basically telling us the number of RAD-paying residents that we're a shortfall of.

MR GRAY QC: Per week?

MR ANSELL: Per week.

MR GRAY QC: Thank you. And can I ask you to explain a graph on 0009, graph 6, proportion of ingoing and outgoing RADs 2 March to 23 August. What this graph is depicting is, in effect, that disparity between the two lines on the other graph depicted as bars; is that a correct interpretation?

MR ANSELL: Exactly. It's all a percentage. So the proportion of residents that are departing are in the orange and residents that are coming in and paying a RAD are in the dark colour in the black.

MR GRAY QC: Yes. Now, I imagine that this is a very difficult thing to try to determine because what, the liquidity of a particular provider will differ from the liquidity position of another provider. Have you had any basis to try to perform an analysis of to what extent this disparity in replenishment rate of RADs is going to impact the liquidity position of providers or is that just impossible to tell because you would need to know too much about the circumstance of individual providers?

MR ANSELL: Yes, it is true it is impossible to tell for individual providers but on a macro level we know that the level of cash that's held by the entire sector is somewhat limited. The majority of the funding from the ingoing RADs is invested in bricks and mortar and so an outflow of approximately $2.6 billion is material to the cash holding of the sector.

MR GRAY QC: You mentioned earlier in your evidence and in more detail in your statement in the passage we took you to that there were in any event some structural issues that were causing you concern about RADs, namely the behavioral trending favour of choosing daily accommodation payments rather than RADs. Also the connection with property prices and in a falling property market perhaps a downward pressure on the replenishment rate of RADs and now we have COVID. What are your conclusions about the combined effect of these things? Is the current climate merely revealing structural flaws that were present all along and where is this all going to lead?

MR ANSELL: Yes, I think it's revealing structural problems with the deposit model that were going to take time and possibly in normal circumstances could be managed better. I think what is happening with COVID is accelerating those realities and a combination of more people wanting to pay out a periodic payment rather than a

lump sum, plus any deteriorating property results from COVID is going to end a really low maximum permissible interest rate is most likely going to drive heavy liquidity strains over the coming months.

MR GRAY QC: And that maximum permissible interest rate you just referred to is the conversion rates between RADs and DAPs, it's linked to a 90-day bill for a bank, interbank lendings is it?

MR ANSELL: That's right. And so it's linked to interest rates. So in periods of very low interest like now, the MPIR comes down to a very low number and becomes affordable for people, particularly if, you know, people are concerned about liquidating assets in the current environment.

MR GRAY QC: So that's yet another factor contributing to this confluence of events that's, what, causing you concern that the replenishment rate for RADs will further deteriorate?

MR ANSELL: That's right.

MR GRAY QC: All right. And do you have any solutions? It seems that you've got a short-term suggestion or solution, perhaps not a solution, but a measure that you recommend be taken and that's essentially something you've directed to the Department of Health, is it, and you've got a longer term proposal which might be difficult to work through but nevertheless deter are serves serious consideration. Could you explain to the Commissioners those two proposals?

MR ANSELL: Yeah. The immediate proposal that we recommended back in March still holds. We don't think it's advisable just to keep a watching brief on this, waiting for providers to reach an insolvency point before they ask for help. The critical element of this and was at the beginning of all of this is that if a provider is finding it difficult to repay RADs, they're probably also finding it difficult to make payroll and this is not a time for us to be confronted with nursing home closure.

And so our recommendation is that the Commonwealth make available a facility that enables resident families to be repaid their refundable accommodation deposits and not causing the insolvency strain or liquidity strain on the providers that are unable to meet them themselves and that they promote the availability of that. That's our major recommendation.

MR GRAY QC: Just before you go to the longer term one, on that major recommendation, can I tell you something and then ask you something. The Secretary of the department told the Commissioners in a session earlier today that the department is monitoring the situation and providers of concern, and it may not have been the Secretary, it might have been other members of the panel. There wasn't any mention of a facility of that kind. I suppose on their behalves I should make the point and ask you - well, they say they're monitoring the situation. It wasn't entirely clear exactly what form of information they're obtaining and how regularly they're

obtaining from the sector more generally. They might be in touch with particular providers by the sounds of it. Is that sufficient?

MR ANSELL: My understanding is they've been very active on the monitoring side of things. In my opinion it's not sufficient. The financial information that they have available to them, the latest is 30 June 2019 which, in my view, there is little relevance on the events that we're witnessing at the moment. They also do have access to information about providers of concern. But the most important information is the information that you have on the screen here, and that is that we are going through an event where a decline in occupancy and any transition away from lump sum deposits is creating pressure on organisations that may not have been on the watch list in the first instance. So I don't think it's adequate.

MR GRAY QC: You've made a point - this is in your statement - about the cash flow impacts of this deterioration in replenishment rate occurring some four to six months after the departure of the resident in question and the deterioration of the versions of incoming RADs to replace the RAD that has left the relevant facility or the relevant provider. And can I ask you, what's your concern about the fact that there is this lag between, in effect, the accrual of the liability and the cash flow effect of that, especially when one considers the obligations in the Corporations Act, for example, not to trade while insolvent? Can you explain why it is that it's important to have a proactive measure in place, in your opinion?

MR ANSELL: Yeah. Because, as you mentioned then, there's a deferral in the election to pay a RAD or a DAP and the time to actually pay the money and the time to pay the estate of the resident discharged. So that lag is, depending on the circumstances, can be three to six months. On the other side the incoming resident has a period of time with which they are able to liquidate their assets and find the funding and so that also takes a period of time. And so the events that we have on the screen at the moment will not take place until some time in the future. The actual cash flow impacts of the first lockdown are starting to hit us in August and September. But much deeper impacts from the current lockdown will hit us before Christmas.

MR GRAY QC: And, finally, what's that longer term potential solution? How might that be approached? I know it's carefully and very cautiously expressed in your statement but what needs to be done here in order to - -

MR ANSELL: I think one of the most important things, there is two critical elements from our perspective. Part of it covered in some of the Royal Commission's propositions but part of it is around encouraging people to build again. So we had a huge amount of enthusiasm for investment in new nursing homes up until the 2016 budget cuts and that has started to stop. If we were to accept that refundable accommodation deposits are not going to be the major instrument in the future then the model for the DAPs or an alternative annuity needs to work.

Part of the reason that it's hard to make it work at the moment is because it's based on

the MPIR, as we discussed earlier, which just goes up and down all the time. It's very difficult to make a decision about an investment in property even if you are an independent party looking at a passive investment, if that rent is going to be going up and down all the time. So having an annuity number based on a reasonable amount, perhaps reflecting the weighted average cost of capital for provision of aged care services or for the delivery of services in a nursing home, is possibly the first step. And most in the rest of the world, a lot of nursing homes are built through grid state investment trusts where the owner of the property is not necessarily the operator.

The second component of that then to make it work is that you can't keep having a situation, as we have in Australia, where the cost of care is exceeding the amount of support subsidies either through residents or through the government to meet those costs. Because what happens is if the provider is unable to maintain a surplus or break even, they will eat into the accommodation revenues. And so the two key elements will be that.

The most difficult thing is that a very delicate transition program where we have over $30 billion worth of residents' deposits, they need to be preserved and the transition arrangements need to be managed in a way that we don't have people lose confidence in paying lump sums while we move to the new model,

MR GRAY QC: Thanks, Mr Ansell. Commissioners, I have no further questions.

COMMISSIONER PAGONE: Mr Ansell, I just want to ask you, if I may, about proposition PR3. If it might be put on the screen if you don't have it there.

MR GRAY QC: Tab 111.

COMMISSIONER PAGONE: I was beginning to think about the terms of this in the last session but some of the evidence you gave made me think of it a little bit more. With (a), just put to one side potential drafting questions and difficulties that (a) may have because it talks about requiring disclosure when becoming aware of material information that affects something and "affects" might have about it an ambiguity that on reflection might be undesirable.

But just assuming that what it means is that you've got to notify the regulator when you become aware that you're unable to pay your debts as and when they become due, which I presume on any view that however you construe "affects", it will probably require you to do that. I'm just wondering what your view is about the trigger point that should be identified for when the provider should be notifying the regulator about that kind of thing? Is that too vague for you?

MR ANSELL: No. I think I understand the question, Commissioner. One of the things that has become quite apparent during this process is that a number of providers don't monitor the changing elections of people that are coming into the homes. A lot of providers tend to monitor their cash flows from a combination of deposits and periodic payments. And so one of the concerns we have is that many

providers may not be aware that there is a cash flow implication that's coming to them shortly.

It is very difficult for them to be able to control or to determine the timing at which the changes in RAD and DAP elections is going to hit their bank account. And so I think the evaluation from a director's perspective as to the point at which they had to raise a flag that they have concerns has to be done both on an operational perspective that they are incurring continuing deficits as well as from a capital perspective that the level inflows from refundable accommodation deposits of outflows are not being met - that the outflows are not being met by inflows. So I think there's probably two components to PR3(a).

COMMISSIONER PAGONE: Thank you. I'm going to put my question again in a slightly different way if you don't mind. It may be you've given me the answer that I need. But if I just refocus the question we'll see what comes up. As the proposal currently stands, that is PR3(a), it might be said that disclosure at the point currently identified is just too late because by that stage you're broke, you should stop trading full stop. Now, the question, I suppose, is what should be the trigger point before it gets to that stage? May I try that one more way? When would you like to be told before it gets to that stage?

MR ANSELL: For a provider that's able to accurately project their financial position, then being aware of an event, you know, over six months time would help enable support, I think. It is difficult to do that. But if you have visibility over your capital flows from resident accommodation payments as well as you're operating deficits, then I think that would put you in a position to be able to raise concerns. Not all providers, as in any business, will have the capacity to be able to provide that much notice.

COMMISSIONER PAGONE: So a well-run business with the capacity to do this would ordinarily have projections. They would have accounts and budgets and they ought, in many cases, have the ability to work out in advance whether they don't have a problem today but if things continue going the way they do, they will have a problem in six months time. Is it your experience that most of the providers that you looked at have that kind of capability?

MR ANSELL: Yes, I believe most would do it in ordinary business circumstances.

COMMISSIONER PAGONE: All right. I wonder whether I might ask, and this as a request not as an obligation for you, if you might think about how you might craft an alternative to (a) that would produce something meaningful ahead of time before its too late?

MR ANSELL: I would be happy to do that, Commissioner.

COMMISSIONER PAGONE: Thank you. Anything, Mr Gray?

MR GRAY QC: No. Thank you very much, Mr Ansell.

COMMISSIONER PAGONE: Mr Ansell, we thank you. I know that I'm thanking everybody and everybody might think they're getting the standard response without meaning it. But we do on every occasion and for you as well, the time and effort that you've put into this has been of great help to us and your evidence this afternoon, I must say, has been helpful also. So we do thank you. And I'm pleased to be able to formally excuse you from further attendance.

MR ANSELL: Thank Commissioners, counsel.

MR GRAY QC: Thank you, Mr Ansell.

THE WITNESS WITHDREW

COMMISSIONER PAGONE: 9.30 on Monday.

ADJOURNED AT 4.26 PM UNTIL MONDAY, 21 SEPTEMBER 2020 AT 9.30 AM

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