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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

9.31 AM, TUESDAY, 22 SEPTEMBER 2020

DAY 97

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 QC: Mr Gray.

MR GRAY QC: Thank you, Commissioner. I Call Dr David Panter and Mr Martin Warner.

DR DAVID PANTER, AFFIRMED

MR MARTIN WARNER, AFFIRMED

EXAMINATION-IN-CHIEF BY MR GRAY QC

MR GRAY QC: Dr Panter, you're the Chief Executive Officer of ECH, an aged care provider in South Australia, which specialises in providing aged care to people living in their own homes and in the community, not in residential aged care settings; that's correct, isn't?

DR PANTER: Yes, it is.

MR GRAY QC: And incidentally, you also hold a role as board director of Leading Age Services Australia, one of the peaks and you're chair of South Australian Council of Social Service, and prior to your role at ECH, you were Chief Executive of the Central Adelaide Local Health Network for two years and held numerous executive roles in SA Health between 2006 and 2012, and you're a qualified psychologist and your PhD is in developmental psychology; is that correct, Dr Panter?

DR PANTER: It is, yes.

MR GRAY QC: Thank you. As for ECH, from origins in the care of war widows needing support in their later years, ECH is a non-denominational, not-for-profit aged care provider of affordable housing and innovative residential options, home care and centre-based services providing allied health, social activities and respite; is that right?

DR PANTER: It is, yes.

MR GRAY QC: And Dr Panter, you've appeared before the Commissioners before. Thank you very much for appearing again. You've also prepared a witness statement which has, in fact, been tendered in the Home Care Hearing held three weeks ago. I'll just give a reference. It's exhibit 20-1, that's the general tender bundle for the Home Care Hearing, at tab 69, RCD.9999.0347.0001. I'll just ask you to verify it, but we won't need to tender it. Can we have that document displayed on the screen, please. Operator, you able to display Dr Panter's witness statement, please.

RCD.9999.0347.0001. Thank you. Dr Panter, is that a copy of your most recent witness statement for the Royal Commission?

DR PANTER: It is, yes.

MR GRAY QC: Dated 30 June 2020. And to the best of your knowledge and belief, are the contents true and correct and are the opinions in it opinions that you sincerely hold?

DR PANTER: Absolutely, yes.

MR GRAY QC: Thank you. I don't need to tender the document, but we've verified it. Mr Warner, you are the co-founder and CEO of Home Instead Senior Care, which you established with your wife Sarah Warner; correct, sir?

MR WARNER: Yes, that's correct.

MR GRAY QC: Thank you. And Mr Warner, you graduated with a bachelor in science from North London University, and had a career in hospitality management and then began specialising in franchising, and you and your wife migrated from the UK to Australia in 1986. You have qualifications in institutional management and health services management and you're a member of the Australian Institute of Company Directors; is that correct, Mr Warner?

MR WARNER: Yes, that's correct.

MR GRAY QC: Thank you. And Home Instead Senior Care was established in 2005 and it operates on a franchise model; is that right?

MR WARNER: Yes, that's correct.

MR GRAY QC: Is it correct to say that the operating model of Home Instead Senior Care is currently based on the Home Care Package Program predominantly?

MR WARNER: No. No. It's - we have private services, we have brokerage services and we have home care packages. So, yeah, there's a reasonably even spread through that.

MR GRAY QC: Thank you.

MR WARNER: (Inaudible), so to speak.

MR GRAY QC: Thank you. And in addition to home care package brokerage services and private services, do you have grants through direct - direct agreements with the government under the CHSP program?

MR WARNER: No, we don't.

MR GRAY QC: Yes. And ....

MR WARNER: The only funding we've received was home care packages.

MR GRAY QC: Thank you. And Home Instead Senior Care currently has approximately 2,600 staff who provide care known within the organisation as care givers and 39 offices around Australia; is that right?

MR WARNER: Yes, yes, yes.

MR GRAY QC: Thank you, Mr Warner. And you've prepared a witness statement for the Royal Commission which was tendered at the Home Care Hearing three weeks ago. It's exhibit 20-1 tab 28, RCD9999.0375.0001. Is that document displayed on the screen the statement you prepared for the Royal Commission, Mr Warner?

MR WARNER: Yes, yes, it is, yes.

MR GRAY QC: Dated 15 July 2020. And Mr Warner, are its contents, to the best of your knowledge and belief, true and correct, and are the opinions in it opinions you sincerely hold?

MR WARNER: Absolutely.

MR GRAY QC: Thank you. Now, Dr Panter, Mr Warner - have you a familiarity with the propositions for new service arrangements which the counsel assisting team proposed in the Home Care Hearing three weeks ago; in particular, for service arrangements dividing services into four categories for the purposes of administration and funding?

DR PANTER: Yes.

MR WARNER: Yes, that's the draft counsel proposed - yes.

MR GRAY QC: Yes. I might just ask that that document be displayed, Mr Warner. It's exhibit 20-1 in the Home Care Hearing. It's tab 59 at page 2. And we'll just have that up on the screen.

In essence, the service arrangements proposed following integration in due course - perhaps, operator, if you could call out just the text beginning "The types of services that older people", etc., to the end of those bullet points, thanks very much, and if we expand that, people will be able to read it.

After integration of CHSP and the Home Care Package Program, it's proposed - it was proposed for the purposes of the Home Care Hearing and these propositions were tested during that hearing, that there be four categories of services along the

lines outlined here. That they be available through a single assessment process adopting an enablement approach, that is, an approach that prioritises enabling people to maintain their independence and avoid deterioration in their health and wellbeing, and that the home at care category - beg your pardon, the care at home category in the last bullet point you see on the screen would have an assessed domain for care management, with a dedicated budget for care management, and that there be clearly defined care management roles and responsibilities.

These points were all dealt with in more detailed propositions, the proposition dealing with that one was HC5, and that there be a reorientation of consumer-directed care towards shared care management, and that the transition to integrated arrangements would involve interim steps such as clearing the waiting list for home care packages and making available social supports through CHSP and escalating the availability of those supports through CHSP so that people did not need to use their home care package to obtain those services.

Now, can I seek the comments of each of you panellists on that broad proposal? I'll start with you, Dr Panter. Do you regard that structure as appropriate?

DR PANTER: I think the structure has huge advantage, it being structured in that way. I think the only - one of the areas of concern that I would have goes back to that issue of care management, and whilst that's clearly articulated in the care at home element, and given due recognition, which I absolutely support, I would want to ensure that there isn't a complete separation between people embarking on a support journey in those other categories around social support, the assisted technology and home modifications, respite care, that their journey needs care management from the beginning. It's the frustration that certainly my organisation has with CHSP services, is that many of those people do need some sort of care management to make full use of CHSP before they eventually migrate into a home care package. But because that care coordination, care management is not part of CHSP, then they miss out.

So for me it's about how you connect those earlier interactions, albeit that they might be funded more effectively and efficiently through a block funding arrangement, but how you make sure that they don't lose sight of that care management need within those lower levels of care, because in our experience, if you don't have some of that, you escalate too quickly into the need for a home care package.

MR GRAY QC: Dr Panter, in your witness statement, you raised your concerns about care management being underdone in various ways in the current system for providing services for people who need aged care and are not in residential aged care settings. You made that point about CHSP not having care management and you say it should, and it should be restored. You also make a point about the Home Care Package Program not succeeding very well in its provision of care management, and you made a point about some analysis by StewartBrown of home care provider Survey Data.

Could I just ask you to expand on that latter point? I'll ask the operator to bring up exhibit 20-1 tab 4, the StewartBrown analysis. We'll go to page 0047 at table 28 and chart 16. I'm not certain that this is the data that you had in mind, and I'd just be interested to seek your views, Dr Panter. Is this - firstly, are these - is this table and this chart what you had in mind when you spoke about ....

DR PANTER: It is, in the sense that it's in relation to - if you look at the chart and you see the reduction in hours dedicated to care management going down against the levels, whereas our experience is that Level 4 packages, because of the degree of complexity of care and the need being met, you actually need a higher degree of care management to ensure that you're maximising that (inaudible) approach and keeping people for as long as possible as they wish to, remaining independently at home. And that's an area that we have focused on particularly at ECH, because we believe very strongly that the majority of people do wish to stay at home for absolutely as long as possible, and indeed, potentially die at home.

And so we have found by having a higher degree of care management, utilising more specialists, for example, clinical nurse consultants, we now also have our own in-house GP service that provides consultation and liaison to hospital specialists, such as geriatricians, in order to make sure that we are checking and reassessing some of these changing needs to enable them to then have the care being provided changed to match that need. That was my observation on that chart, is that we would - I would expect on our evidence more hours going towards care management, the more - the higher level of the package, because of the higher complexity of needs being addressed.

MR GRAY QC: Yes. The only explanation that occurred to me when I read other parts of the report was that the unit price, the average unit price being charged for care management as one goes up the packages, up the levels of package, seems to be increased and its highest to level 4. I don't know whether you have any ideas as to what is causing this, in effect, counter-intuitive decline in hours spent on care management as complexity increases, and do you have any immediate ideas about what could be done by way of solution?

DR PANTER: I think the - the critical issue for me is about wanting to ensure that the care management is seen as a valued element of the package, and that's valued at every level in terms of the regulation, for example, that for the Safety and Quality Commission to be focusing on the quality of the care management and whether that is actually delivering the value for the client as intended. And I certainly am aware from my discussions with other providers that there seems to be huge variability in understanding what care management is and certainly what good-quality care management actually looks like, and the degree that you need to potentially go to, to ensure that somebody is getting the best possible out of their package to help them continue to live at home longer.

So, for me, my initial interpretation of this data was then whether or not people are operating on the basis that by the time you get to Level 4 it's almost inevitable you're

going to be going to residential and do we take the foot off the pedal, so to speak, in terms of the care management, whereas in our experience, that's when you need to increase it, and we're trying to track our performance and ability, and it's a bit difficult to interpret some of the data, because of what's available nationally, but from what we can see, we think that around about 45% of people being in a home care package migrate to residential nationally, and our equivalent figure, because of what we believe is a heightened focus on that care management, is actually 15%. One-five per cent. What we're seeing ....

MR GRAY QC: We'll leave it there. I'll take you up on that point about the potential for outcomes-based funding a little later in the examination, but thank you, Dr Panter. Mr Warner, can I go back to the broad structure outlined in the outline of new proposed service arrangements for home and community aged care, and I'd be very interested in the perspective you bring as a specialist provider of, to the extent that you're getting Commonwealth subsidy, home care package services and what your views are about this broad structure, please.

MR WARNER: I'm supportive of it. My position all along has been the fact that I'd like to see the CHSP and the Home Care Packages combined into one system, and it is a natural continuum from very low-level care, so to speak, right the way through to high-level care and also opportunity to bring in another level, which will be something along the lines of kind of like a Level 5. I'm very supportive of these. All these aspects are exactly what we experience right now, in care at home, for a home care package there are people who want social support, there are people who want personal care, there are people who need assistive technology and so on. So I support this - the types of services that you put forward there. I think as well that when it comes to the care management - do you want me to comment on that, in my perspective?

MR GRAY QC: Yes, please.

MR WARNER: When it comes to the care management, our experience is very clearly that at the lower level there's a smaller degree of care management required to help clients manage their package and get the services they want. Without a doubt, in our business, as you go to Level 4, it's much, much higher, and so - the first time I've seen that graph, so that came as a little bit of a surprise to me, it certainly isn't our experience; far from it. So I wasn't quite sure what the - what the numbers related to, but it's the first time I've seen it, so it's a bit hard to comment on it but I just went "Oh, less hours?" It doesn't seem to make sense to me.

MR GRAY QC: Yes, it seems to be saying less hours, not necessarily less cost, because there could be higher unit rates because of greater clinical expertise on the part of a care manager, higher level of complexity, but certainly less hours, yes.

MR WARNER: Yes.

MR GRAY QC: Less hours as a percentage of overall care provided.

MR WARNER: Mmm. OK.

COMMISSIONER BRIGGS AO: The difference isn't it, I think, that we're talking about a larger base figure at the higher level, so it may not be less actual money on coordination, but proportionately, more funding may well be going to the delivery of the support services. So I think we've got to be very careful how we interpret these data.

MR GRAY QC: Yes.

MR WARNER: Thank you.

MR GRAY QC: We'll go to the next point, which is propositions in the funding and finance hearing, this current hearing, which have been advanced and tested, and these are in tab 111 of the general tender bundle for this hearing. I will ask the operator to please display FF 1. FF 1 is a proposal for independent cost review and pricing by an aged care pricing authority. And Dr Panter, you've mentioned a number of things in your statement about the absence of an empirical underpinning for the levels of home care funding, both in the CHSP context and the home care package context, referable to any measurement of the need - the need for and cost of high-quality aged care. Is this proposal for independent pricing the solution, or at least part of the solution, Dr Panter? Do you support this proposition?

DR PANTER: Yes, I do support it. I think it is part of the solution. I think to have an independent body that's looking at exactly what the cost and, therefore, reasonable price structure should be is absolutely appropriate, and is consistent with what you see elsewhere in sort of health and ageing. I know that comparisons have been made, for example, to the Independent Hospital Pricing Authority, etc. So I think I do see that having this sort of independent body that can oversee that process and do that degree of examination would be very helpful.

MR GRAY QC: Yes. And you say in your statement - this is at paragraph 9 on page 3 that:

> *Aged care providers are not adequately funded to provide quality care.*

With the biggest issue being a lack of understanding of the cost of providing high-quality care services and that there's been no significant change in funding levels in home care.

Do you see a need for interim measures while an independent pricing mechanism is established, given that, on the current evidence before the Royal Commission, as we're looking at a time line of at least 18 months, and possibly longer in order to achieve that capability?

DR PANTER: I think there needs to be some sort of interim arrangement, because at

the end of the day, the current funding, both the CHSP and for Home Care Packages, essentially those dollars buy less now than they did when the original sums were conceived. And, yes, so with CHSP, for example, and again, I've talked about this in my witness statement, we've ended up with a rollover of existing deeds, and for us, that's around about $6.5 to $7 million worth of service, but that amount of money hasn't changed now for seven years, and it's been rolled over for another two years, and so it inevitably buys less hours of service, because there are various increasing costs to do with keeping pace with salaries, etc., etc., that have to be accommodated. So the net effect is that that amount of money buys less hours, and each year we go through an acquittal process with the Department of Health to justify - and I have to say, that's always then accepted - that we're going to have less hours. But it does mean that, overall, there is less support for older people.

And it's the same within Home Care Packages. If you look at what has happened over many years now, then there's an increase for the government version of CPI, but nothing else. And, therefore, you know, over 10 years, the dollar value in terms of how many hours of care it could potentially buy does reduce. And that, again, has an impact on the ability for someone to carry on living independently at home.

MR GRAY QC: So pending an integration of the two separate programs that currently exist, the two main programs, CHSP and Home Care Package, and (b) pending establishment of the capability to perform independent cost reviews and set prices independently of the executive government, what's to be done in the interim? Can I ask you about this: the system's currently capped on a per capita basis as regards the packages that are available, and it's also in a sense capped, is it not, under the CHSP program, although there doesn't seem to be a central repository of information about how many people need CHSP services but aren't receiving them, because that's really a matter of trying to tally all those acquittals of the kind you just mentioned. Is that a fair summary of the situation? And does - if so, does the solution - does an interim solution involve removing - removing those restrictions or relaxing those restrictions?

DR PANTER: I think it does require a relaxation. I mean, particularly - I mean, the CHSP is also distorted, because of how many people are receiving more hours of CHSP because they're waiting for their right level of Home Care Package. So that has a consequence of silting up the CHSP system, it was already under stress, and certainly, we can see from our perspective that there are people who need the sorts of services that CHSP was originally intended for, that lower level, early entry, who are just not getting it. If you look at South Australia today at most portals within MAC for CHSP, most providers have got them closed because they're completely full. They can't offer any additional services.

With regard to the Home Care Package one, I do think there's an interim arrangement that potentially is - even if it was just to look at what could be drawn from the ACFI experience, because again, as I have spoken about elsewhere in my evidence, when we ran our trial to see what we could actually support in terms of complexity of care in people's homes and what that cost, a year or so ago, we went through a process of

taking people who were essentially on a Level 4 package and assessing their need using the ACFI formula for their care component had they been going into residential aged care. What that showed on occasion is potentially up to $60 more per day for their care, if they'd been in residential, compared to being at home, and we, using your benevolent funds, topped up their package if necessary.

MR GRAY QC: I'll just ask the operator to display page 0005 of your statement, just under paragraph 12, where you refer to this study.

DR PANTER: Yes. Because in that piece of work, as I say, we were able to demonstrate that we could keep people at home, with higher degrees of complexity, much longer, and indeed in some cases, until the point of death in their home, which was their choice. Simply by, as I say, taking that ACFI funding formula and applying it to home care, obviously eliminating the accommodation costs, because their accommodation is already met, they're in their own home, but just looking at the care component.

So I would argue that even in the interim, there could be some work done to look at how that assessment process for the care component could be addressed. And as Mr Warner's already indicated, and again, I've got - in this element you've got on the screen at the moment, this is not necessarily out of line with what David Tune was recommending, some two years ago now, about the introduction of a Level 5 Home Care Package, but it's taking that ACFI funding, the formula that's already there, but allowing it to be used for people receiving their care at home for that care component.

MR GRAY QC: Thank you, Dr Panter. Mr Warner, at paragraph 17 of your statement, you also give support to the notion of an additional level of funding - for example, an HCP Level 5 and you've furnished case studies to the Royal Commission in at least one of which there's an example of how, by supplementing the costs of home care from private sources, a family was able to bring a person in effect back from residential care and keep them at home, and so that's a concrete illustration of the point you're making. Can I ask you about your general views about adequacy of funding in the Home Care Package space, because that's the area where you're operating? There's a bit after conundrum here, isn't there, because there's an underspend on average of home care packages by something like $8,000 per person, I believe. Quite an enormous amount of accumulated unspent funding already exists on the books of something around a billion dollars worth of unspent funding, we believe. So how to reconcile these points, and what's your view about the adequacy of funding in the Home Care Package space?

MR WARNER: I found actually a very interesting and common question, is the industry adequately funded? Because it's typically responses about "No, we need more money, we need more money." I thought, let's focus upon what's happening in our space and our business and that was exactly that, which is that we had a lot of unspent funds sitting in our bank accounts, which we don't want, and that it is really that - the whole package wasn't being used. So it's hard to say for me that the

industry is - isn't adequately funded when there is a significant amount of money sitting in the bank, not being spent. So that was the - that was the basis upon which I said "No, I think there is adequate funding as it sits for those people who have been given the funds."

I wasn't thinking of a much broader outlook on whether CHSP is funded adequately and so on and so forth. So I said that I think it's adequately funded but that there is a complexity here and the issue is that there is a problem of moving from one level of care to another level of care, and so, for example, from 2 to 3, whatever. It's a very time-consuming process, and that is part of the problem, which is that what we should be able to certainly, you know, in that sense it's not adequately funded, or even when you get to a Level 4 and you get to point where you need more funds, which is the reason why I need we need a Level 5.

So I think it's the flexibility of the system to fund, which to me seemed to be more important than the quantum amount. That's the way I read it.

MR GRAY QC: Yes. Is now a good time to ask you about your care recipient deposit concept, because although perhaps that doesn't directly go to the point of whether the levels of the Home Care Packages are adequate, it's really raising another funding adequacy point, isn't it, and could you explain why you believe that's necessary and what it would be?

MR WARNER: Yes. I think the questions that the Commission asked us were about one of those areas where there needs to be more effective, where funding or where there are challenges in controlling costs and so on, and I put it down to three areas. One of those was in terms of cash flow, because if you're starting with a client, then there's certainly a period of time where you have to work with that client, first of all, for them to become a client, or a care recipient, so you have to meet up with them and so on and so forth and then you also have to explain the services. So the issue here is the time from which you get an initial inquiry from a potential care recipient right the way through to when you actually start services.

Now, in the private model, that could be very quick indeed. That can be just a couple of days. But in the government system, for a whole range of good reasons there's a much longer process. But we've got right now, helping people understand - they say they've been assessed or they get an assessment or whatever it may be but they don't even understand whether it's for a CHSP and whether its for a Home Care Package. I can give you a really good example, it actually was about my mother, which was when I contacted MyAgedCare about that, somebody came round eventually and I actually attended that. We'd asked for a Home Care Package, most definitely that's what we wanted. When that person came around, they were sitting there with my mother and myself, what was happening was it quickly became obvious to me that this person wasn't from ACAT, they were from RAS, they'd come to assess for CHSP, which was clearly not what we asked for and clearly not what was appropriate for her. She had very much a high level of need.

So that was an example of one step in the process. The next step of course we move on to when they have been assessed, we have to spend time with them going through what - what level they're on, what kind of services they're requiring, we have to get a budget together, we've got to take them through the aged quality system standards. We have to sort out their individual funding, that they may have to have an income test for and a whole range of things, so that in itself is a long process and it usually involves a number of visits backwards and forwards to clients. So there's a degree of complexity in that.

So by the time you got all this worked through and then you start the services, and by the way, you then get your money four weeks after you started services, typically, that's a long period of time.

What we do in our private services is we say to a client, "Look, we get this all in place, but you will pay a deposit", and that's typically two weeks' deposit and what that is about is assisting with cash flow and it's also gaining a commitment from that client. They can move up that private service overnight if they want and there's no penalty but it's really about gaining the commitment and also providing some of the support for cash flow.

What I'm suggesting to the Commission is that what happens is that with that service, that the Commission or the government - should I say the government pay a deposit to that provider. That deposit would perhaps last, say, up to six months, to enable that to cover the cash flow. Thereafter, it's offset against ongoing fees. A very simple process just to enable cash flow to, you know, not to become a massive issue, and in a growing industry, cash flow can become a very large issue, so it's support from the government, it's a bit of a win/win, I think.

MR GRAY QC: You make a number of other recommendations, these are all on page 0005, for improving administrative processes. Just to briefly summarise - you say the way the monthly statements are required to be prepared is not logical, and doesn't enable providers to use standard accounting software, and that should be addressed; correct?

MR WARNER: Yes. The way it's worked is that we provide a statement to the client or care recipient based on what income they should have received under their package, and we balance that against what has actually been spent on their package. It's just a simple software solutions, don't talk about what should've happened, they talk about what money did actually be expended and what money was received, and so it doesn't match up and it means there's a lot of workarounds to make that happen. You have incoming of expenditure which is reality and what we're dealing with is an amount that comes in for which half of it goes into unspent funds and we're trying to reconcile it all. It's just a complicated process. If it was just worked on normal accounting statements it'd be simple. It's just one small but painful example of how administering the processes could be improved.

MR GRAY QC: And you make a number of recommendations when it comes to

user contributions and means testing. You say the form which is a combined form for both residential and home care is incredibly burdensome and can run to 100 pages and the Royal Commissions have heard some evidence from Mr Costello about this, and furthermore, you raise a recommendation or you raise a point to the effect that the government should be the - in effect, the custodian of user contributions. At present, we understand that providers are the recipients of user contributions, and they have a discretion to waive them, and there are marketing practices and the like whereby user contributions are waived by particular providers. Your proposal to have government receive those contributions would, in effect, iron that out or preclude that practice, and establish uniformity of the user contributions practices through the home care segment. Is that a fair summary, Mr Warner?

MR WARNER: Yes. What I'm trying to achieve here is that we have - the providers are here to provide care management and deliver the services, but essentially, the funding all remains with the government, and we're here to create statements, we're here to collect money and so on and so forth on behalf of government, then send it back to the government. I think the thinking here is trying to say, well, look, if this is moving towards where we provide - pay for the - or we invoice the government for services, after they've been delivered, which is movement towards arrears payment, then the whole financial or reconciliation and the statement for client can just simply sit with the government because they would know what the income tested fee is that they have to pay, they would know what services have been delivered because we will send them an invoice in arrears, so the whole reconciliation can simply sit with the government and they would then also be holding onto the unspent funds.

They would have the details of that. They can collectively see the quantum of unspent funds and how they could then choose to manage those unspent funds and one simple, perhaps naive, suggestion here is that that will maybe enable all those unspent funds to free up and speed up the process of people moving from one level of care to another.

So it's really better use of those funds because honestly they're no use to the provider sitting in a bank account. They really aren't. They just have to go into a separate account and it's (inaudible).

MR GRAY QC: Can we go to the co-contributions regime that the counsel team are proposing in this hearing. This is tab 111 at page 0009 beginning at proposition FF 13. You'll see there's a structure here, Mr Warner, for a vastly simplified regime of contributions. In effect, the design concept is that there be a modest price signalling fee that people will pay, subject to a safety net. So that if they really cannot pay, there will be a safety net, but there will be a relatively modest pricing fee to encourage prudence in the expenditure of the person's package of subsidy, because they have some skin in the game, and they will also encourage consumer engagement in the services that they're being provided because of the axiom that if you have to pay for something, you take a greater interest in it than if you don't.

The proposal here is, for social supports, $5 a service or perhaps a percentage might

be easier to manage of actual services incurred or received. So actual expenditure. It could be 5, could be 10%. A similar contribution - this is at 14 - for assistive technology and home modifications. A similar contribution for care at home, that's FF 16 and no fee for respite because of the significant interest that society has in ensuring that informal carers get the respite they need without any impost being necessarily justified on them. Now, what are your views about this structure for user contributions?

MR WARNER: My view is that, in principle, I believe people should, if they're able to, should be able to - should make a contribution. The current process we have right now is quite complicated because there's an income-tested fee and it has to be changed and we have to go back and change all our administration to support that. So it's a complicated way. The one you put forward here, which is there is no means testing, but people, overall, will be happy to make a contribution to it, is a simpler method.

I think in terms of how that money is collected, for such small amounts of $5, is an administrative consideration, maybe that is through a direct debit system, so to speak, which can be set up with care recipients, or alternatively, I think an even more desirable scenario would be that that would be a direct link from the client's funds somehow through to the government holding the statement and managing that whole transaction process.

But, in principle, I think people should make a contribution to that, and I notice you put in there about the hardship provision, so people who can't do that for hardship, that sounds reasonable to me. It's a small amount, yeah, but I don't know how that ends up in total quantum for the government, but that's my principal position, yeah.

MR GRAY QC: Thanks, Mr Warner. Dr Panter, in your statement, you've expressed some concern about certainly the current user contributions arrangements. One of the things you said - this was on pages 3 and 4 - was that very few pensioners can make the contributions they're currently required to make of the daily fee for Home Care Package services which is calculated at 17% of their pension without compromising some aspect of their quality of life. What are your views about this alternative, vastly simplified structure, which has a hardship safety net but otherwise no means testing?

DR PANTER: I think it is a sensible solution. I agree with what Mr Warner has said about the administrative costs of trying to put in place the system. And it's probably worth also highlighting that in the data that I provided here that's on the screen, then that 65% that were not paying before co-payment, they were making that nominal - and it was between $1 and $5 - and one of the drivers for that was the fact that even when people were struggling to live on their basic pension, they felt guilty if they weren't making some sort of contribution, when there was an expectation that they would make a contribution. And so, certainly, people wanted to feel that they were doing the right thing.

It was about 24% that were making no co-payment simply because they just could not afford it, but 65% were making between 1 and 5, with only the remainder paying the full co-payment, but as a consequence of our experience, we have decided in our current pricing round to remove the co-payment, because it was becoming increasingly a cost burden, trying to collect the co-payment for those who weren't making the full co-payment, and at the end of the day it was costing more than was coming in to administrate it.

So that's why we made the decision this year, in our pricing restructure, to forgo the co-payment. It was clearly that funding ....

MR GRAY QC: Should the function of collection be on government rather than all the providers?

DR PANTER: I think if it was - I mean, I think it needs to be a simple process. I mean, if it could be linked to the pension itself, then that's one possibility, but then, you know, not everybody will be having their government pension as such. So there needs to be a simple way of collecting this - these funds, and for them being accounted for. Even more so at that nominal level, because, again, there is likely to be a high cost associated with administering that co-payment.

The other challenge is - which is worth commenting on, we're probably at a tipping point, I think we've now reached it with the ECH. But we did have an initial barrier to moving away from cash for those co-payments. People were very reluctant to do it electronically, for a whole variety of reasons, but we have seen - and it's one of those positive consequences of the COVID-19 experience, that that's been the shift, even for those people who are very reluctant to go to electronic for any sort of payment-type systems and now have moved towards that.

MR GRAY QC: Thank you. Operator, we'll go to FF 6, please, in tab 111. This is the proposal for a funding mechanism based on individualised bundles and it's predominantly the thinking of the team, the current thinking of the team, that this would apply to care at home, that category of services we mentioned a short time ago, and I'll start with you, Dr Panter. What's your view about this proposal as an appropriate approach to determining the entitlements of people needing - assessed as needing care at home services?

DR PANTER: Again, I think it's a step in the right direction. I sort of read into this sort of the potential for sort of casemix-type analysis sitting behind this in terms of how the bundles are constructed. Certainly, part of my analysis of the underspends with the existing system is to do with the crudeness of those four levels, and if somebody's need falls, you know, just above the value of the Level 3, there's nothing more to be done than to give them a Level 4, so you're automatically potentially working with an underspend from day one because it doesn't match their required need at that point.

So having some bundling and funding linked to that which is linked back to need and

the ability to fluctuate up and down in the course of somebody's journey would make it I think a more appropriate and equitable service that's being provided.

MR GRAY QC: Thank you. Mr Warner?

MR WARNER: Look, in principle I completely agree with this. I think that - I think it's about we have to be a competitive market as well. Where there is market failure, I can understand that that may not work necessarily the same way, but I completely agree with it. Yeah. Nothing more to add. It's just I think appropriate, yeah.

MR GRAY QC: The corollary proposition, I should take you straight to is something you've already touched on, Dr Panter, and it relates to that study you did with the 12 residents who were in ECH's care, whereby ECH topped up from its own funds approximately $60 a day to achieve funding parity with a notional ACFI level of care component funding for those people. It's FF 8, which proposes that, for people wishing to remain at home, funding should be available up to the level of the funding they would receive if assessed for residential care, and I assume, Dr Panter, you'd be in support of this. It's really on all fours with what you said in your statement and what you said a minute ago; am I right?

DR PANTER: Absolutely, yep. I think we've now got ample evidence from our own experience about what is possible to support in terms of people staying at home, as I say, until death.

MR GRAY QC: Yes. And Mr Warner?

MR WARNER: Look, I read what David had put and I agree with him, that the exercise - the sample that they went through and keeping people at home was great, I really liked it, and I think it should be topped up to that, another level. I think it's a good benchmark.

MR GRAY QC: Yes. Can we go to assessment. Again, there may not be too much need to spend long on this. We have developed different propositions or put forward different propositions on assessment. We had a proposition in the Home Care Hearing. We've got a more comprehensive set of principles for assessment in this hearing at FF 11. I think I did advert to the Home Care Hearing proposition about assessment.

I'll just say at this point of the transcript that it was to orient the assessment process in favour of an enablement approach, as I mentioned a moment ago. FF 11 is more comprehensive. There have been some augmentations of this principle suggested by other witnesses in the hearing. There's a lot of text which appears under FF 11. I don't know if you have it available to you, but perhaps, operator, if you could just expand out so that we can see the principles a through to f. Thank you.

Mr Warner, I'll start with you. What's your reaction to this set of principles to guide assessment of need? The overriding design purpose here being that we have one

avenue of assessment, a person can, in effect, have all their needs for aged care assessed through one process, and from their perspective, it's really a seamless exercise as to how those needs are met. There might be some complexity behind the scenes in different funding arrangements applying to enable the supply of those services, but the person should receive a seamless experience.

Are these principles the right principles for that assessment? Mr Warner?

MR WARNER: I believe so. One of the things I put is that we need to have, in a sense, like one system, one program, one assessment process and so on. So I think that's a really strong move in the right direction here, was about the reassessment which needs to happen more frequently. The area I think which may be challenging is that if we have a whole range of different assessment based upon what people's needs precisely are. If you're thinking of moving away from having, for example, five levels of funding to very specific personalised funding levels, then that might be a bit of a challenge as to whether someone should receive $11,000 a year and someone should receive $11,280 a year. You know, it starts getting quite complicated as to how that's done. I would find that quite challenging for the assessor, but the principles here are exactly where I would like to see. I completely support them.

MR GRAY QC: Thank you, Mr Warner. We might come back to that point about the various gradations in funding that might flow from an assessment process of the kind identified in this proposition in just a minute, because there had been various iterations proposed about how exactly assessment should occur and how it might intersect with individualised budgeting, a form of classified or casemix informed budgeting and how that might flow to mechanisms and I do wish to ask you both about some detail on those various iterative proposals in a minute.

I'll just go to Dr Panter, though, now, on the basic principles for the single assessment process, the single but scaleable assessment process. Dr Panter, your views?

DR PANTER: Again, supportive of having that single assessment process. I think the critical features are the trigger for reassessment and the evidence required for that. I would - because, currently, as I say, we feel very frustrated on behalf of our clients when we can see that somebody is - their needs have changed significantly. We're trying to get a reassessment, and basically, nine times out of 10, the message back from the current RAS ACAT systems is "Unless that person is already overspending on the budget for their current level, don't even consider coming getting a reassessment." Which is ridiculous, because we're trying to be timely and prevent decline, rather than waiting for decline to actually happen. So I think it's the fluidity of the assessment system, how we ensure that you can get timely reassessment, and what is the evidence on which that reassessment is taking place.

MR GRAY QC: Dr Panter, what should be the involvement of the provider in any reassessment process? We've heard some views quite strongly expressed about the

need for assessment to be independent of the provider by way of a check and balance on the flow of public moneys, but we've heard other views about the importance of the provider's perspective - after all, the provider is the one who knows the care recipient best. What are your views?

DR PANTER: I think for me this is the iteration between the assessment process and the ongoing care management. You know, for us, when I talk in my statement about active care management, we go through a process where we're collecting intelligence on a care recipient, both directly from them, the observations of our staff who are going into that person's home, observations of family members, using technology where appropriate to gather intelligence, and that information feeds in to, in some cases, daily, in others weekly huddles of our senior care management staff, in order to make some determination about what's happening to an individual, and whether their services need to be upped or downed, altered, etc., etc. That, to me, provides very good evidence that could feed in to that reassessment process, provided by an independent assessor.

I don't think it is necessarily a good thing for the provider to do the formal assessment, but they should be in a position to provide evidence into that assessment process, because as you say, they have got that better relationship on a day-to-day basis with the care recipient.

MR GRAY QC: And Mr Warner? Your view on that?

MR WARNER: Yeah, I agree - I think the authority independently to rely with the assessing authority, but the knowledge lies - a lot of the knowledge lies with the provider. So they need to have input into that. I think - I like the fact that it is independent, but there must be - in terms of authority, but there needs to be input from the provider who intimately knows the client.

MR GRAY QC: Thank you. Payment in arrears and acquittal in the Home and Community Care setting.

COMMISSIONER PAGONE QC: Just before you go to that, Mr Gray.

MR GRAY QC: Yes, Commissioner.

COMMISSIONER PAGONE QC: Just keeping on the other proposal for a moment - what about the process the other way round, namely that the provider does the initial assessment as selected by the person but with a subsequent evaluation of that by an independent body? Does that have merit, and if it does, which of the two would be better?

MR WARNER: Can I comment on that?

MR GRAY QC: Please, Mr Warner.

MR WARNER: My view on that would be that that is a feasible, absolutely feasible way of handling that assessment. I think the point I was trying to make is that the authority at the end of the day, that authority needs to lie with an independent body, as opposed to the provider, but it's perhaps - and I think the provider would need to, in a sense, justify to an assessor, I think Mr Panter raised this, a reason why you want to have this assessment take place so there's got to be a bit of homework done by the provider anyway to put the case forward, so to speak. So it would perhaps, in a sense, kill two birds with one stone by putting the authority with - not the authority, but putting the initiative with the provider and then the decision is made by to the assessor.

COMMISSIONER PAGONE QC: It's really just a question in my mind of which comes first. I can't help thinking that if it was me, I'd prefer to go to somebody who I think was likely to do the provision, and be sure that I had negotiated with them what I was going to get and that they could provide it, although I would then want somebody else to have the final say, so that the person doing the provision wasn't directing me down a path that really was in that person's best interests rather than mine. Mr Panter, do you want to comment on that?

DR PANTER: Yes, I mean, I think it has to have that check and balance. I think it can work in that way, and indeed, some of the frustration offered by experience by care recipients is that a provider when they're taking on an individual who's come to them having been through the assessment process often has to reassess themselves anyway, in order to finetune the proposed care plan, etc., etc.

So there is potential - and I was dealing with a client the other day who was complaining, quite rightly, that they'd gone essentially through the same assessment process about three times within the course of 10 days, because of the way in which the RAS and ourselves had coordinated around somebody's particular needs. So I think the assessment itself can be frustrating and it needs to be straightforward. But you do need that check and balance. But it could be, as I say, the independent assessment first that goes in, or as you've indicated, how that's then picked up in terms of the evaluation of the provider, and the validation of the assessment in order to ensure that the client's not being driven down a particular path and public moneys are being used appropriately.

COMMISSIONER PAGONE QC: And do either of you have any sense of the extent to which there might be more or less mismatch between assessment and revision, if you had the provider do the first assessment or the evaluator do the first assessment? Do you see what I mean?

DR PANTER: Yes. From my perspective, I would - it depends upon the quality of the assessors. What we've found is that - hence why we always need to do some sort of reassessment when somebody joins our service, is because our assessments are done by current active practitioners, and often, the assessors in the RAS are people who are - you know, not necessarily current in their practice, in terms of making - of the delivery of services, which does have an impact on the way you might assess

somebody.

COMMISSIONER PAGONE QC: Mmm. Mr Warner?

MR WARNER: I think that the - I think your proposal is a far more consumer-friendly proposal, for want of a better way of putting it, to start with the provider, but I think you still just need to keep that independence overall but I think it's a good way to go.

COMMISSIONER PAGONE QC: Thank you. Sorry.

COMMISSIONER BRIGGS AO: Yeah, no, if I could pick up on - this is clearly an issue that is quite vexing for us, as we think through these details, and I've been struck by the evidence that we've received from the Commonwealth around the problems they had with the ACFI arrangements. So, in those cases, providers can, in fact, assess, and that pushes up the absolute costs, and what then appears to have occurred is that the Commonwealth had a knee-jerk reaction and froze indexation and so it went on.

So it seems to me that there's a need to find a route through here, which avoids knee-jerk reactions, has proper costing or pricing according to cost, but also, a level of independence and trust in both the assessments and the process for reassessing as we go forward.

Would you care to comment on those things, to give us both a bit of a flavour of that, please?

MR WARNER: I listened to the hearing that you're referring to, which surprised me because I wasn't aware of that sort of situation arising. So I think from a government point of view, I'd want to ensure that, you know, there is - things are being handled prudently and appropriately, but the reality is, the provider is very close to that client, and the provider can have a lot of input, but someone has to make a decision at the end of the day about what that amount of - what that assessment should come in at and what that value should be. And so I think it is a shared process, but ultimately, it has to be with, I think, the assessor to make that call. And that's the way I would see it.

I think you do need to avoid those kind of circumstances you've spoken about for residential care.

DR PANTER: I would agree. I think that we need to make sure we have a system that recognises that there's always going to be a spread of providers in terms of their performance. It will never be an ideal position where every provider is excellent and is driven by the right values, etc., etc. So we have to make sure the system is designed, acknowledging that there is potentially going to be poor performance or poor performance.

So this is exactly your point, Commissioner, I think that the ability of providers to distort an assessment process has to be there as a possibility and therefore how do you mitigate against that? Therefore having the separation or some of the independence, whether it's at the beginning or as part of the evaluation and validation process, to my mind, is absolutely essential.

COMMISSIONER BRIGGS AO: Thank you both. That's quite helpful.

MR GRAY QC: Thank you, Commissioners. Dr Panter and Mr Warner, I'll go now to the topic of payment in arrears and acquittal and I'll just make a brief statement and see if you agree with it.

The government has flagged and has prepared legislation to move the process of funds administration in the Home Care Package Program to an arrears-based payment system. In a way, that will look after acquittal. Acquittal being proof of expenditure of a particular subsidy for a particular purpose. Well, payment in arrears will necessarily only occur once there's been payment for - for a purpose that reflects the assessment of need of the particular person. Is that a fair summary?

DR PANTER: Yes, yes.

MR GRAY QC: And, Mr Warner, you've raised some cash flow issues about the transition to payment in arrears and perhaps the mechanics of payment in arrears once it's up and running. Your deposit proposal would cover some of the points that you've raised about the long delay after so-called onboarding or the commencement of the process of assessing and commencing services for a particular care recipient. It's also been suggested that accruals-based accounting might cover some of the cash-flow problems; that is, once a provider incurs a liability to pay a particular expense, that should be sufficient for it to be able to claim payment under the payment and administration for Home Care Packages and if that were the case, there will be a far less acute cash flow payment presented because payment might be received shortly after the incurring of the liability to make the expenditure and before the cash actually leaves the provider's account.

What do you say about that?

MR WARNER: Just trying to get my head around that concept. I'm not an accountant, but I'm familiar with the kind of systems they have. It seems to me, though, that we don't incur that expense until we've actually - it's taken place. And so we don't account for that taking place. For us it's you, you know, basically twice a month. So we don't account for it until then. So unless we just sent that account in every time we incurred it then the government wouldn't know what they have to pay us.

So I just can't quite - perhaps I'm misunderstanding something here, but it just seems to me that we can't - we share that information and expenditure with the government through an invoice, but if they don't pay us that invoice, you know, until we've been

able to give them the invoice, then we've got a month's - basically a month's cash which we would've paid out to our staff before they can get it to us.

MR GRAY QC: Yes.

MR WARNER: Because they don't know how much the amount's going to be anyway. The government won't know how much it's going to cost them during that month until we send them the invoice so I'm just struggling with the concept here, sorry.

COMMISSIONER PAGONE QC: Mr Warner, I think you've actually got the concept quite well. The question is whether the invoice is sufficient. So accruals accounting means that - and, indeed, although - obviously it's not an exercise in whether you're doing your tax return the right way or not, but almost all of the providers would probably need to account on an accruals basis rather than on a cash basis. It's reasonably rare for cash accounting to take place. So the invoice, when you have it, is an invoice to be paid, and the evidence that there's an amount to which you're entitled to get back.

My issue really is a slightly different one, and that is, so in a theoretic world, accruals accounting produces a perfect matching in an ideal world. It produces a perfect matching, because you've got the invoice, so you now have a liability to pay, and you send the invoice to the person that's going to reimburse you, so that they have an obligation to refund you, so in a perfect world, you've got a match and the timing is, in theory, completely matched.

The reality, though, probably is there will still be a lag between you having the invoice and having to pay it, and the refund. So I suspect that the providers will still be able to pocket for a period of time. What I don't have a sense of is whether you're going to be pocket for a week, a month, two months or three months. Do you have a sense of that?

MR WARNER: Well, thank you, yes. Thank you for clarifying that. I completely agree with what you're saying and the issue isn't so much whether it's the accounting method, be it cash or accrual. The reality is the physical cash that's not in the provider's bank account yet the money has been expended and when you're starting a new client, and all the time and effort that's been expended to get that client actually on board, let alone the actually delivery of services.

What happens there effectively, though, is that that surplus that you make from the client, so to speak, will take time to come through to turn into - it won't happen overnight, but I think it's very straightforward for somebody to do an analysis and say, "Well, I think that could - that expenditure that you put onto that client will turn into a surplus over a period of time", and I just put forward a proposal for a six-month period, but I think they could require a little bit more analysis and say, "Well, when does that actually turn into cash, that the surplus you have from that client turns into cash into your bank account?"

So that's my point. It's really just to try and say, what is that time? I think it's completely correct. We don't know exactly how long that is.

COMMISSIONER PAGONE QC: Mr Panter, you might want to comment on that too. I then have another question to ask you.

DR PANTER: I think the acquittal ....

COMMISSIONER BRIGGS AO: You're on mute, Dr Panter.

DR PANTER: I'm not on mute at this end. Can you hear me now?

COMMISSIONER PAGONE QC: We've lost you.

MR GRAY QC: I can.

COMMISSIONER PAGONE QC: So much for tax accounting, Mr Gray.

(LAUGHTER)

MR WARNER: I can hear David.

DR PANTER: Right, I can hear you, but they can't hear us, I don't think. But I lost the Commissioner during his description of accrual accounting as well.

MR GRAY QC: I'm informed there's a technical difficulty with the audio in the courtroom and we might need to stand the matter down and see if we can resolve that.

COMMISSIONER PAGONE QC: Alright. We'll stand the matter down for two minutes.

ADJOURNED **[10.48 AM]**

RESUMED **[10.50 AM]**

COMMISSIONER PAGONE QC: Dr Panter, I think we were waiting for you to respond before.

DR PANTER: Thank you. Yes, so I was just expressing my support for the acquittal process, but it is around the efficiency and the speed with which that actually happens, particularly given that it may be some smaller providers who have less cash flow that may fall foul of an acquittal process and those small providers, in

our experience, are often those who are working with particular niche communities, perhaps from CALD backgrounds, etc., and so it's the way in which the arrears payments are made and how efficiently and quickly they're actually paid.

COMMISSIONER PAGONE QC: Yes. Yes, well, that sort of actually leads into the second question that I wanted to ask, and that is: one of the things that really has concerned me during the course of, in particular, this hearing over the last week and couple of days, but also from what we've heard in the past, is that some providers are on very tight margins and doing it tough and having difficulties making ends meet. A process that would keep people - providers out of pocket means that a significant proportion of funding will be shifted onto the providers, some of whom might not be able to deal with the additional carrying of the cost of funding, you know, effectively the interest, whether paid or unpaid, or simply the cost of carrying that part of the economic burden of the system, which I imagine is not insignificant in economic terms. So I was actually quite tempted by the idea of Mr Warner that some form of deposit be made available to the providers.

At the moment, the legislation seems to provide that those people, particularly small providers, who think they've got a problem should go to another government department to ask for assistance. I can't remember off the top of my head the name of the authority that they're supposed to go to. But that just strikes me as adding to the burden of administration for the very people who don't have it. But a deposit might work because you put people in funds, and the funds would be to be applied as the payments become - have come in, and they ought - both in theory and in law, no longer part of unspent money; it's just a payment in advance. Do you have some sense about what kind of carrying costs should be needed as a deposit?

MR WARNER: What we do in our business at private level is typically two weeks' services, and the challenge is for home care is not so much the big capital cost, it's always working capital. Particularly the challenge here is that we're in a marketplace whereby the demand just continues to grow, and that is really why we think this is an appropriate suggestion, because I don't think that it's appropriate for the providers to pick up that entire funding. So two weeks is what we use at a private level. But I've got to be honest, we haven't done any kind of absolute analysis on this; it's just what works. That's what it's come down to.

COMMISSIONER PAGONE QC: That sort of makes sense, though, doesn't it, that about two weeks of cash flow might be a kind of figure that's needed as a deposit. Thank you for that.

Dr Panter, do you want to add to that?

DR PANTER: I would support Mr Warner in this proposal, and I mean, to give you some sense of scale, for the acquittal process and the impact you would've had on ECH when it was going to be introduced - sorry, the arrears system when it was going to be introduced, and we at the time had about 840, 850 home care packages and we were going to have to move about $1.5 million out of reserves into cash in

order to manage that process of payment to arrears. And we could afford to do that because we had those reserves in our benevolent funds, etc. But for many organisations, that was not going to be an issue. It wasn't possible. So to have some sort of deposit-type process or some element that enables, particularly those smaller providers, to manage their cash and their liquidity would be very helpful.

COMMISSIONER PAGONE QC: Yes, Mr Gray.

MR GRAY QC: Thank you, Commissioner.

Dr Panter, I'll stay with you. Now's the time I'd like to elicit from you your views about outcomes-based funding, or at least incentive elements in home and community aged care funding arrangements. It seems that the advent of an arrears-based acquittal mechanism of some kind might be the occasion on which some sort of outcomes-based uplift could be added to the funding that's provided. What are your views about the criteria on which any sort of incentive mechanism of that kind would operate?

DR PANTER: I mean, I think that we need to make sure that the system overall does - is that balance of making sure that it not only incentivises good practice but doesn't have perverse incentives which fuel bad practice, particularly given the spectrum of potential providers.

And, certainly, you know, I know when I have been looking for support for family members and friends, the judgment I'm making about a provider is, if the goal is to enable somebody to carry on living independently at home for as long as possible, and indeed, for them to die at home, if that's their choice, then I want to look for a provider who has a track record and the evidence base of actually being able to achieve that. Whereas most of the focus at the moment is on inputs and, you know, it's not a huge amount, but I would say about 10% of people that we deal with around home care package, for example, whether they're going to use us, it's usually the client or a family member sitting there with an Excel spreadsheet, comparing us with other providers on inputs. How many dollars per hour for this type of service, that sort of service, its, etc. They don't necessarily get round to asking the question of "Well, actually, what's your evidence for how do you support people? How long is their tenure of staying at home? How many people do you actually enable to have a good and respectful death at home?", etc and what is the quality of life that's provided?

And those sorts of - for me, those are the sort of outcome markers that should be more available for people to understand and have access to, and I think the funding mechanism for home care should recognise those factors and not just be based upon inputs, and I would want to see some sort of blended model which has both some upfront payments linked to inputs, but also on the six-monthly annualised basis, acquittal process or whatever, there should be something which actually looks at outcomes and rewards or otherwise for the outcomes that are being achieved.

MR GRAY QC: OK. So it's really distinct from an acquittal of the particular expenditures incurred, you're looking at those as inputs and they have their place, but you're talking about an overlay of an outcomes-based incentive payment of some kind?

DR PANTER: Yeah. My big fear is that - and I will draw a direct comparison, say, to primary care services, where, in Australia, we have primary care driven by the medical benefits schedule, which is input payments. We have no measures of quality, of whether or not people are getting a good service or not. It fuels expenditure because GPs can claim item numbers without demonstrating that that test was needed, that intervention was needed, etc., etc. And I compare that to the UK model, which has a blended, where it's inputs, but also, evaluation of the population being served, and whether the outcomes - whether they're essentially keeping people well and for how long and what their levels of chronic disease are, those sorts of things. So I'd like to see that sort of blended approach where we're looking at recognising inputs but also keeping a focus on the outcomes that are delivered.

MR GRAY QC: Thank you. We're up against time, so, Mr Warner, I won't be able to go to you in detail on that proposition, but is it something that you agree with, or not necessarily?

MR WARNER: Oh, it's a rather technical area from my perspective. Our focus is very much ....

MR GRAY QC: I'll leave it there because you're up against time. Can ask you, though, Mr Warner, about the more rigorous reporting that might be imposed as a result of another set of proposals we've made towards the back end of our propositions.

If the operator could please put up PR 1. We have in mind a proposition that the prudential regulator be empowered to, in effect, tighten up the reporting regime. Now, the focus has been mostly on the financial reporting of residential care providers. The current financial reporting regime, as it pertains to home care providers, is less stringent than the regime for residential care providers, in that home care providers essentially are reporting profit and loss and not balance sheet items, and don't receive RADs, so aren't accounting for in-flow and outflow of RADs. All that being so, there's still an important public interest in understanding whether home care providers are getting into financial management difficulty, so there is a public interest argument for perhaps more regular financial reporting by home care providers and perhaps to a greater level of detail than is currently provided, and this is - the scope for this to be imposed is opened up by proposition PR 1, which the operator might be able to put up on the screen in a minute. But perhaps you have it available to you. It's a proposition for the prudential regulatory body to be empowered under statute to require aged care providers to submit regular financial reports. It's up now. Thank you.

Mr Warner, what are your thoughts about this proposition? Is it appropriate, or is it too burdensome?

MR WARNER: Well, I appreciate the government wants to ensure that the service they're providing is going to remain solvent, so to speak, and it's got all the reports it needs to do some analysis. The main thing I would say is that, you know, for example, in our business, we're not just government. You know, so we can provide whatever P&Ls you want but it doesn't necessarily reflect anything to do with government, so I just need to say you have to be cautious about what you're looking for and what you're going to use it for. If it's purely to understand whether the business is solvent, I can appreciate that. But there's a lot of other things that we need to understand what government is actually trying to achieve out of that. That's the main point I'd make. I have no resistance to it but it's just got to be relevant and appropriate, is all.

MR GRAY QC: Yes. We've also got a continuous disclosure proposition at PR 3, which might give the regulator advance notice of looming insolvency. Have you formed a view about whether that's appropriate to be applied to home care providers?

MR WARNER: Only from the point of view that if, you know, government wants to protect its investment, so to speak, and so on, yeah, that's fine. I mean, reporting is not an issue for us. We would prefer not to have a lot of reports which are sometimes still meaningless or are they just going to sit there and draw or something or what? Anything that's really relevant, absolutely, to improve the quality, I completely support it, but it just needs to be agreed as to what's appropriate and what's relevant. That's the main thing to me, not just someone saying, "We need all this information, so the more information the better." That really is the sort of area which gets me frustrated.

MR GRAY QC: Yes. Dr Panter?

DR PANTER: I'm very comfortable with the propositions. I think that we need to have greater transparency across the sector as a whole, and certainly, in home care, and I do think that that disclosure around the financials, and again, you know, do support what Mr Warner said about making sure that the processes aren't onerous and creating unnecessary administrative costs, but that the financial health of an organisation will potentially have an impact, good or bad, on the quality of service and the quality of outcomes that that organisation is delivering for the client at the end of the day. And so, to have that transparency and greater transparency around the financials and the financial health of home care providers seems to me entirely appropriate. It's something I would expect as a taxpayer, as well as a potential user of the service.

MR GRAY QC: Yes. Finally, Commissioners, if I may go on for another five minutes.

COMMISSIONER PAGONE QC: Mmm.

MR GRAY QC: Thank you. Dr Panter, I want to raise an iteration of the proposed structure for the home and community services, which has been ventilated in the evidence. As you will have seen, our proposals are for grant funding, that is, direct contractual arrangements between government and provider for the first three categories of services that we had displayed at the commencement of the hearing from exhibit 20-1, tab 59 page 2, social support assistive technology home modifications and respite care will be grant funded; care at home will be package funded.

Now, there's been a suggestion that, for care at home, it might be appropriate to move sooner rather than later to a case - in effect a casemix-informed method of assessing eligibility for various levels of funding or more complex care at home, and for basic domestic needs, to have them payable, in effect, on some sort of fee-for-service basis or activity-level basis.

Dr Panter, that sound like a helpful iteration to you?

DR PANTER: Yes, I think it is. I'm not - I've been following this hearing through, as you'd expect, and certainly was very interested in some of the propositions being put forward by Professor Eagar in terms of her - I think it was described as a compromise sort of model around some of these elements. I think that to have that flexibility in terms of care at home, and I will just bring another bit of my own evidence, just because it also creates the opportunity to get a better interface at the home care level, between those other bits of the system that inevitably impact on somebody's ability to stay at home, and that's the hospital system and the GP or private (inaudible) assistance and that's what we're finding in getting some of the successes we are in helping people stay at home longer, is how you liaise between those elements, and also substitute.

So we now are able to provide more structured care in a hotel-like environment for people as an option/alternative to going into hospital, for example. And we're able to fund that through some of somebody's package.

Many providers wouldn't necessarily be doing that, because they wouldn't have the ability, wouldn't necessarily think that was possible. But we have started to do it. It's had real improved benefit for the individual and enabled them to not go to hospital, stay out of hospital, albeit not quite in their own home, but very quickly go back to their home, and to have that ability to flex within the package, and to have that more sophisticated casemix-type model underpinning the assessment process, without necessarily going as far as individualised budgets, I think, would be very positive and very helpful.

MR GRAY QC: Thank you, Dr Panter.

Mr Warner, I'll give you the final word. Do you wish to comment on what Dr Panter's said, add anything, disagree?

MR WARNER: The main thing I want to say in terms of what we're doing here is that the social support side of things, I understand that a lot of that would need to be grant funded, but I think it's - it's - we need to open up that grant funding in a wider way to providers. It seems to be locked in. The bigger disadvantage, I find, is that it actually captured a whole group of potential clients in one area, and when you grant-fund that to particular organisations, it's, in a sense, a feeder into the rest of the business for them. So I think that there's a degree of - I don't think it's the most efficient and effective way in terms of providing choice to clients.

That's one area I'd comment upon in that area. But I understand some of the thinking behind it. I just think the whole opportunity for organisations to receive those grants needs to be expanded.

MR GRAY QC: Thank you very much, Mr Warner. Commissioners, I have no further questions.

COMMISSIONER PAGONE QC: Yes. Thank you. Well, let me thank you both again very much, Dr Panter, this is your second appearance, but both of you have put in submissions in the past, and they've been very helpful to us in our work. We're very grateful for the efforts that you've put in, and we thank you very, very much indeed for the assistance that you've given us. I'm delighted formally to excuse you from further attendance, and thank you again.

COMMISSIONER BRIGGS AO: Thank you.

THE WITNESSES WITHDREW

COMMISSIONER PAGONE QC: We'll adjourn now for 10 minutes.

ADJOURNED **[11.11 AM]**

RESUMED **[11.22 AM]**

MR GRAY QC: Thank you, Commissioner. I call Professor Henry Cutler.

PROFESSOR HENRY CUTLER, AFFIRMED

EXAMINATION-IN-CHIEF BY MR GRAY QC

MR GRAY QC: Professor Cutler, you're the director of the Macquarie University Centre for the Health Economy, and you've had that role since 2015; correct?

PROFESSOR CUTLER: Correct.

MR GRAY QC: You're an experienced health economist, you've got a PhD in economics, UNSW 2009, a masters in economics at USYD in 2002, and a bachelor in business from UTS in 1997. You've previously worked for KPMG as director of national league of health economics, and Macquarie University Centre for the Health Economy is a strategic university initiative developed to undertake innovative research on health and aged care systems and in your role as director of the Centre For Health Economy, you've conducted a great deal of - well, a good deal of research into the aged care system in Australia, including financing mechanisms such as the exchange between RADs and DAPs and topics of that kind. Is that all correct?

PROFESSOR CUTLER: That's all correct. I suppose my aged care experience also extends to my work at KPMG and also Access Economics.

MR GRAY QC: Thank you. Could I just ask you about a statement you've recently prepared for the Royal Commission, and I should thank you for appearing again in the Royal Commission, because you appeared back in February as well. This statement is RCD.9999.0380.0001, dated 21 July 2020. It should be currently displayed. Is this a statement you've prepared recently for the Royal Commission?

PROFESSOR CUTLER: It is.

MR GRAY QC: And are its contents, to the best of your knowledge and belief, true and correct, and the opinions in it opinions sincerely held by you?

PROFESSOR CUTLER: Yes, they are.

MR GRAY QC: I tender the statement.

COMMISSIONER PAGONE QC: That statement will be exhibit 21-25.

EXHIBIT 21-25 - STATEMENT OF PROFESSOR HENRY CUTLER

MR GRAY QC: Thank you, Commissioner. I should have asked you beforehand, perhaps, Professor, but there are some minor corrections of a typographical nature you wish to make?

PROFESSOR CUTLER: Yes, there are. So ....

MR GRAY QC: At paragraph 26 in the first line, do you wish to delete the words

"lack of"?

PROFESSOR CUTLER: Yes.

MR GRAY QC: So that reads:

There has also been a potential underinvestment in new facilities.

PROFESSOR CUTLER: Correct.

MR GRAY QC: And in paragraph 44 on the fourth line, where there's a reference to the average price agreed between providers and residents, should that be the average accommodation price?

PROFESSOR CUTLER: That's correct.

MR GRAY QC: And should the last word of paragraph 47 on the next page be "quality" rather than "competition"?

PROFESSOR CUTLER: Correct.

MR GRAY QC: Thank you. Are there any other corrections?

PROFESSOR CUTLER: No.

MR GRAY QC: Thank you. Now, the Royal Commissioners have heard evidence over the last seven days, Professor, about funding levels in residential aged care being inadequate. That's, in effect, been acknowledged by the Department of Health. I won't seek to elicit evidence from you about that foundational proposition. But I will seek some theoretical assistance from you about linkages between prices, costs and quality in health economics.

In your statement at paragraph 27, you refer to some broad-based research originating from Germany on these topics, and you go on in your statement to refer to the linkage or the correlation between prices and quality. You've also been furnished with a report prepared for the Royal Commission by the University of Queensland on the costs of aged care, which attempts to correlate expenditure on care with quality outcomes.

PROFESSOR CUTLER: Uh-huh.

MR GRAY QC: What are the linkages between costs, prices, quality and efficiency in this context?

PROFESSOR CUTLER: Yes. So we know that the amount of funding given to a residential aged care provider and the way that the funding is delivered can impact care quality. The reports or the literature that I referred to in my witness statement

has shown in particular that there is a relationship between prices and quality, at least within German nursing homes, so higher prices have significantly increased quality - increased quality based on an index comprised of seven risk factors.

We know that price plays an essential role in the delivery of aged care, so when we look at - look at the way that price is thought of, in particular, within a competitive market, organisations can compete on price or quality, and if they are competing on price, then there is a potential situation whereby if quality is not measured very well, then organisations can compete on price and effectively push prices down, which means that there is less scope to maintain quality. So, for example, if prices are pushed down by the market, it means that some providers may reduce their quality to compete at a price level. So we know that there is a relationship between price and quality, and we know that there's a relationship between costs and quality as well. So if we look at the UQ report, titled "The Cost of residential aged care" ....

MR GRAY QC: Tab 14.

PROFESSOR CUTLER: Sorry?

MR GRAY QC: I'm just telling the operator to bring up tab 14, thank you.

PROFESSOR CUTLER: OK. So there is a correlation between increased costs and better quality within that report and that makes sense. So it costs more to produce better quality, so the only way for a residential aged care provider to fund improved quality is to receive higher prices. I think one of the interesting ....

MR GRAY QC: 0554, just while you're talking, sorry, Professor.

PROFESSOR CUTLER: One of the interesting points that the UQ report states is that they didn't find a strong association between higher quality and higher staffing hour per resident per day. Normally we would think that an increased cost due to increased quality is because of more labour input. But in actual fact, it's probably a little bit more complicated than that. Not only is it labour input, but it's most likely going to be staffing quality, the way that the environment has been set up, management systems, structures, those types of things. So, overall, yes, there is a strong relationship between cost, quality and prices.

MR GRAY QC: Thank you. Now, in your report, one of the things you said on this point, paragraph 39, is that fixed prices are more likely to increase quality. Does that flow from what you've already said? Is that, in effect, the corollary of competition on price not necessarily being conducive to good quality outcomes?

PROFESSOR CUTLER: That's right. So if quality is poorly measured, and one would contend within residential aged care, it is poorly measured, that is a point where if someone wants to residential aged care they find it difficult to measure the quality of their care, then people are going to be more responsive to price. So in a market where there's poor quality measurement, providers are more likely to compete

on price. If we fix prices, then the only way that providers can really compete is on quality, and we can see that both in the theoretical literature and the empirical literature, particularly around competition for patients in hospitals.

MR GRAY QC: In your statement - this is at 35 and 6 - you refer to the concept of cost efficiency and you say there are some impediments to cost efficiency in residential aged care. What do you mean by that?

PROFESSOR CUTLER: Yeah, so - so a couple of things. So first of all, you - as a provider, you are often incentivised to reduce costs. And the reason is because you can obviously make more profit, and you could potentially also reduce price to attract more consumers. One of the issues with the residential aged care sector is that there are relatively high occupancy rates. So within the StewartBrown report that was recently released, it suggests that the occupancy rates is around about 94%, on average. That's mostly within metropolitan regions. So that means that, given that there are high occupancy rates, the incentive to attract additional people into residential aged care facilities is somewhat moot. That's, I suppose, a result of the structure that's been set up within the residential aged care sector. So there is high barriers to entry that are imposed by the way that the government allocates bed licences. So there is effectively a cap on the number of bed licences that are issued, through the national aged care planning route and that in some ways reduces competition and the need to seek further efficiency costs.

MR GRAY QC: If we go back to the UQ report, is one of the conclusions drawn there that by comparison with countries around the world, Australia actually performs well on cost efficiency overall?

PROFESSOR CUTLER: Yeah, so that is - that is what the report says. I'm always wary of comparing the Australian setting within national settings, in aged care and health care, because we have different systems, and often, studies have different methodology, different assumptions, different data availability. In this case, there's large differences in the way quality is measured within aged care. And since efficiency crucially relies on adjusting output for quality, then you'd be expected to see differences in efficiencies across studies. I suppose the other point that I'd like to make is that that statement made in the UQ report is based on a literature review that was undertaken - undertaken by the same team, and within that literature review, I think there was about maybe - maybe 35, 36 studies. Half of those were from the US, and then the - the next 25%, so around about 70, 75%, were from the US, Switzerland and Finland. So we don't really have a good understanding of the efficiency of residential aged care providers in a whole bunch of different countries and we don't have anything particularly from countries like the UK.

MR GRAY QC: A minute ago, you said something about the importance of - the importance of understanding the relationship between price and - I won't get it right, Professor, but it's something about the importance between the relationship of price and outcomes, especially where quality is not well observed.

PROFESSOR CUTLER: Uh-huh.

MR GRAY QC: I wonder if you could explain that further and what would be your proposals about how quality should be - quality observations should be improved in our system here in Australia.

PROFESSOR CUTLER: Yeah. So, as I said prior, you know, there's primarily two components within the market. There's the price and then there's the quality that's delivered. What we have at the moment within the sector is a situation whereby someone who goes to a residential care facility, who is looking to maybe place their mother or father within that facility, who can see the quality potentially of the rooms, the shared common areas, the chandelier that's hanging from the ceiling, but doesn't have a very good understanding of the quality that is being provided within that facility. And one would argue that they only receive or better understand that quality once they enter the facility, and even then, it may be difficult for them to determine the quality of their care, because they don't have anything to benchmark it against. It's not like they've been to another or most people haven't been to other aged care facilities.

So it means that the nexus between price and quality is somewhat broken, because you cannot compare the price to the quality of care that you're receiving very well. And that means people, because they can't view quality, are not probably that responsive to quality.

One of the issues that we need to deal with, I think, in the aged care sector is making sure that those quality metrics are available to people when they enter residential aged care, and we do have a national aged care quality indicator program, but it is fairly immature in its development, and I would argue that the indicators within that probably don't represent the type of value that people are looking for within care.

So, yes, they do look at some quality indicators, but we know that there are a whole bunch of other factors, so social activities, food, for example, that also are important to a resident, and they should also be included in a framework, a quality indicator framework, and that indicator framework should be made available to residents as they enter care, and easily compared across residential aged care facilities, maybe through, for example, some quality index.

MR GRAY QC: So in the absence of us having a basis to properly measure care quality at the moment, and also by reference to those other constraints you touched upon, including the things that - some of things you mentioned in your statement, the rationing of allocation of places and suchlike, are these all - are these all indications that we can't rely on, in effect, a demand and supply free market mechanism to determine price and therefore we need some sort of regulatory intervention on price?

PROFESSOR CUTLER: That's correct, yes. So we have a situation whereby competition is somewhat restricted in residential aged care because of the national aged care planning ratio and the aged care allocation rounds. We have a situation

whereby the resident or their family cannot determine the quality of care very well, as they enter a residential aged care facility, and we also have the situation whereby most people, when they enter residential aged care, are in a very vulnerable position. So it's something that they may not want to happen. It's often done out of necessity, and in some instances, there is limited time to find a residential aged care provider because someone may be in hospital who needs to find alternative accommodation outside of hospital.

So, in that instance, there is a difficulty for the consumer or for the resident to assess quality compared to price, and that suggests that there should be some continued regulation of price on care.

MR GRAY QC: Thank you. With that contextual theoretical framework, and with the way you've explained how those concepts link to conditions on the ground in the aged care system generally in Australia, can I now test with you a number of propositions that the counsel team have been raising for consideration of the Commissioners during this hearing, and they've also been commented on by the witnesses through the hearing. I'll start with FF 3. This is tab 111. Tab FF 3 is on page - I beg your pardon, proposition FF 3 is on 0004 and it's, in effect, a statement about when a particular body we're calling the aged care pricing authority should be responsible for the determining what, if any, regulation is applied to private prices for aged care services, and there is a statement of principle about, in effect, the onus being in favour of regulation, save where it's demonstrated that there's a workably competitive market for the relevant services. Do you agree with that proposition?

PROFESSOR CUTLER: I do, yes.

MR GRAY QC: And in terms of the types of regulation that might be appropriate, what are the sorts of interventions, regulatory interventions, that might be appropriate for the various services?

PROFESSOR CUTLER: Around pricing?

MR GRAY QC: Yes.

PROFESSOR CUTLER: Yes. So I think there needs to be price caps for living expenses and for care, primarily because we don't have a competitive market, and in some instances, there may be some providers who, for want of a better word, take advantage of a situation whereby there isn't a good, strong relationship between price and quality.

In terms of accommodation - so we have a situation which is a little bit different from living expenses and care. Accommodation is something that a person can, in some ways, view in terms of quality. They get to see the room, they get to see the building, and its state. They also get to see the common areas. So, in some ways, they have an understanding of the quality of accommodation that they will receive. Having said that, though, because there is limited competition within residential aged

care providers, ie, there are high occupancy rates, there is still the opportunity to - for a provider to ask for a price that is much greater than what the accommodation is worth. And I think, in those instances, we want to ensure that that individual is protected somewhat.

So I personally think that the way that it is currently operating, whereby we have some flexibility in accommodation below a threshold, a 550,000 threshold, works well, and if we are seeking additional - an additional price above 550, then, in some ways, that needs to be justified.

MR GRAY QC: OK. Thank you. Can I just ask you about occupancy levels, because that factored - that featured in a response you just made, and you'd referred to us StewartBrown report on a 94% average occupancy level across residential care a minute ago. If the occupancy was level was in fact down around 90 or slightly below 90%, would that change any of the analysis that you've just expressed to the Commissioners?

PROFESSOR CUTLER: No I don't think so. You know, it's really about: how can a facility charge price above what a room is worth? And, so, in some areas, there may be a situation where there is competition, and that competition does drive down prices, or at least stops prices from increasing exponentially. But, in other areas, that may not be the case, and we have to think about what the aged care market really is. It's not a market as such; it is a local market. People aren't willing to travel long distances. So the relevant market for an individual is, let's just say a 10, 15-kilometre radius, and so there will be variations across different parts of Australia as to competition levels. And so I think it's still appropriate to ensure that those residents who are in areas where there is limited competition are protected.

MR GRAY QC: Is there a case for a higher level - a higher form of regulation than the current form of provisional limit and waiver by the Pricing Commissioner of accommodation charges? For example, if a resident is looking for aged care services in an area where there is a real constraint on supply and occupancy levels are very high, or if - or if there is - well, I'll just leave it at that to begin with. Across-the-board, is there an argument for a form of gradation of accommodation changes based perhaps on an analysis informed by land prices in different regions? Or different areas of distance from capital city centres?

PROFESSOR CUTLER: So you're referring to accommodation prices; is that correct? So everything above 550, and how that's calculated?

MR GRAY QC: Yes. Is there an argument for a heavier form of regulation about accommodation prices, whether that be in the form of a lump-sum deposit or a daily charge, than the current arrangement whereby the Pricing Commissioner may waive the upper limit of 550 based on fairly loosely defined criteria of relevant considerations.

PROFESSOR CUTLER: In this situation, we need to think about the administration

costs of introducing a much more detailed approach to regulation, and in my opinion, I don't think that's required. I think one of the benefits of the current arrangement is that it sends a strong signal to providers that we're not going to tolerate accommodation being priced at an amount that is significantly higher than what the accommodation is worth. And I think that is the - that is the real benefit from the current approach. It's the signal to providers that we want you to ensure that your price reflects in some ways the cost of accommodation.

MR GRAY QC: I'm going to ask you in more detail about the possible mechanisms by which the price caps that you've, in effect, advocated on living expenses and care might be determined, but before I do that, can I just ask you just to confirm a few things that the Royal Commissioners have heard from others this week, or over the last seven days, I should say, and that is that there's an argument in economics for prices to be arrived at which reflect the cost inputs necessary to provide the services for which the prices are charged, and there's an argument in economics against, in effect, cross-subsidisation of the costs of providing other services from revenue and through prices charged for distinct services. Have I basically got that right, that there's an argument in economics that pricing should be reflective of the cost inputs for the particular services and there shouldn't be cross-subsidisation across different services?

PROFESSOR CUTLER: That's right, yes. So the problem with cross-subsidisation is that it introduces perverse incentives. So, for example, if you were to allow accommodation to cross-subsidise care, then you have a situation whereby people are paying more for their accommodation, and they may not be receiving the complete benefit from the care, ie, that care is cross-subsidised for everyone within the facility, rather than just that individual. It can also lead to some other interesting outcomes as well. So, for example, if care was not properly funded and providers are cross-subsidising care through accommodation, then you would expect that for those areas that have high land values and high property values, where there's likely to be high accommodation prices, and the capacity to charge more for accommodation, above the cost of accommodation, then those people are more likely to receive better care, compared to someone who lives in an area with low property values, and that may be considered inequitable to some, given that care may not then be based on - may not then be completely based on need.

So from that perspective, it is better for outcomes and more efficient if care is appropriately funded for its cost, and accommodation is appropriately funded for its cost.

MR GRAY QC: I want to leap down the list of propositions to a proposition about acquittal of care expenditure. I just want to ask whether what you've just said is a good argument supporting a requirement for acquittal of care expenditure, so that it's, in effect, transparent to the governmental system manager what particular providers are spending on their care, and whether that is, in effect, reflective of the subsidy that they've been paid to provide care. It's proposition FF 12 on page 9. And underneath the bolded words, it says:

The funding arrangements should provide a clear line of sight between the source of funding and the expenditure on care. The Australian Government should require approved providers of aged care services to acquit overall expenditure on care or care staffing hours on a quarterly basis ....

Professor, what's your position on that requirement?

PROFESSOR CUTLER: I mean, my position is that, first of all, we should be measuring outcomes rather than inputs. So, in a perfect world, we would have an aged care system whereby we have a quality indicator program that gives us a very good understanding of the quality of care that's being delivered in residential aged care. I think that's something that should be put on a reform agenda, and upfront, ie, it's one of the first cabs off the rank.

In the absence of that though, we might be thinking well, are providers actually spending the money that's given to them by the government on care, and we'd like to think that they are. I understand the desire for an acquittal process, but at the same time, it needs to be balanced, because an acquittal process can add additional administration costs on providers. Depending on what the acquittal process is, it can reduce the ability of providers to be flexible with their staffing arrangements. And I also want to add that there's no guarantee that increase staffing equals improved care. As I said before, the UQ report suggests that that is not always the case, and in some ways, it's more about quality of the staff, plus the amount that's provided that will determine quality. Of course, good care is not guaranteed, even if you increase costs. It relies on the interaction of staff with their environment. It relies on management structures and systems, infrastructure technology. Also the culture within the aged care facility, training, leadership, those types of things.

So while I understand the acquittal process is there, I think it should be, if introduced, a temporary process until we can better measure quality.

MR GRAY QC: Thank you. Let's get back to, in effect, the mechanics that might be involved in determining what is a - a reasonable cost price for care, and I want to put up FF 1 and FF 2. These are proposals for independent pricing for - well, a range of potential aged care services, but given what you've just said, I want to suggest that they would at least include care and living expenses, or the charges for basic daily living needs.

What do you say about the detail of proposal FF 1 for this independent mechanism, we called it the Aged Care Pricing Authority, to review information including cost data to conduct cost studies and benchmarking into set or at least recommend levels of funding that are needed to meet the cost of delivering, in particular, care and basic daily living needs?

PROFESSOR CUTLER: Yeah. So I think it's - I think it's a really important proposition, and I think it's absolutely necessary that we have an independent

authority that evaluates cost data and determines prices. So, in the past, we haven't had that, obviously. We've had ACFI. ACFI has individual prices and, in some ways, that has been used to manage government budgets by adjusting prices within ACFI, which, you know, doesn't necessarily reflect the cost of care. So I think - I think it's a really important proposition.

MR GRAY QC: And can you - well, are you able to comment on FF 2 as well? Does that go without saying, that the funding levels that are set must include indirect costs that are necessary to the provision of the particular service?

PROFESSOR CUTLER: Yes, yes, of course it should.

MR GRAY QC: And these principles about the undesirability of cross-subsidisation, is it in these processes that they really need to come into play, you need to be careful to ensure that the cost, the inputs on which these prices are set or recommended, are only the costs of providing the services so priced and you're not bringing in costs for other services. Is that how it works?

PROFESSOR CUTLER: That's correct, yes. So defining what you're paying for, and then working out a price for that service.

MR GRAY QC: And going back to what you said right at the start of your evidence about how we don't understand quality very well; we don't know how to measure very quality very well yet, would that be a critical input in the process as well?

PROFESSOR CUTLER: Yeah, that's right. So prices must be set to the level of quality that we desire, rather than the current levels of quality, given that there has been a suggestion throughout the Royal Commission process that quality is not appropriate within the aged care sector. So that is an important component within setting prices, determining at what level of quality should the residential aged care sector achieve.

MR GRAY QC: Let's just look down the list to FF 7, which is a proposal, and we have predominantly in mind here residential care. It's a proposal for aged care services to be funded through casemix adjusted activity based funding arrangements. In that narrative underneath there is a reference to the work of the team led by Professor Eagar in developing the new casemix adjusted activity based funding model, AN-ACC.

So, Professor, this would require the determination, would it, of something like a national efficient price analogous to the national efficient price determined annually by the IHPA for hospitals, and that would anchor a casemix model such as AN-ACC? You've expressed some caution about whether efficiency is the right lens through which to convert the costing studies that are performed by this body into recommended or determined prices.

Can you explain that to the Commissioners, please?

PROFESSOR CUTLER: Yeah. So I suppose my caution around a national efficient price is based on two components. So, first of all, if we think about an efficient price, it means that some providers will not be able to cover their costs because they are inefficient. Obviously that's the purpose of setting an efficient price, to encourage providers who have high costs to reduce their costs. But setting an efficient price when some providers are significantly efficient may result in some providers exiting the market and leaving some residents stranded. Or, in addition, some providers may reduce their quality to reduce their costs to meet an efficient price. And here is where, you know, we come up again with the issue around quality, measuring quality appropriately, to ensure that things like, you know, introducing a national efficient price doesn't mean providers try to meet that efficient price by reducing their quality.

So, you know, under a national efficient price, we maybe have a situation where more efficient providers can flourish, but in some areas, you know, you may have some providers that don't flourish, and this is, I suppose, particularly an issue for areas that have limited options, rural and remote areas, for example, whereby, if the price is not set appropriately, then, you know, you may have a situation where you don't have an aged care provider in close proximity.

The other point I want to make is also the difficulty in setting an efficient price. And the reason why I say that is because efficiency is to be measured on some outcome measure relative to cost, but the issue is that, unlike utilities, outcome within residential aged care is not homogeneous. It is quite variable and it depends on the quality of care that an individual receives and how that individual responds to that, that receipt of care.

So developing a national efficient price crucially relies on measuring output and measuring the quality of that output. And that may be difficult in a situation whereby we're looking at residential aged care and - unless we've got good data on output and outcomes and quality.

MR GRAY QC: Can I just ask you about the extent to which what you've just said is, in fact, compounded, I suppose, by a certain dissimilarity between hospital admissions and the experience of a person in residential aged care. A hospital admission is essentially a course of treatment for a particular episode in that person's health, and it has a defined beginning and a defined end, and presumably, there's very often a procedure that's undertaken. There might be several, and there's an outcome, and all of that seems reasonably measurable and there's also very high volume, so what sometimes called by mathematicians the law of large numbers comes into play, by which you can smooth out volatilities in the individual experience and get a picture of a pattern of cost inputs for a particular kind of hospital admission. To what extent does that hold true for aged care, and what are the tools by which the pricing authority might have to cope with that and on which side should it err, on the side of average costs or efficient costs?

PROFESSOR CUTLER: Yeah, so there are going to be differences in the mix of residents that come through a facility. I suppose the first point I'd like to make is that should be assessed at the provider level rather than the facility level. The second point I'd like to make is there are some provisions within hospitals, for differences in volume. So relatively large hospitals are funded by one method, activity-based funding, and providers - sorry, hospitals that are smaller are funded through another means. I suppose if we were to take into consideration differences in resident mix - I mean, I - yes, there will be variation in funding, given that there may be small numbers, and there may have to be some adjustment for relatively small providers, particularly if they are in areas that may have higher costs, so, for example, in rural and remote areas, where their access to labour may not be as good.

MR GRAY QC: Still in our proposals, if we go to FF 5, please. I beg your pardon. We'll go to FF 4. If we go to FF 4, we've proposed that the authority, this pricing authority, should be able to examine and make determinations about loadings to be payable in thin markets. AN-ACC itself has a mechanism for, on the Monash scale areas in MMM 6 and 7, those rather remote places, to receive, in effect, block funding by way of one of the tiers of funding under AN-ACC.

So I suppose, Professor, there are ways in which these matters can be addressed, either through AN-ACC or through loadings. Would that be your view?

PROFESSOR CUTLER: Yes. Yeah, yeah. And I think, you know, you do want to ensure that, particularly in thin markets, access remains available to potential residents and residents who are currently in residential aged care. So, yeah, it is a standard way of accounting for some differences in costs.

MR GRAY QC: Yes. Thank you. Maybe by way of last resort, if loadings are unsuccessful, the proposition also envisages the possibility of simply commissioning a provider to be the provider of last resort on, in effect, whatever price can be negotiated with that provider. Is that a suitable and appropriate failsafe mechanism?

PROFESSOR CUTLER: I think so, yes.

MR GRAY QC: Now, can I just ask you about the connection - and I think we've got to take it one category at a time - the connection between setting subsidy levels and the potential for setting price caps. If we take care, are the two things, in effect, synonymous? Are we talking about one and the same thing, the authority setting something that operates both as a subsidy level and as a price cap, subject to any user contribution through means testing?

PROFESSOR CUTLER: Yeah, that's right. So I don't think there necessarily have to be one and the same thing. You can have a price cap that providers are allowed to reach, but at the same time, the government may provide some level of subsidy that is below that price cap, and the difference would then be made up between - well, be made up by co-contributions to care. That is a plausible option. We just want to make sure that that price cap is set at an appropriate level, whereby the difference

between the subsidy and the price cap doesn't exclude people from care.

MR GRAY QC: Would you have the same pricing authority perform functions relevant to the determination of subsidies?

PROFESSOR CUTLER: In terms of trying - in terms of trying to work out how much the subsidy should be set at?

MR GRAY QC: Yes.

PROFESSOR CUTLER: Yes. That would be a natural activity within an Aged Care Pricing Commission, given that they hopefully would have good robust cost data.

MR GRAY QC: Yep. Let's focus now specifically on living, unless there was anything else on setting both price caps and subsidy levels for care, but we probably covered it, I think.

PROFESSOR CUTLER: Yep.

MR GRAY QC: We'll go now to basic living needs and the charges for that and the expenses for that.

PROFESSOR CUTLER: Uh-huh.

MR GRAY QC: The current situation is that, for some time now, the basic daily fee to cover living expenses has been price-capped at 85% of the basic single aged pension, hasn't it, Professor?

PROFESSOR CUTLER: Yes.

MR GRAY QC: And it is the fee that is, in effect, mandated for the provision of a range of daily living services which are defined in delegated legislation. The evidence is - and this is primarily StewartBrown; it's fallen behind badly and it's now significantly underfunding the provision of those daily living needs. What should be the approach of the pricing authority or regulator to this - to this matter, in your opinion, Professor?

PROFESSOR CUTLER: Yeah, so it's a bit of a tricky one, because we have a situation whereby 85% of the single pension is being used for daily living expenses, and now, we have providers saying to us, "Well, in actual fact, that isn't enough. We need more." I suppose one of the roles of the Pricing Commission would be to ensure that they get a good understanding of how much it costs to deliver daily activities, and where there is variation in daily living activities, why that has occurred. It's hard to ask someone to pay more for daily living expenses when they've got no more to give, ie, there's a significant proportion of people, most people within residential aged care, who are on a single pension, and so, taking more from that, I think, would not allow them to spend money elsewhere for social activities, for

example.

MR GRAY QC: Well, can I suggest this: should the regulator or the authority, on the basis of the cost reviews, and perhaps differentiating between different regions on the basis of remoteness, say, come up with a subsidy level or a price level - let's call it a price - for daily living.

PROFESSOR CUTLER: Uh-huh.

MR GRAY QC: And for people who have the means to pay that price, they should pay it in full, or for pensioners, or for other people who don't have the means to pay it, their contribution should be capped and for a pensioner, presumably, it should be capped at 85% of the basic single aged pension, but the government should top up the difference between 85% of the single basic aged pension and the price that's been determined by the authority. Would that be an appropriate approach?

PROFESSOR CUTLER: Yes, I think so. Yes. Yeah. I mean, the important point is, you know, you don't - you don't want providers to be ramping up their daily living expenses because then the government would be - potentially the supported residents taking on quite a bit of cost. So you still want to ensure that you have some control over those prices.

MR GRAY QC: What about so-called additional services? What role do they play here? The Royal Commissioners have heard a bit of evidence about it, or about them, and also about the predecessor of extra services, but I think we can focus on additional services now.

PROFESSOR CUTLER: Yep.

MR GRAY QC: What's the connection between them and, in effect, sort of guaranteed basic daily needs, and should any regulatory approach over and above what's currently done be applied to additional services?

PROFESSOR CUTLER: Yeah. So I look at this as a comparison of needs to wants. So daily living expenses, care, residents need those activities. Additional services fall more into the wants. And I think the difference between the service characteristics also is that it's much easier to evaluate the price that you're being charged in a residential care facility, compared to what you would've been charged outside of a residential care facility. So it is therefore harder for a provider to increase prices for additional services beyond what is reasonable. So, for example, if you were looking for a haircut and the provider is charging you $150 for a haircut, you know that something is a bit fishy, because you could get a haircut outside of a provider for, let's just say, $50. So I don't think there needs to be regulation around pricing for additional services.

MR GRAY QC: OK. Is there any scope for - and this is perhaps controversial - additional care? What's the situation with additional care? There

have been views expressed in some of the material before the Royal Commissioners to the effect that, in terms of economics, provided an acceptable minimum high quality of care is mandatory, and that is what is provided in return for subsidy, to which there might be user contributions, subject to means testing of course, then over and above that amount, in the health system, for example, we have private health insurance, we have a private health system sitting alongside the public health system. What would be wrong with having the ability for people to purchase additional care over and above that minimum high quality? What are your views?

PROFESSOR CUTLER: So I think people should be able to purchase better-quality care, if they have the funds to do so, and the desire to do so. One of the issues that we have, though, is that, for some residents, they may be priced out of the market. As I said, most residents consider the residential aged care sector as being within a 10 to 15 kilometre radius. And you have a variation in wealth within suburbs. So you don't want a situation whereby you have four or five providers who've all decided that they want to provide high levels of care and charge high prices when you have individuals who just can't afford those prices. So, yes, allow some people to provide more care - sorry, allow some providers to provide better care for those who want it, but you need to make sure that access is maintained for others.

MR GRAY QC: And does that involve, in effect - and this is, I think a feature of the current system - that a provider that's receiving Commonwealth subsidy to provide care must provide care at that subsidy amount, and at no more, and it's, in effect, completely at the option of the care recipient to make arrangements for more, and they're free to make arrangements for more, but it could never be a feature of the system that a provider is permitted to demand more for care, more money for more care. Is that a fair summary of what you're saying?

PROFESSOR CUTLER: I'm not too sure whether I'd put it in those terms. I think we just need to ensure that we have options for those who want to pay for more care, and those - and options for good-quality care for those who can't afford to pay for more care. And one of the barriers to that currently is the fact that we have the national aged care planning ratio. So if you had a market whereby there are a bunch of providers who decide they all want to provide very good care, and they won't allow individuals in unless they can pay for that very good care, then you're more likely to have a gap in the market, because there are restrictions to entering that market due to the ACAR and the national aged care planning ratio.

So we need to ensure that the market is competitive before we start allowing providers to charge more for care.

MR GRAY QC: Yep. Thank you. Can I go to another proposition. This is a transitional one. I think you've probably already given evidence that covers it but I'll just make sure that we get your view on the record. It's FF 10, immediate funding measures to improve quality of residential aged care homes. This is a proposal which is intended to cover that transitional period before the independent pricing mechanism is up and running, and it's a proposal - it will probably come up on the

screen in a minute - it's on page 0007, FF 10. Thank you.

It's a proposal for acquittal-based increases in staffing levels in the interim before the independent pricing mechanism is up and running. I think a minute ago when I was asking you about acquittal, you said it might be acceptable as an interim measure. What do you say about this proposition as an interim measure?

PROFESSOR CUTLER: So this is the - the Australian government should make additional funding available to increasing staffing levels?

MR GRAY QC: Yes.

PROFESSOR CUTLER: Yeah, look, I think that the Australian Government does need to make additional funding to aged care providers. As I said, though, you know, increasing staffing levels is not just about the staffing level; it's also about the quality of staff. So there needs to also be investment in training for staffing, and the quality of staffing, if that was also increased, is likely to improve quality as well.

MR GRAY QC: Yes. Thank you. I'm going to ask you in a minute about the approach that should be taken to transitional arrangements at a higher level of generality. That was one particular detail, but from a health economics perspective, I wanted to get your views on what are the principles that should inform the sequencing of reforms and the approach to governance of the implementation of reforms.

But before getting to that, there are just a few more details I should ask you about. On the accommodation side, you've told the Royal Commissioners - and thank you - that, in effect, you view the current form of regulatory scrutiny of accommodation prices as appropriate and as proportionate and that going further might be disproportionate and of course we're talking now about that provisional limit of $550,000 for a RAD or its equivalent, DAP, and about the ability to approach the Pricing Commissioner for a lifting of that limit in specific cases.

Should the criteria on which the Commissioner acts be more prescriptive than they currently are? They're fairly loose at the moment. What are your views?

PROFESSOR CUTLER: Yeah. I mean, I don't think so. I think they're set appropriately. As I said before, it's really about providing a signal to providers that you're not going to be able to set an accommodation price that is grossly inflated compared to the cost of accommodation, and I think the Pricing Commissioner can gauge as to whether that's occurring through the information that they currently receive.

MR GRAY QC: Should the accommodation supplement, so, that is, the subsidy paid by the government, in effect, on behalf of people who subject to a means test are not able to - are deemed unable to pay for their own accommodation in whole or in part, should that be determined by the pricing authority?

PROFESSOR CUTLER: Yes. Yes, I think it should.

MR GRAY QC: Should it be a uniform figure as it essentially is at present for all new and refurbished facilities or should it vary based on land prices or some sort of metric of remoteness from the centre of capital cities?

PROFESSOR CUTLER: I think ultimately that's a question for the Aged Care Pricing Commissioner, that they need to answer once they've collected data on the costs of accommodation. So it really depends on the variability in costs associated with accommodation. If there is huge variability, then yes, there is an argument for trying to refine that price, but if there is, you know, a fairly homogeneous cost for accommodation, then I think an average price is probably appropriate. Again, we need to trade off the administration burden with potential outcomes.

MR GRAY QC: Would the concept of a sector-wide or perhaps broadly segmented weighted average cost of capital be a useful input into the pricing authority's deliberations about setting the accommodation supplement?

PROFESSOR CUTLER: Yes, it would be, yes. It would give them a good understanding of how much it does cost for accommodation.

MR GRAY QC: Have you had a chance to familiarise yourself with the report of Frontier Economics at general tender tab 23, so that's exhibit 21-1, tab 23?

PROFESSOR CUTLER: I have looked through it, yes.

MR GRAY QC: And is that the sort of analysis you'd expect to be taken into account by the pricing Commissioner on that matter of setting the accommodation supplement?

PROFESSOR CUTLER: Yes, that's correct. It's a fairly standard approach to looking at accommodation costs.

MR GRAY QC: OK. Now, outside the accommodation supplement, we're into the area where you've got non-supported or unsupported residents, but you don't see a case for price capping the accommodation charges for them. You've given your answers to the Royal Commissioners about how they should be treated and you're effectively content with the current system?

PROFESSOR CUTLER: Correct.

MR GRAY QC: Thank you. What about the conversion between RADs and DAPs? You've referred in your statement at paragraphs 17 to 19 to a significant body of work you've done over the years and that you are currently engaged in doing, in considering issues raised by RADs in the system, and you've done modelling in the past about, in effect, expected behaviour by people in converting between RADs and

DAPs. Firstly, is there any currently prescribed methodology for - I beg your pardon; I withdraw that. I think you've already answered it.

Is the current conversion rate between RADs and DAPs an appropriate rate, both in terms of its amount, but perhaps more importantly, in terms of its derivation and the methodology for its calculation, which I understand is based on a 90-day bank bill?

PROFESSOR CUTLER: Yeah. So there's a couple of points I want to make here. And I'm referring to arguments that are within the sector as to whether the DAP should be converted from a RAD using an MPIR or a WAC.

I suppose my answer depends on whether we're taking a consumer perspective or a provider perspective. And also, when we're talking about equivalents, what are we talking about the equivalents of? So if we take a consumer perspective, and we assume that the NPR is used to ensure a DAP is equivalent to a RAD, then from a consumer perspective, the NPR should really represent the opportunity cost of using a RAD. So, for example, if you have a RAD that was worth $100,000 for argument's sake, and the real cost of that RAD to the consumer is the - is the return on investment that they would not otherwise have - that they would not otherwise receive, so that 100,000 may have been invested in bonds or stocks or kept in the family home, and there's a return on that. So that means that the cost to the consumer of a RAD is the opportunity cost of not receiving funding elsewhere, and let's just say that's 5%. On a $100,000 RAD, the cost to the consumer is really $5,000.

Now, if we think about the DAP, setting a price based on an MPIR greater than 5%, so what might occur if you were, for example, to use a WAC, means that the consumer will pay more for selecting a DAP. So the price to the consumer is therefore - when I say consumer I mean resident or the families and friends - the price is therefore not equivalent, based on whether a person chooses a RAD or a DAP, and the difference in price will crucially depend on the difference between the - what the person could otherwise have received in their return, and their WAP. So, in this situation, you may have - and the WAC that has been used to convert to the DAP.

So in this situation, you may have an example where you've got two people with the same assets, the same income and the same room, but they're effectively paying different amounts for the room because one chose a RAD and one chose a DAP.

Now, if we take the provider perspective, and some may argue that this is fair, so, that is, because a person has chosen a RAD, which means less cost of capital, then they should pay less for their accommodation. However, obviously, some residents may think that is unfair, because they may not understand that choosing a DAP would've cost them more, essentially. We also need to consider how accommodation prices are set. So prices are typically not a direct reflection of the cost of building and financing a room. They also include some type of margin. So a room may cost, for example, 250,000, whereas the RAD may be set at 400,000. So there is a margin

there.

So we need - we need to then think about, OK, well, is it appropriate to apply a WAC to the $400,000 RAD, when that is priced as the cost of the room, plus an additional margin, and I would suggest that it may not be. I think we all have to remember that providers have other levers if the WAC is greater than the MPIR. In particular, a provider can increase their accommodation price, and from my perspective, I think that is probably the most appropriate tool they should be using when thinking about covering the costs of their capital.

MR GRAY QC: Thank you. So just one quick question. Right at the start, and I probably should've asked you then, you referred to the opportunity cost of a person electing to lodge a RAD, a deposit, rather than electing to pay a daily fee or a daily payment.

PROFESSOR CUTLER: Uh-huh.

MR GRAY QC: And when you said that you the gave the example of, say, it might be 5%, the opportunity cost might be 5% of the principal, if it was $100,000, or it'd be $5,000 per annum in term of opportunity costs. What did you mean there? Was that the lost opportunity of investing $100,000 or was it an interest rate on a loan?

PROFESSOR CUTLER: That's right. Well, it's effectively the opportunity - it's the cost of the lost opportunity of not being able to invest that elsewhere. So $100,000 that comes out of an account or some other asset means that they're not receiving a return on that asset. That's provided to the aged care provider, and therefore, the cost of that RAD to the individual is the lost opportunity.

MR GRAY QC: So, Professor, there's a sense of a Solomon-like approach to the perspectives of both sides in the answers that you've given as to what an effective - well, what an appropriate conversion rate should be. We've heard from some of the industry witnesses, some of the providers who gave evidence yesterday, fairly forcefully expressed evidence to the effect that pinning the conversion rate to what's, in effect, an interest rate or something akin to a yield on an instrument is likely to cause volatility, particularly in the current climate, when yields are very low, it's going to undercompensate a provider. It's going to possibly tend to lead to a flight of elections away from RADs and into DAPs and that might have liquidity implications, at least if it's repeated on a mass scale over a long time and that might be compounded by falls in property prices and lead to a bit of a run on RADs in a worst case scenario.

But we've seen in the report of Frontier Economics that we mentioned a moment ago in part 7, a clear argument that an interest rate is an appropriate conversion rate, that is, an interest rate on an imputed loan is an appropriate conversion rate for a DAP, because that's what the economic function of lodging a RAD is. It's in fact to confer or provide an interest-free loan to the aged care operator, and Frontier have gone through a process of imputing both an expense and revenue stream by reason of that

activity in the course of their economic analysis of returns done in another paper.

So, in the end, where do you come down? Do you say that, in fact, the interest rate approach is the more appropriate approach because a return on capital is already taken to be embedded in the quantum of the RAD, or do you say a WAC approach is fairer?

PROFESSOR CUTLER: Yeah. So I would tend to suggest that an interest approach is probably the more appropriate approach, but at the same time, you know, we want to ensure that the rate is set so, you know, in some ways, there is an equivalence for the consumer, for the individual, for the resident who's paying a RAD and a DAP. And if there is a large difference, as I said, between a WAC and what they could otherwise receive, then there would be distortions. People will choose potentially a RAD if a DAP is too expensive or vice versa.

In terms of volatility, yes, there is volatility, but there's also volatility when we think about a WAC as well, because a WAC is just a composition of equity and debt, and the rates on equity and debt also change. You know, I obviously haven't done the analysis, but it would be interesting to see what volatility there is between a WAC versus an interest rate, and then the final point I'd like to make is that the volatility in some ways can be mitigated by providers by adjusting their accommodation prices. So as the interest rates go down, obviously, the DAP will also go down, but in some ways, that can be compensated for by increasing accommodation prices.

MR GRAY QC: Thank you very much. Can I turn now to a series of propositions on community supports and home care. The propositions are numbers 5, 6 and 8. Number 5 is a proposition that certain forms of community supports will be best funded through a combination of block and activity-based grant funding by direct agreement between the governmental system manager and the provider in question, and we have in mind here social supports, assistive technology, home modifications and respite care.

What are your views on that proposition, FF 5, Professor, and its extension to those categories of services?

PROFESSOR CUTLER: Yeah, look, I mean, agree. It could be funded through a combination of block and activity-based funding, but I also want to make the point that, within that proposition and within the document itself, there's no reference, really, to other types of funding that could be used. So, for example, outcomes-based funding. I know that there are people out there who aren't big fans of outcomes-based funding, and indeed, we've seen in the hospital sector that outcomes-based funding is really difficult to achieve effectiveness, you know, if you look at the literature, probably about 50/50, whether your outcomes-based funding model will actually improve outcomes.

But in these studies, many of them have been undertaken in primary care in hospitals. It's not the same as aged care. And we know that aged care providers

respond to financial incentives. So, from my perspective, I think that we should be continuing to explore outcomes-based funding models, to see whether they can, indeed, induce some form of improved quality.

MR GRAY QC: Thank you. Propositions 6 and 8 are for individualised bundles, and we have in mind here predominantly care at home, particularly, perhaps, the more complex or intense needs for people to receive care at home. There's an issue about exactly what the individualised bundle or package or budget should cover, and there have been various iterations and proposals ventilated during the hearing and during the previous hearing on home care. That needs to be read in tandem with FF 8, which, in effect, caps out the funding available for care at home on par with the care component of the funding that a person would be assessed to receive in residential care.

What are your views on these matters, Professor?

PROFESSOR CUTLER: Are you referring to the proposition FF 6 or FF 8, or both?

MR GRAY QC: Both, in tandem.

PROFESSOR CUTLER: OK. Yeah, look, I tend to agree with those propositions. You know, aged care services can be funded through individualised bundles. You know, we just - look, I mean, it's - yeah. Look, I agree with the propositions. I don't see that there is, you know, any necessary reason why not to agree with them. The maximum funding amounts for care at home, proposition FF 8 - so I suppose my only - my only response there is that, you know, there's a potential perverse incentive here, if the provider were responsible for determining whether an individual receives care at home or in residential care. So, from my perspective, I think the assessment should be undertaken by an independent assessor.

MR GRAY QC: If the funding is equivalent, might that mitigate that perverse incentive?

PROFESSOR CUTLER: Yes. Yes. That's true. I mean - well, I suppose - I suppose then you have to, though, think about: what is the provider delivering? Are they delivering both home care and residential care - ie, both types of care - or are they just delivering one type? And if it's one type, then, obviously, a provider would probably want to ensure they keep that individual.

MR GRAY QC: Yes. Thank you. Can I go to means testing, and I hope you've had a chance to reflect on our late addition to the propositions at FF 20 in particular. It's that proposition that I wish to receive your opinion on. Are the principles for redesign of a means testing for user contributions towards residential care under that proposition suitable, do you think?

PROFESSOR CUTLER: Yeah, I think so. So, under that proposition, it really shows that there seems to be inequities in the way that people are asked to pay for

their care in proportion to - and accommodation in proportion to their means, their financial means. So, yes, I agree with those propositions.

MR GRAY QC: Thank you.

PROFESSOR CUTLER: That proposition.

MR GRAY QC: I want to now come back to this point about transition, transitional principles, and we'll ask that the principles that Royal Commission staff have prepared for a framework for transition and implementation be displayed. This is a document prepared by staff of the Royal Commission, not by yourself, Professor, but you've had a chance, I hope, to familiarise yourself with it. It's titled "A Framework for Transition and Implementation". Thank you. RCD9999.0534.0001.

Professor, I understand you wished to make an addition to the principles, but, subject to that addition, can I ask you for your views on those principles? Perhaps the addition first.

PROFESSOR CUTLER: Yeah. So my addition is really around ensuring that there is ongoing monitoring of the impacts of change on the sector. So, within that document, there is a discussion on monitoring, but when you look at the explicit framework recommendations that are made ....

MR GRAY QC: The second page?

PROFESSOR CUTLER: Yeah, the second page, there doesn't seem to be a reference to monitoring. So I would probably like to see that more explicit, and the reason why is because large reform will result, hopefully, in large change, and within large change, there is potential for perverse behaviours to occur, or outcomes that were unanticipated. And so I suppose what I'd like to see is an explicit recognition that any change, any reform process, has a good-quality monitoring framework around it; in particular, monitoring the quality of care being delivered, monitoring prices, and also, monitoring access to services, because at the end of the day, we want to ensure that people have access to good-quality care, and in some instances, if the aged care sector does go through rapid change, that may not occur, and we want to ensure that that situation is mitigated.

MR GRAY QC: Thank you. And one of the points that is raised - this is the second bullet point - is adaptive implementation. Can I just ask you - and this is really my final question - that monitoring that you've mentioned, is a key use for that monitoring that it would be made available to an active system manager or other manager responsible for implementation, so that they could refine and adapt iteratively to meet unforeseen circumstances? Is that really the utility of the monitoring?

PROFESSOR CUTLER: Yeah, that's right, yeah. So making sure that we understand what changes are occurring within the sector as it transitions from one

environment to another. In terms of adaptive implementation - yes, I think that's important, but we also want to make sure that that doesn't allow the fundamental principles of reform to change; it doesn't allow, you know, some key reform planks to change, that may then have a flow-on effect to other reform mechanisms. So there has to be a very good understanding of how changes that are occurring and will occur through reform interlink, because you may change one piece of reform, and that may have flow-on effects to other parts of the system and other parts of reform.

MR GRAY QC: I have no further questions.

COMMISSIONER PAGONE QC: Thank you. Yes. Thank you, Professor. Thank you for the amount of effort that you've put into your statement and for being available to help us think through these difficult questions. I formally excuse you from further attendance, and thank you very much for having assisted us as you have.

PROFESSOR CUTLER: Thank you.

THE WITNESS WITHDREW

COMMISSIONER PAGONE QC: Now, Mr Gray, what time do you want to resume, at quarter to? Is that right?

MR GRAY QC: If we could resume at 2.30. I might make some brief remarks about what you've heard, without intending to be comprehensive, and then we've got another witness at 3pm, and that will then be the end of the hearing. That will allow you, the Commissioners, to keep whatever travel arrangements you might've made. That witness at 3pm is an overseas witness and can't appear before 3pm.

COMMISSIONER PAGONE QC: Yes. The only concern is the end time. Will you have enough time so that we will be able to start the 3pm witness at 3pm, so that you will be able to finish with him at 4pm?

MR GRAY QC: Yes, and that's because the remarks I intend to make are in no way a comprehensive closing of the hearing; they're simply some remarks about mainly housekeeping matters, and a very brief overview of what's transpired.

COMMISSIONER PAGONE QC: If you need to start a bit earlier, then we can do. It's just that we don't want you to be squeezed at that stage and then squeeze the others.

MR GRAY QC: Well, we could start at 2.15, but there will probably then be a short break between the end of my remarks and calling the witness. But I suppose that's fine.

COMMISSIONER PAGONE QC: I think we might do that, to be safe, Mr Gray.

2.15.

MR GRAY QC: Thanks, Commissioner.

ADJOURNED **[12.51 PM]**

RESUMED **[2.17 PM]**

COMMISSIONER PAGONE QC: Mr Gray.

MR GRAY QC: Thank you, Commissioner. We wish to call one more witness, Dr Pieter Bakx, a health economist from the Netherlands.

Commissioners, you'll recall evidence at the Home Care Hearing three weeks ago on the Dutch aged care system, from Professor Jos Schols, a Professor of Old Age Medicine. Dr Bakx's evidence will complement that evidence by providing details on financing issues. But due to the time difference between here and the Netherlands, I propose to call Dr Bakx no earlier than 3pm. In the meantime, I wish to use the available time now to make some very brief closing remarks about this hearing.

Over the hearing, we've tested 19 propositions concerning funding arrangements and eight propositions concerning prudential regulation, and financial management oversight. And the evidence has also addressed some potential long-term financing options and raised some issues concerning capital financing of accommodation-related investment in residential aged care. However, our examination of those matters has been somewhat selective. We note again that a separate consultation is occurring on capital financing issues, and submissions are invited on such matters, including RADs, DAPs, capital grants and related capital financing matters.

Today marks the end of this public hearing element of the inquiry into these matters, but more remains to be done, Commissioners, before the counsel assisting team can put its recommendations to you on the matters raised in this hearing and the broader matters concerning funding and financing which may well affect your final recommendations. We intend to formulate our proposals on those matters following this hearing and to present them to you in about a month's time.

In my remarks now, I will in essence deal with some housekeeping issues, and I will identify to interested parties some additional issues which arose, and which were not covered by the propositions we formulated in the lead-up to this hearing, and without limitation to the points I'll mention during these remarks, all parties which of course received grant of leave to appear in this hearing may make written submission on anything raised during the hearing, provided they do so at a time to be stipulated by

you, Commissioners.

I understand a direction has been prepared for your consideration. We would be proposing that submissions from parties which received leave to appear in this hearing be made by no later than 6 October 2020.

The main themes around which the hearing was structured were as follows. First funding adequacy, including the deterioration in funding performance of the sector, its likely causes and how to avoid them in the future, and in particular for the future ensuring that aged care is funded to a level that's well calibrated to meet needs on both the level of the individual receiving care and in an aggregated sense system-wide.

Now, in this regard, Commissioners, we of course tested propositions FF 1, 2, 3, 4, 5, 6, 7, 8, 9 and 11, 10 being the interim proposition about raising staff and staffing levels subject to acquittal of staffing level-related funding.

We tested those propositions with a large range of witnesses, including providers of various different scale, the Secretary and senior officers of the Department of Health, key analysts and industry observers, and experts such as Professor Woods and Professor Cutler, Professor Piggott. There was a broad consensus for the establishment of independence pricing of subsidy levels and certain price caps in what would amount to a revolution in the fundamentals of aged care funding for the future, that insertion into the system of an independent pricing mechanism.

And we heard from the CEO of the Independent Hospital Pricing Authority, Mr James Downie, about how a similar model of independent pricing in aged care to the one he applies in hospital funding could be achieved. One of our witnesses was Professor Kathy Eagar, whose team's work has been of course instrumental in developing a casemix model for residential care which could work in combination with independent pricing.

Moving through the themes, next was identifying the best options for stable long-term financing for the system. We addressed this through evidence from the Honourable Paul Keating and the Honourable Peter Costello, Dr Ken Henry, Professors John Piggott and Michael Sherris, and the Secretary to the Australian Treasury Steven Kennedy and his colleague Ms Jenny Wilkinson. We heard the evidence of the Japanese aged care system and its employment of long-term care insurance to provide about half of the public financing of aged care in that country, which of course is a country that faces significant challenges in this respect, by reason of its steeply ageing society.

And soon after I've concluded these remarks, as I mentioned at the start, we expect to hear further evidence of a comparative and international character about the financing of aged care in the Netherlands.

Next, in terms of the themes, the hearing gave attention to the principle of attaining

an equitable balance between public financing and contributions from the individuals who are receiving the services and doing so in a way that doesn't impede access to those services.

There's some important context to mention here, Commissioners. Pursuant to leave granted yesterday, we've added two documents to the general tender bundle at tabs 133 and 134, and these documents summarise Australian Government expenditure on aged care by comparison with other services for older people in Australia. These two documents record that in 2017/18, direct expenditures by the Australian Government on older people accounted for a little over 21% of all direct government expenditures. Direct expenditure on older people was almost $98 billion. This figure is not just aged care; it includes expenditures on income supports for older Australians, and medical services, and one can also analyse the figures by reference to tax expenditure forgone by reference to superannuation, for example.

The new documents in the tender bundle also record that expenditures by the Australian Government state and territory governments and individual contributions to aged care amount to over $30 billion, and of this individuals directly contribute a bit over $5 billion.

The private component of aged care financing may not, in a sense, be large by comparison to the public component, but it's still significant, and it's significant for reasons other than mere size. Consumer contributions are known to improve consumer engagement, and therefore, to put pressure on quality outcomes and the like. They also play an important role in promoting the objective of intergenerational equity, a concept explained by Professor Piggott, as well as vertical equity, another concept explained.

The retention of user contributions as a piece of the architecture of the aged care funding and financing system. The retention of those contributions towards aged care costs, including co-payments for the costs of care, received widespread support from the witnesses called in this hearing. No witness in terms opposed the imposition of some form of user contribution. However, of course, reform of a means-testing arrangements is sorely needed and this was repeatedly emphasised by the witnesses.

The evidence of the consumer peaks, Treasury and Professors Woods and Piggott was particularly important on these matters, and we must remember Mr Costello was, while being very scathing, really, of the administrative arrangements currently in place for means testing, was, I think, supportive in principle of the concept of means testing, provided it's done in a way that isn't so burdensome.

Mr Keating had a different approach altogether. He proposed post-funding of aged care by establishing loan accounts, which would be settled upon the deceased of the person who's received Commonwealth subsidised aged care from their estate. This, of course, is another form of means testing, although not affecting the person during their life. It involves a means test - a means-tested approach in the sense that if the

estate doesn't have the means to meet the debt, then the debt will not be satisfied.

During the hearing, we advanced propositions for user contribution of means testing reform in the shape of propositions 13, 14 and 15, 15 being the proposal that there be no fees at all for respite. 16, 17, and in the alternative to an element of 17, 20 as well. So we're raising two propositions in respect of contributions to care for residential care, one that there should be no contributions required for the care component of the costs of residential care, on the basis of the universality principle; that these are services of a kind to which the Australian community would expect that people will have access for free. But in the alternative, and in light of the sentiments expressed by many of the witnesses, we have in the alternative to that measure, proposed means-testing reform in respect of both the care and accommodation components of residential aged care funding.

Commissioners, much remains to be done in developing these topics. For example, further consideration of them will involve exploration of fair and appropriate measures to bring the value of the primary residence into the means-testing arrangements to a greater extent than at present, while not prejudicing the rights of others who share the home.

Moving through the themes of the hearing next, while calibrating funding to needs the system must include features ensuring accountability for expenditure of that funding on the purposes for which it's been provided. And those measures must be proportionate. They must take into account administrative burden and the need to retain flexibility in order to foster innovation. We don't want to stifle innovation by inflexible requirements in this regard.

On these topics, we've tested propositions FF 12 and PR 1. These propositions were, in the main, broadly supported, although many witnesses expressed interest in how the detail of those propositions might be fleshed out. It must be said that some witnesses expressed concern at the imposition of the acquittal obligation foreshadowed in FF 12, depending on the precise content of any such acquittal obligation.

Next, Commissioners, we examined reporting and prudential measures to protect against financial risks that might endanger continuity of services, to the people who need aged care, some of whom are very vulnerable, of course. That question of ensuring that the system manager or prudential regulator or both understand risks of a financial nature that are on the horizon is critical to safeguarding the recipients of care from harm to their interests and welfare. In a way, the potential Commonwealth exposure via the guarantee scheme for refundable accommodation deposits is a secondary issue when it comes to financial risks. But financial risks can, in some cases, prudentially place Commonwealth-guaranteed loans at risk as well.

Now, we've tested in this regard all of the PR propositions 1 through to 8. Our inquiries in our submission have left no doubt, Commissioners, that the current prudential regulation and financial oversight arrangements are inadequate to ensure

the sustainability and stability of the aged care system. There's a pressing need for reform in this area.

In the words of Mr Jaye Smith of the Department of Health, the current prudential framework is not fit for purpose and requires fundamental reform.

Mr Callaghan considered that the prudential regulation regime needed to be more strongly focused on ensuring the stability of services provided to older people.

We also note the evidence of Mr Corderoy, agreeing with the propositions, but emphasising the importance of liquidity as the major indicator of prudential risk according to the work that he's done.

Now, in terms of the themes of the hearing, this final theme only received some attention towards the end of the hearing and it's going to need to be developed, including by reference to material that I will be able to tender in a moment.

The theme was transition and implementation and the principles that should govern transition and implementation. I raised these with Professor Cutler in the last session just before lunch. They should include a pro-active and accountable role for a governmental body in steering the transition and a carefully constructed sequencing of the reforms. The transition must be accompanied by monitoring. According to Professor Cutler, monitoring of the quality of care delivered as well as prices and access to services. And very importantly, it must be capable of adaptation to unforeseen developments while maintaining its direction towards clearly defined major reform goals.

Commissioners, I omitted to tender the document that I raised with Professor Cutler and I will do so now. It's RCD.9999.0534.0001, and I ask that that be accepted as a freestanding exhibit.

COMMISSIONER PAGONE QC: That will be exhibit 21-26.

EXHIBIT 21-26 - RCD.9999.0534.0001

MR GRAY QC: Thank you. Commissioners, although we'd not formulated any particular proposition covering the topic of transition and implementation, we did raise one transitional proposition for the improvement of staffing in residential aged care funding arrangements. That was FF 10.

At the Home Care Hearing three weeks ago, certain of the hearing propositions in that hearing were of that nature and we've now identified the need for additional transitional measures of the kind identified by Mr Corderoy of StewartBrown and the need to consider those and we will be working on those in the course of formulating our final proposals for your attention, Commissioners, in about a month's time.

We'll submit those to you when we present our recommendations on other matters at that time.

At that time also, we intend to address you on the need for further system governance arrangements which would facilitate a proper implementation of the reforms that we will be raising for your consideration.

In many ways, the Home Care Hearing three weeks ago or so and this hearing have been complementary hearings. Certainly, on the issues raised relating to the funding arrangements for Home and Community Care. Your consideration of funding arrangements for aged care provided in the community must be closely informed by the issues that were addressed in that hearing, including those details about service arrangements that were traversed in that hearing.

There's an outstanding piece of housekeeping from that hearing I'll now attend to. The propositions which were provided to witnesses in that hearing were in a document dated 7 August 2020, and that was at tab 1 of the general tender bundle for that hearing, exhibit 20-1. As I explained at the outset of that hearing, shortly before that hearing, we, the counsel team, assisted by all the staff of the Royal Commission, altered the detail of our proposed new service arrangements for care in the home, and that alteration was set out in a document which was provided to witnesses shortly before the hearing, and was reproduced at tab 59 of the tender bundle in that hearing and I've been taking witnesses to that document ever since, including today.

We've now prepared an amended version of the proposition that's affected by that change, the proposition that was affected by that change was proposition HC 2 in the Home Care Hearing. For the sake of completeness, we would like to put that amended version of HC 2 on the record and tender it now in this hearing. It could be added as a new tab to the general tender bundle at 136, if the Commissioners please.

COMMISSIONER PAGONE QC: Alright.

MR GRAY QC: While I'm on the tender bundle for this hearing and dealing with housekeeping matters, can I just put on the record the fact that there are documents at tabs 91 and 92 relating to aged care expenditure constraints. It's a document I've taken you to in another form, Commissioners. 91 and 92 are the document on expenditure constraints and the accompanying spreadsheet workings. The Commonwealth responded to that document, took issue with certain aspects of it, and we generated a new version of that document in the accompanying spreadsheets, and the new version is at 114 and 115. So the old version is in the tender bundle and will remain so at tabs 91 and 2; the correspondence from the Commonwealth is also in the tender bundle and the new versions of those documents, which are the ones to which I've been taking you to, Commissioners, during this hearing are at 114 and 115.

Commissioners, there are additional tenders on the topics of system governance and

provider governance I wish to make. These, of course, were not traversed during this hearing, but this is, in effect, our last opportunity to tender them into evidence before you, and I now seek to tender a bundle of six signed witness statements which I can refer to as the system governance tender bundle, comprising witness statements from the following individuals: Associate Professor Gemma Carey, Robert Bonner, Professor Hjalmar Swerisson, Professor John Pollaers, Professor Gary Sturgess and Mr Mike Callaghan. And I tender the system governance tender bundle. Perhaps that should simply be given an exhibit number referable to this hearing.

COMMISSIONER PAGONE QC: That will be 21-27.

EXHIBIT 21-27 - SYSTEM GOVERNANCE TENDER BUNDLE

MR GRAY QC: Thank you. I'll now tender five signed witness statements, which I will refer to as the provider governance tender bundle, comprising witness statements from Ms Liesel Wett, Ms Anne Cross, Professor Graeme Samuel, Miss Suzanne Vardon and Miss Janet Anderson, the Aged Care Quality Safety Commissioner. I tender that bundle.

COMMISSIONER PAGONE QC: That's 21-28.

EXHIBIT 21-28 - PROVIDER GOVERNANCE TENDER BUNDLE

MR GRAY QC: Thank you, Commissioner. For the remainder of these remarks, I will confine myself to points that are either potentially outside the scope of the propositions we advanced during the hearing, or that although they might be within the scope of the evidence you heard, they clearly call for a responding submission from a party with leave to appear on perhaps what might be loosely regarded as the procedural fairness ground. I probably need not specifically and in detail identify matters in the latter category, but I'll do so on one or two points in any event out of an abundance of caution.

The points that might require an answer, and I won't beat around the bush, the answer would be from the Commonwealth, relate to findings we might invite to you make on the question of what led to what's said to have been funding inadequacies, particularly in residential aged care. You've heard significant persuasive evidence, in my submission, that aged care providers are being stretched beyond their limits by a funding system designed to, in effect, give priority to the Australian Government controlling its expenditures on fiscal grounds. Papers prepared by staff of the Royal Commission show a trend of expenditure constraints imposed by government across the aged care system. Tabs 114 and 115. The evidence before you identifies constraints that apply in each of the major program streams, although it's perhaps been most acute in residential care by reason of those rather dramatic events

concerning indexation pauses.

In the Commonwealth Home Care Support Programme, there are limitations on the issue of grants, the scope of activity which is funded under those grant agreements, and Dr Panter perhaps gave you the most important evidence of all in that regard just this morning, about the inadequacies of simply rolling those over, over the last two grant periods.

In the Home Care Package Program, the Australian Government limits its expenditure of course through controlling the number of packages which are issued in accordance with the target provision ratio, and Commissioners, you've heard a great deal about this, you've heard a great deal about the long waiting lists. Removing those waiting lists has the - the cost of removing those waiting lists has been quantified in the billions of dollars. The planning ratio or the target provision ratio also applies as a cost control mechanism in residential aged care. And even more significantly, perhaps, given the fact that there is now some capacity on average in residential aged care by reason of the occupancy rate having dropped a little, costs in residential aged care are controlled through the Australian Government's indexation of the prices that are paid to residential aged care providers through the Aged Care Funding Instrument, ACFI, and the method of indexation that's applied to the various 64 potential levels of funding under ACFI is known as COPE and it's been in place since about the 1990s.

The Department of Health's evidence is that the combination of factors which comprise the rate at which ACFI subsidies increase under that indexation method are inadequate to keep up with the costs of providing residential aged care. All witnesses agree on this point. In other words, the cost of providing the current quality of aged care is rising faster than the rate of indexation of the price paid for it by government, and the effect of this must be, even without any improvement in quality outputs, to reduce the ability of providers to provide care in accordance with the current standards. They're in effect being squeezed and must choose between financial viability and providing the level of care that's the minimum standard required to support their residents - an impossible situation.

And added to that, there've been, of course, the two periods where government paused or froze the indexation of ACFI altogether, first in 2012/13 and the second in about 2016/17. And the Department of Health has also acknowledged the serious financial implications of those pauses or freezes.

In a response to a Notice to Give Information or a Statement tendered at this hearing, the Department of Health has said that, in 2012/13, the freeze was to address concerns over overclaiming and to bring growth more in line with estimated sustainable funding levels, and that the 2016/17 freeze was said to be because ACFI claiming growth was again higher expected.

Witnesses from the department including Dr Murphy, the Secretary, claimed that the indexation freeze was justified on the basis that there was overclaiming. This is said

to be determined on the basis that the ACFI claims rose faster than expectations of acuity in residential aged care. There does not seem to be a connection, in our submission, between the reasons for the increase in ACFI costs and the decision to freeze indexation, certainly not a reasonable connection.

The freezing of indexation created a challenge for every provider, not just those who may have been the subject of the allegations of overclaiming by the Department. A challenge for every provider to try to provide the expected quality of aged care with less and less money to do so. The Department witnesses asserted that the pauses in indexation were appropriate responses - these are perhaps not the exact words, but this was the gist of the evidence - appropriate responses to abuse of the funding model or the use of it in an unintended way by the aged care sector.

We submit that that characterisation is insupportable. If there was overclaiming then the appropriate response would've been investigation and, subject to the results of any such investigations, targeted sanctions action against particular providers found to have been overclaiming. But the response from government was not limited to using regulatory tools to investigate, or even to educate industry about this serious issue. Instead, the Department's position was in effect a form of collective sanction, and this was inappropriate.

We say the better explanation for what occurred and a more rational explanation for the collective measure that was taken was simply that the Australian Government was unwilling to meet the rising costs of the system it had set up. When Dr Murphy said that the huge increase in costs at the time would've certainly placed an unexpected fiscal pressure on the government, and that was at transcript 9449, in saying that, Dr Murphy was tacitly acknowledging that fiscal motivations were at the heart of the action taken by the government.

This fiscally driven decision seriously affected and continues to have seriously affected the financial performance of providers, putting pressure on the quality of residential aged care. Dr Mellors said that the current funding levels were inadequate to deliver the current level of quality of care to older people in Australia, let alone the kind of care that we would all like to provide. Her comments were reflected in a large number of other statements in evidence before you at this hearing, Commissioners.

I've made these remarks because I wish the Department to be clearly on notice that we are considering proposing findings to you on these matters, Commissioners. The Department and any other party with leave to appear might wish to make responding submissions on the matters I've just mentioned.

The more important point perhaps is not to repeat the mistakes of the past, and to establish a lasting solution which restores trust and instils confidence. Confidence is critical on all sides. Confidence on the part of the community, so that we can all prepare for old age and for our loved ones' old age without fear of the future. Confidence on the part of providers so that proper investment is encouraged. And

confidence on the part of government in accountability for the expenditure of public money on proper purposes. Confidence on the part of a dedicated and skilled work force and confidence from all that high-quality and safe care will be the result now and on into the future.

The time has passed for the determinations of subsidy amounts to be paid to aged care providers to be left in the hands of an agency with diffuse policy responsibilities or to be given cursory attention or attention at long intervals from time to time. Aged care funding is as complex as it is expensive. It deserves the specific focus of specialist statutory body.

The Secretary of the Department of Health supported our proposition in support of an independent pricing body, but considered that it should only make recommendations to government rather than binding determinations of funding levels, and that's a matter on which we invite submissions, together with any other issues raised by the evidence in the proceeding, and it's a matter on which we intend to address you in a month's time.

Numerous witnesses who appeared before you in this hearing agreed that there's a need for an independent authority to at least make transparent recommendations to government about the subsidies that providers are to be paid for the aged care services they supply. The former Chairman of the Aged Care Financing Authority, Mr Callaghan, emphasised that the independent authority would need to be trusted by both government and the aged care sector, and you heard similar views from Mr Downie, the CEO of the IHPA.

We note that Professor Kathy Eagar's evidence was that she supported the creation of an independent pricing function but not a new authority. She considered that, for example, it would be appropriate to add aged care pricing to the functions of the IHPA, rather than creating a new statutory agency. The providers who gave evidence yesterday all supported the introduction of an independent price-setting authority, and the banks on yesterday's panel noted that to the extent that independent pricing would attract additional investment to the sector then they'd support its introduction, although there were some concerns that it could limit profitability, depending on the scope of its functions.

Commissioners, of course, in case this hasn't been obvious, we are proposing that the pricing body, whoever it may end up being, will exercise functions of a far broader nature than the functions currently exercised by the IHPA. Those functions would extend to other aspects of potential economic regulation. We also accept points made by the likes of Mr Callaghan that it's necessary to give very careful attention to a precise description of the responsibilities and functions of the body, and to set its objectives.

Interim measures, Commissioners. There's an urgent need for additional funding to be provided before we're going to be able to establish an independent pricing function, and our proposition FF 10 is apposite in that regard. And once independent

pricing is established, it will supersede all aspects of the current process of determination of funding, for example the 64 levels of ACFI funding, including their indexation.

But because independent pricing will take some time to establish, an interim measure is justified forthwith to replace at least the COPE indexation method and to mitigate its accumulated effects. This is particularly urgent to ensure the financial viability of residential care providers in regional and remote areas.

Commissioners, we're considering additions to the propositions we've tested in this hearing in this regard including some that have been advanced by Mr Corderoy to address this point. For example, Mr Corderoy proposed that the Australian Government provide a subsidy to all providers of residential aged care to effectively amount to an increase of the base amount for the basic daily fee by about $10 or exactly $10 per bed, per day for all residents. Mr Corderoy also proposed - and this was one option for amendment of the COPE indexation arrangements - that indexation could be based on the annual Australian Bureau of Statistics wage price index, plus an add-on of an additional 1% to allow for award and enterprise agreement increases for aged care workers. Another possibility might be that the indexation method could be amended, Commissioners, to compensate for the fact that sector wages in this sector are below average wages.

Again, these arrangements could continue until independent pricing is established and once that authority is established, then its arrangements should supersede the need for indexation. Indexation, will, in effect, be built into what that function - what that function performs.

In addition, given what we've heard about the financial viability of providers, especially in regional and remote Australia, the Australian Government should make immediate amendments to the viability supplement to ensure it's better targeted to the costs of service delivery in these areas. This was a matter raised in the Mildura Hearing. I beg your pardon, the Mudgee Hearing.

This could be achieved by ensuring that the supplement is calculated as a percentage of the daily ACFI subsidy rates based on remoteness area and adjusted such that the loading amounts are increased per remoteness area. Again, this arrangement could continue until independent pricing is established.

As I mentioned a minute ago, Commissioners, the role of this body is not confined to pricing. On the basis of our submissions in particular FF 3 and 4, the role would include evaluation, assisting evaluation of the depth of so-called markets or pockets of supply of services, and assisting the system manager to intervene appropriately where there are thin markets.

Commissioners, we anticipate you will be greatly assisted by the report of Professor Menezes and his evidence in deciding the approach that you ultimately recommend as to when regulation should be applied, and Professor Cutler has now added to that

body of evidence.

Both professors' evidence supports the need for lighter-touch regulation in respect of certain aspects of the services in question, such as accommodation charges for unsupported residents. There are a range of regulatory measures that are available. Market conduct regulation, price monitoring, and at the heavier end of the regulatory spectrum, for care and living costs in the residential sphere, price capping.

Another point on which we will be working on further development of our propositions is the service and funding arrangements for support and care in the community. In this hearing, as in the last hearing on home care, we of the Counsel Assisting team have been testing with witnesses a number of propositions on that topic. Professor Eagar made the point, Commissioners, that you can't conceive of funding and program design independently and we agree. It's a relationship which definitely flows both ways and no more so than in the case of community and home care.

We tested propositions FF 5, 6 and 8 in this hearing. FF 5 describes the service types which should be block or activity or a combination of those funded on that basis. FF 6 describes the services which would be funded by individualised budgets. And there've been further iterations of proposals in that regard and we need to take those into account when we make our submissions to you in a month's time.

FF 8 describes a new approach to setting the maximum amount of funding available to a person staying in the home and that received broad support.

In the Home Care Hearing, we tested a set of service arrangements for home and community aged care, of course, and I've referred to the exhibits and mentioned the new and amended form of proposition HC 2, which I just noted have been added to the tender bundle. We also tested transitional funding related measures in HC 1, HC 4D and HC 6F. In this hearing, as well as testing those funding arrangements - I'll withdraw that, Commissioners. I think I've already covered that.

And without in any way diminishing the importance of the other propositions we tested during the hearing and the evidence of the many witnesses who contributed, I'll conclude my remarks at that point.

We have about five minutes or so to go before Dr Bakx will be available. Would you mind - he's available now, I'm told.

COMMISSIONER PAGONE QC: Unsurprising. It's only three minutes away. So we may as well get straight on to it.

MR GRAY QC: Thank you. I call Dr Pieter Bakx.

DR PIETER BAKX

EXAMINATION-IN-CHIEF BY MR GRAY QC

MR GRAY QC: Commissioners, I'd seek to dispense with any oath or affirmation for this witness as he's overseas.

COMMISSIONER PAGONE QC: Yes. Thank you.

MR GRAY QC: Dr Bakx, can you hear me? It's Peter Gray, counsel assisting.

DR BAKX: Yes, I can hear you.

MR GRAY QC: Thank you, Dr Bakx. Is your full name Pieter Bakx?

DR BAKX: Yes, that's right.

MR GRAY QC: And what is your current role and your institution?

DR BAKX: I'm an associate professor.

MR GRAY QC: And is your institution Erasmus University Rotterdam in the Netherlands?

DR BAKX: That's correct, yes.

MR GRAY QC: Thank you. What's your research area and your expertise?

DR BAKX: I studied the impact of healthcare financing and I focus on long-term care financing, which you call aged care in Australia.

MR GRAY QC: Thank you. You've created a document for us which is in the nature of a submission entitled "Three aspects of the Dutch experience with financing aged care". I'll ask that it be displayed. AWF.680.00032.0001. Is that a copy of the submission you sent us?

DR BAKX: Yes, it is.

MR GRAY QC: Did you prepare that submission in response to the Royal Commission's consultation paper 2 of June 2020, Financing Aged Care?

DR BAKX: Yes, I did.

MR GRAY QC: Thank you. Are the opinions in this submission opinions that you sincerely hold, Doctor?

DR BAKX: Yes, I do.

MR GRAY QC: Thank you. Could you please briefly outline the different groupings of publicly funded supports and long-term care services available for older people in the Netherlands?

DR BAKX: Yes, I could. So the biggest one is the Chronic Care Act, which finances care provided (audio volume dropped) then there is the Health Insurance Act ....

MR GRAY QC: Could you just hold on a minute, Dr Bakx. We've just got an audio issue. We'll just see if we can sort it out. Do you want to just say something, Dr Bakx, and we'll see if the sound is coming across now.

DR BAKX: Is it better now?

MR GRAY QC: No, it's still very faint. Please bear with us.

DR BAKX: What about now?

MR GRAY QC: Yes, that's much better.

DR BAKX: Is that better? OK, now we've got it back.

MR GRAY QC: Thank you. So back to the different groupings of publicly funded supports?

DR BAKX: So there's the Chronic Care Act that finances institutional care, so care in nursing homes. There's the Health Insurance Act that pays for home care. And there is the Social Support Act that pays for social supports and that includes domestic help and activities to maintain a structure of daily life for the elderly.

The first is the Chronic Care Act and the Health Insurance Act are both social insurance and that is mandatory for everyone to enrol in and to - and essentially pays for the long-term care for everyone. The third one is tax funded. So the Social Support Act, that is tax funded, and that is administered through the local governments, the municipalities in the Netherlands.

MR GRAY QC: Thank you. I just wanted to ask you about a particular feature of funding provided under the Chronic Care Act, or perhaps you might describe them as benefits ---

DR BAKX: Yeah.

MR GRAY QC: --- payable under social insurance under the Chronic Care Act. Is it true that a person receiving an assessment as being eligible to receive care in an institution under the Chronic Care Act may choose at their discretion to stay at home

and spend that same budget on care that they would've received in an institution, and spend it on staying at home?

DR BAKX: Yes, that is correct. Although they don't get the full budget, but they get the same amount of hours of home care. So they get the same amount of hours of care that they would've gotten in a nursing home, but they now get it at home, which may have different expenditures.

MR GRAY QC: OK. That's interesting that it depends on the amount of hours, not on the euro value figure for the budget.

DR BAKX: That is correct.

MR GRAY QC: So might it be more or less expensive to purchase that care, but the main thing is that the same hours are delivered; is that the point?

DR BAKX: That is right, yes.

MR GRAY QC: OK. Thank you. Has that measure been evaluated for its effectiveness in maintaining the health, wellbeing of people and avoiding institutionalisation?

DR BAKX: No, it hasn't. It has been in place for many years, I don't know when it started, but it has been there for quite some time. I did study a fairly similar aspect of the system, which was whether people who were eligible for nursing home care, some of them who are at the threshold of being eligible, close to being eligible for nursing home care, for those who were just eligible, I compared them to those who are just ineligible. So those who would stay home mostly, and the others would mostly go to the nursing home, we compared to spending the next two years for these two groups and what that research showed was that if you added up all the spending, so all the home care, all the nursing home care, but also the medical care of these people, that was essentially the same in the Dutch case.

MR GRAY QC: In either setting? The same whether they stayed at home ---

DR BAKX: Whether they stayed home, yeah.

MR GRAY QC: --- just below eligibility or whether they went into an institution because they were just above eligibility?

DR BAKX: Yeah.

MR GRAY QC: OK. Thank you. In respect of these groupings of services, let's focus on the two that are financed by social insurance, care in the home under the National Healthcare Insurance Act and care in institutions or taken at home at the election of the care recipient under the Chronic Care Act. What are the financing arrangements that apply to raise the money that's needed for funding those services?

Let's start with National Healthcare Insurance Act.

DR BAKX: Yeah, in the National Healthcare Insurance Act, there is premiums that people pay, and part of the premium is - is income dependent, so that is taken from the earnings, from someone's earnings, and that's the same for everyone with the same income level, and then there is the second part, which is called the nominal premium, which is set by the health insurer that someone chooses, and that premium is that paid directly to the health insurer, that is the same for everyone who is enrolled in that health insurance plan.

MR GRAY QC: Is that social insurance scheme for national healthcare or under the National Healthcare Insurance Act essentially privately managed by private insurers, and that, in that respect, there's a difference between that insurance scheme and the insurance scheme for the Chronic Care Act?

DR BAKX: Yes. So in the National Health Insurance Act there are private entities that act as insurers, whereas the Chronic Care Act, that is - yeah. That is - that is a public scheme with regional offices that are part of the government that organise - no, sorry, that is not entirely correct. But the main difference is that there is competition, so someone can choose which health insurer they have. Within the Chronic Care Act, you cannot choose which regional office organises the care for you, because you live in a certain region and there is one office in that region.

MR GRAY QC: OK. And so in respect of the, in effect, privately insured National Healthcare Insurance Act social insurance scheme, does the government have to take measures to equalise risk so that policies can be granted or issued by the private insurers to anybody in the community without doing a risk assessment of those individuals?

DR BAKX: Yes, that is right. So these private - so in the National Health Insurance Act, these private insurers, they have to accept everybody who wants to be insured through them, but of course, the expected costs for these people are not the same at all, and to give these health insurers the incentives to contract high quality but relatively low spending care for everybody, there is a risk equalisation system that aims to give proper incentives to health insurers to take care of everybody who wants to be insured through them.

MR GRAY QC: And in the Netherlands, is that principle of, in effect, requiring the insurer to provide the same terms to anybody approaching them for a policy, is that known as community rating or community risk rating, or is that ....

DR BAKX: Yeah, that's community rating, yeah.

MR GRAY QC: Community rating.

DR BAKX: Yeah, but that also means that they have to charge the same premium to everybody. So that essentially goes a step further. It means that you not only have to

accept everybody, but that you also have to set the same premium for everybody.

MR GRAY QC: Yes. Thank you. What about the scope of private co-payments or co-contributions by the users of the services once a benefit is granted under either of these two social insurance models? What are those arrangements for private co-contributions, co-payments, whatever one wishes to call them?

DR BAKX: Yeah, so in the Chronic Care Act, there is an income dependent co-payment, so people pay a part of the spending on the nursing home care that they use, but how much that is depends on their income and on the amount of assets that they have.

In the National Health Insurance Act, in principle, there's a deductible of about, I believe, 385 euros, but that does not apply to GP care to home care, which is - yeah, which is the aged care that is financed through that scheme. So there's no deductible there.

MR GRAY QC: And is that deductible applicable in any particular period, or is it just once in a lifetime when the person commences using the home care?

DR BAKX: It's annual but once again it does not apply to the home care. So it does apply to, for example, hospital care but not to home care.

MR GRAY QC: I see. Thank you. In your submission, you refer to one of the benefits of social insurance as being that insurance generates value as it creates financial certainty about one's future, it reduces the need for large precautionary savings and means that people may spend this money on other things during their life.

You also refer to the need for any co-contribution or co-payment regime not to negate that benefit. What would be the guiding principles for designing a co-contribution regime so as not to negate that benefit? Is it simply a matter of the size of the co-payment?

DR BAKX: So it's a matter of the size of the co-payment, but it would also be best - acknowledge that there are differences between people and how much risk they can bear, so, of course, someone with large - with a high income and possibly a large amount of rather liquid assets would be able to bear much more financial risk more easily than someone who doesn't have these financial resources. That's one. And the other one is that there is - that - that the insurance system should aim to put a sort of - to put a limit to what someone can expect to spend on elderly care at the end of their life. So if there's some sort of stop loss, that would definitely - that would definitely be another feature that would be helpful there.

MR GRAY QC: Is another word for a stop loss like a lifetime or an annual cap, perhaps both?

DR BAKX: Yes.

MR GRAY QC: Are there both annual and lifetime caps in Dutch social insurance for home care?

DR BAKX: No, there's definitely no lifetime cap, because everything is done on an annual basis, but there is a maximum co-payment per year, yes. That is essentially a cap.

MR GRAY QC: Is that maximum co-payment income or asset dependent or both?

DR BAKX: Yep, both.

MR GRAY QC: Do you know off the top of your head how high it goes as a percentage of assessable assets?

DR BAKX: No, I can't say that from the top of my head. I do know that if you are at the highest income and asset class, it is going up to roughly, I believe, 25 to 30,000 euros per year.

MR GRAY QC: OK. And is that the approaching the actual full cost of the care services?

DR BAKX: No, not at all. That's a lot more.

MR GRAY QC: So are we talking about, what, it's only about a quarter?

DR BAKX: From the top of my head, so the nursing home costs, the price of a nursing home depends on how - how much care you use there and for, I believe - I believe it's - for the lowest, for sort of the - lower amounts of care that you may receive in a nursing home, it's about 80 euros. So in that case it would be about a quarter, yeah, but it's probably higher than that, yeah.

MR GRAY QC: Yes. Thank you. And so what you've just explained to our hearing about the caps, the annual caps, is that restricted to Chronic Care Act, social insurance for institutional care, or is it the same for National Healthcare Insurance Act, care in the home? Is there also a cap in the ....

DR BAKX: No, there's no cap there, because there is no - I mean, that is fully paid through the national health - through the health insurers. They pay for 100% of the costs, so there's no cap there.

MR GRAY QC: Thank you. Of course. You made that point before.

Now, is home care - I just want to ask you a few more details about National Healthcare Insurance Act benefits, and the system of financing it. You made the point that home care is, in effect, covered by the same insurance scheme as

healthcare is, and you've referred to GP visits and the like, but it seems that there are different contribution rules, different user contribution rules, depending on different service categories. So I think you said GP visits have a contribution?

DR BAKX: Everything that is called sort of first line of treatment, so GP care and home care, they are exempted from the deductible, but the other services, such as, for example, hospital care, there the deductible applies.

MR GRAY QC: Pardon me. I got it round the wrong way. So that's interesting. There's a concept of first-line response.

DR BAKX: Yeah.

MR GRAY QC: And the deductible doesn't apply. But ....

DR BAKX: That is correct.

MR GRAY QC: But what's the philosophy for applying the deductible to hospitalisations? What's the reason for that design feature? Is there a rational reason for that?

DR BAKX: I'm not sure - I'm not sure what the intention was, but my understanding is that - that it encourages people to seek as much treatment from their GP and at their home, so sort of they're relatively seeking the - first line of treatment serves as they require relatively few resources. So of course spending - yeah. Treatment in the hospital is much more expensive than treatment by a GP, for example.

MR GRAY QC: And it's consistent with that principle that there therefore is this contribution regime, albeit means tested and albeit subject to an annual cap for institutional care under the Chronic Care Act; is that a fair summary?

DR BAKX: Yeah, it is, yes. It's never designed that way. I mean, it has historically grown that way, but yes, that is how it is now and that is correct.

MR GRAY QC: Yes. Can I just ask you a bit more about the private insurers under the National Healthcare Insurance Act social insurance scheme. We did ask Professor Schols some of these questions but you're the financing expert so I'll ask you.

Approximately how many insurers are there and is there essentially free choice irrespective of region to choose any one of those insurers you wish?

DR BAKX: Yes. So there are 21 health insurers that are - that come from 11 concerns. But I must say, the four largest ones, they capture about 85% of the market. So there's four really big ones and then there's a number of smaller ones, but everybody is free to choose from each of these, yes.

MR GRAY QC: Thank you. And I suppose this is probably a dangerous question to ask, but if it's possible to answer it briefly, that'd be great. What is the --- generally speaking, is there a particular structure of these entities? Are they mutual funds?

DR BAKX: My understanding is that some are privately owned companies - are private companies, and some are mutualities, yeah, mutual funds.

MR GRAY QC: OK. And was the introduction of, in effect, private provision of insurance arrangements, subject to that risk equalisation measure, a recent - is this a recent thing, a recent innovation?

DR BAKX: The Health Insurance - so the National Health Insurance Act started in 2006, and home care was transferred from the Public Long-Term Care Insurance Act to National Health Insurance in 2015.

MR GRAY QC: And was it only at that point that long-term care became subject to private insurance arrangements?

DR BAKX: Yes.

MR GRAY QC: Yep. And has the effect of that transition five or so years ago been evaluated? Has it been a success on any particular metrics?

DR BAKX: No. I tried to evaluate it with some colleagues last year, but we didn't get really far. I mean, I can't say if it, for example, saved costs. I don't know that. No, it was - it turned out to be too complicated.

MR GRAY QC: OK. Now, can I just ask you a bit more about this division of the setting of the premium in social insurance for home care under the National Healthcare Insurance Act, division of the premium into this fixed component that's, I think, uniform across the country, and the nominal component that depends on the insurer.

DR BAKX: Yeah.

MR GRAY QC: How is that - why does that nominal element differ? What is being offered by the insurer? Are there extra quality offerings? What is driving that difference in the nominal premium?

DR BAKX: So there are quite some differences there. So it could be the service level of the health insurer, so whether you can only approach them online with questions or with bills, or if you can phone them, so it's - it's the service level of the health insurer. It's the number of providers that they contract, and it's whether they - whether they - I don't know the English word, but I'll try to describe it - whether they - whether the provider sends the bill to them, and they just pay the full bill or whether you have to pay the bill first to the provider yourself and then submit a claim to the health insurer and see if that gets reimbursed fully or - yeah, or

....

MR GRAY QC: I see. Yes. And the difference in those administrative arrangements for payment could affect the margins of the provider, so they could therefore affect the premium?

DR BAKX: I - I'm not sure if I understood that correctly.

MR GRAY QC: I'll leave it. But thank you. Those are the sorts of things that can affect the premium.

For the two-thirds centrally fixed premium, would it be right to think that that is, in effect, an actuarially determined - that is, there's a complex process of predicting the expenditures of the aged care - I beg your pardon, the National Healthcare Insurance scheme expenditures for a given period, and the two-thirds is set on that, and then the insurance company is conducting its own actuarial estimate of the expenditures it will face, based on demographics, risks and the like?

DR BAKX: Yes, that is ....

MR GRAY QC: They're both separately conducting that calculation; is that how it works?

DR BAKX: Yes. I must say, I - I earlier said in an earlier meeting, I indeed said it was about two-thirds that was set that was sort of the set national income-dependent premium. It's about a half of the total spending instead. But that's just numbers, but the idea is indeed that that is set first and then that is supposed to cover about half of the expenditures in the coming year, and then each of the health insurers subsequently, the second step, sets their own premium and announces that, and that - yeah, that's their choice, how to set their premium and they take into account how much they expect to spend and how much reserves they have.

MR GRAY QC: Thank you.

DR BAKX: But they set it annually.

MR GRAY QC: Thank you. Annually. So given that the financing of the system for the payment of benefits to fund home care is separated into those two tiers, this might be a difficult question to answer, but is the system or is either of the two components of the system run on a pay-as-you-go basis, so that, in that given year, the premiums are set so as to match as closely as possible the forecast expenditures of that year? Or is it intended to build up an accumulation of reserves?

DR BAKX: No, it's pay-as-you-go.

MR GRAY QC: Yes. Both elements; is that right?

DR BAKX: Yes.

MR GRAY QC: Yes. With the risk equalisation payments, is that - is that centrally administered but somehow tailored to the particular risks faced by each insurer, each of the 21 insurers? How does it work?

DR BAKX: Yeah. So there is - that's centrally administered by the government, and there is - it's essentially an allocation formula, based on the criteria of the people that are insured. So it's individual level criteria for people that are insured through each of the health insurers.

MR GRAY QC: I see. So one of those 21 insurers might happen to have a client list that's heavily weighted with older people or people who might have a particular chronic condition, and in that case, they might receive a greater risk equalisation payment; is that right?

DR BAKX: Yes, in that case, they will receive a greater equalisation payment, yes.

MR GRAY QC: Yes. And how are the benefit levels for - and we're still on home care - particular forms of service, nursing, personal care, perhaps various allied healthcare services determined? Are they centrally fixed or centrally determined on the basis of past cost data, benchmarking studies? How is that done?

DR BAKX: There are maximum prices for activities, so home care is paid for by the hour. There are maximum prices for each of these activities and these are based on - on costing studies. But I must say, in recent years, there has been experiment, and that covers most of the home care now, in which health insurers and providers negotiate what they call an integrated tariff. So for all types of activities, they calculate - they negotiate one integrated tariff that is specific to one combination of a provider and an insurer. That pays for most of the home care now, that's how most of the home care paid through by the health insurers is financed now.

MR GRAY QC: Is that simply the same for every single person in home care, or is it casemix classified in some way, so that there are people with lower needs who might attract a lower integrated tariff and people with higher need whose might attract a higher one?

DR BAKX: It's specific to one combination of a health insurer and a provider, so the health insurer pays based that tariff for each of the clients that is sent to that specific provider. My understanding is that these health insurers and providers, they take into account the casemix of the provider when setting that integrated price they negotiate. That integrated price also varies a bit between same providers for the same health insurer.

MR GRAY QC: Thank you. In institutional care, under the Chronic Care Act, same question: how are the funding levels determined? Is that on the basis of past costs and costing studies and benchmarking or is there some other process?

DR BAKX: Yes, so the basis of the - so there is a basic maximum tariff, and that is - that is based on actual costs with sort of that maximum tariff in the background. Each of these regional offices negotiate a rate at an annual - annually, with each of the providers. Yeah. So the actual amounts paid are below that maximum, below that maximum tariff. On top of that maximum tariff, there are some orders, there are some other spending that may be - that is for regions that are a bit more expensive than others, and to improve quality. So there is essentially an additional payment for that.

MR GRAY QC: When you say for regions that are a bit more expensive, is that because labour might be scarce or they're more remote?

DR BAKX: Yes, because I believe - I believe it's more for labour market scarcity.

MR GRAY QC: Yes. And staying with Chronic Care Act social insurance again - is there just the one central government insurer?

DR BAKX: Yes. There is one central social insurance fund. And that is administered by the government. To get back - sorry, apologies for that - to the answer to your previous question about the tariffs for the nursing homes - there is, as I said before, there is some distinction between how much care someone needs in a nursing home. So someone who needs relatively little care in a nursing home, the tariffs are - the prices are lower for these than for someone with dementia, for instance.

MR GRAY QC: There are levels of eligibility for particular funding or particular levels of care? Is it defined as care in hours of particular kinds or is it defined as a budgetary level?

DR BAKX: Yeah, it's defined as a package. It's defined as sort of a - a package of care and support that someone receives, so there's no sort of entitlement to a certain amount of hours, but it's more sort of a range.

MR GRAY QC: And is that defined in euros or in hours by relevant service types?

DR BAKX: It's defined as a - so the tariffs are set in euros.

MR GRAY QC: Thank you. And just going back to the point in 2015 when the change occurred and the social insurance for home care became, in effect, privately managed, and perhaps going back to the earlier change that you mentioned - at a certain point, was it the case that there was one social insurance scheme for both home care and institutional care?

DR BAKX: Sorry, I just lost the connection for a second.

MR GRAY QC: Oh.

DR BAKX: Can you hear me?

MR GRAY QC: Yes, the connection has been restored. Thank you, Dr Bakx.

So I was just asking, prior to those changes where home care - home care became privately insured, and prior to an earlier change that you mentioned in your evidence, at some point in time, is it the case that institutional aged care or long-term care and aged care provided to people in their homes was actually administered under the same social insurance scheme?

DR BAKX: Yes, that was the case before 2015.

MR GRAY QC: So why did that change? What was the reason for hiving off or separating the home care component and handing that over to private management?

DR BAKX: There was a number of reasons. I think in part it was politics. One of the ideas behind - behind this transition was that - was that this - this - these regional offices, they had very little incentive for organising the care effectively, and efficiently, so organising high-quality care at a low cost, and it was thought that the health insurers, they might be provided with more incentives to do that.

MR GRAY QC: Thank you. But as you said before, we still have an evaluation. It's only about five years ago, I suppose, but we don't have an evaluation yet of whether it's been a success.

DR BAKX: That is correct, yeah.

MR GRAY QC: My final question, Dr Bakx is - it's a bit of a difficult one. Tell me if it's too speculative. Does the existence of the social insurance scheme in both of these spheres, Chronic Care for institutional and National Healthcare for home care, confer an intangible community benefit, creating a sense that there's a social contract for sustainable provision of long-term care for older people? What's your experience of this?

DR BAKX: Yes. So I - so my experience is that I - I, of course, now contribute, as I've been paying premiums for this Chronic Care Act, for instance, for a number of years, and I expect that - that a system that will cover most of the spending, if I might need it at the end of my life, will be there. So, yes, that is - in that sense, it creates - it creates expectations for the future for those who pay now, yes.

MR GRAY QC: And does this actually relate to what you said a little earlier about - and I quoted from your submission on people being able to have financial certainty about their future, and reduces the need for large precautionary savings?

DR BAKX: Yes. It does do that, yes.

MR GRAY QC: Is it confined to that, or does it have greater benefits than that? For example, is there now, in effect, a political compact guaranteeing sustainability on into the future?

DR BAKX: No, there is - there is no - I mean, yeah, to me, it's essentially that. But, then again, I'm - I'm an economist, and that is sort of the thing that I - that I look at when looking at these types of systems. So, to me, that is the main component.

MR GRAY QC: Thank you very much. I have no further questions, Commissioners.

COMMISSIONER PAGONE QC: Dr Bakx, I just want to make sure that I've understood something you said earlier on to Mr Gray. You described the system as essentially a pay-as-you-go, but presumably, you're paying an annual amount, and you're not getting anything at this stage.

DR BAKX: Yes.

COMMISSIONER PAGONE QC: Yours is all future. So, presumably, what happens is that the insurance companies gather money on the basis of what they will need to meet expenditure this year, but do they not have some sense about creating a fund for future earnings - sorry, for future payments into the future?

DR BAKX: That's correct. There is no such - there is no such funds.

COMMISSIONER PAGONE QC: That doesn't sound like what insurance companies usually do. Insurance companies usually get premiums, and they apply the premiums in part to pay amounts, but also in part to create a fund from which they make profits and they can draw upon into the future. Is this different from the usual insurance principles, or am I just misunderstanding your answers?

DR BAKX: No, it is indeed different. It is indeed different from what you describe, from - so they are not gathering funds to pay for any costs that are in for 2040, for example. So the people who pay premiums in 2040, they're expected to pay the premiums that are needed in that year to fund the spending in that year.

COMMISSIONER PAGONE QC: And why do insurance companies want to get into the business?

DR BAKX: To be honest, most of the - as far as I'm aware, all of the 21, or at least the larger ones, have been in the business for years. So they - they were already there before the 2006 reform.

COMMISSIONER PAGONE QC: And, presumably, they're in the business, in part, to make profit?

DR BAKX: They're not allowed to - to - to pay out dividends to shareholders

currently.

COMMISSIONER PAGONE QC: No, but presumably, they make surpluses, though, presumably; yes or no?

DR BAKX: I don't know that, if they make a surplus.

COMMISSIONER PAGONE QC: I see.

MR GRAY QC: I have one further question, Commissioner, if I may. Dr Bakx, with regard to the premiums that are levied - and that's done, I think you said, through the tax system - are those premiums uniform, that is, uniform for people of the same income level, irrespective of age, or are they progressive with age; that is, are there higher premiums levied on people who are older?

DR BAKX: No, the premiums are only income related.

MR GRAY QC: Thank you.

DR BAKX: If you talk about the Chronic Care Act; is that correct?

MR GRAY QC: Both the Chronic Care Act and the National Health Insurance Act.

DR BAKX: Yeah. So, in both cases, it's not age related. So, in the National Health Insurance Act, as we discussed before, there's the two types of premiums. One is income related and the other not, but yes, the income related one is only related to income and not to age.

MR GRAY QC: Thank you. And a further question. Does that simply apply to all taxpayers above, what, the age of adulthood? Is that 18?

DR BAKX: Yes, it does.

MR GRAY QC: OK. Thank you.

COMMISSIONER PAGONE QC: Well, I suppose related to that - one of the issues that sometimes gets mentioned here is that there may be an intergenerational issue about you contributing now, although you're not likely to be getting any benefit for some time. Is that something that's of concern at all in your country?

DR BAKX: It is, yes. So, of course, if health - if health expenditures grow, and in particular, if aged care expenditures grow, there is more intergenerational redistribution, and it might be the case that, in the future, there is not sufficient - there aren't a sufficient number of young people to pay for all the aged care costs of the elderly. That is indeed - that is indeed a risk.

COMMISSIONER PAGONE QC: And are there projections about the likelihood of

that happening and how to mitigate that risk?

DR BAKX: Well, aged care expenditures in the Netherlands are expected to rise - to rise quite drastically in the future. But it's really hard to - to keep - to keep healthcare expenditures in check. I think in both the social - in both the health insurance - Social Health Insurance and in the Chronic Care Act, there are budgets, budget caps, overall budget caps that are set by the government, for example, in response to this, and there's also other initiatives going on to keep spending low, and spending growth low, mostly.

COMMISSIONER PAGONE QC: Good. Thank you, Professor. No further questions?

MR GRAY QC: No further questions.

COMMISSIONER PAGONE QC: Professor, thank you very much for making yourself available. It's always difficult to have these links from what might be almost exactly halfway around the world, and we're very grateful that you've made yourself available. You have the distinction of being the last witness in these hearings, and thank you very much for being available. You've been very helpful.

DR BAKX: Yes. Sure.

MR GRAY QC: There's no summons.

COMMISSIONER PAGONE QC: No summons. Thank you.

MR GRAY QC: Thank you, Dr Bakx.

DR BAKX: Yes.

THE WITNESS WITHDREW

MR GRAY QC: Thank you. That concludes the hearing from our perspective. Thank you, Commissioners.

COMMISSIONER PAGONE QC: Thank you, Mr Gray. We'll obviously consider the submissions that you've made to us, and no doubt the ones that will be coming in the weeks that follow, together with those that others make in response to the directions that we made about submissions.

We should take this opportunity to thank not only you and the other members of the counsel team, instructing solicitors, and the large - I shouldn't say "large", but the number of people behind the scenes who are less visible and whose work is really very, very valuable, and we thank them also.

We need also to thank a number of other people. Our hosts in the premises here in Sydney. It's been wonderful to be able to use this room with the computer equipment that we've had. It's made things a lot easier than if we'd all been tucked away in our living rooms at home or in chambers trying to conduct what is an important inquiry into aged care for the country, with very depleted resources.

There are, of course, also the IT team, whose work behind the scenes is wonderful. We've had only a few breaks, and they've managed to deal with them very efficiently and quickly. So our thanks to them. Without their work, we would not have had the connections that we have had, and that's been really wonderful. There are lots of other staff, including security staff, that are less visible, and they often get forgotten, but without them, a lot of things couldn't happen. So our great thanks to all of them for allowing all of those things to happen.

I think we'll now adjourn until ....

MR GRAY QC: A date to be fixed.

COMMISSIONER PAGONE QC: A date to be fixed, that I suppose would be the best way of putting it, yes.

HEARING CONCLUDED AT 3.44 PM

Index of Witness Events

Index of Exhibits and MFIs