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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, FRIDAY, 23 OCTOBER 2020

DAY 99

MR P. ROZEN QC appears with MR GRAY QC as counsel assisting

COMMISSIONER PAGONE QC: Mr Gray.

MR GRAY QC: Thank you, Commissioner.

CLOSING SUBMISSIONS BY MR GRAY QC (CONTINUED)

MR GRAY QC: Commissioners, we are going to go to parts 3.13 and 3.14 out of the order that appears in the written submissions and then we will go back to 3.10, 11 and 12 and carry on after morning tea with part 3.15.

Part 3.13 is entitled "Better Access to Healthcare". The healthcare needs of people receiving aged care are, on average, more complex than the needs of the general population. There's a close relationship between the quality of the healthcare that people receive, if they're also receiving aged care, and the quality of life they get to enjoy while also receiving aged care services, yet the two categories of services are separate, they're separately funded, there are separate service delivery arrangements for them.

This creates a number of complexities which need to be addressed very carefully, and on an ongoing basis.

The complex needs of people receiving aged care services ideally require a coordinated multidisciplinary response, in our submission, involving various people across both the healthcare and the aged care systems. High levels of frailty and acuity mean it's difficult for some people receiving aged care, particularly those living in residential care, to travel to receive healthcare services. There must be access, therefore, to outreach healthcare services for people who need them, and by that I mean services which will travel to where the people are who need those services.

I'm now at point 1014 of the written submissions and about to embark on an explanation of the 16 recommendations that appear in this part, part --- point 13.

Any breakdown in the relationship, Commissioners, or the meeting point, sometimes called the interface between aged care and healthcare, will likely have very significant and significantly adverse impacts on the health of people receiving aged care and therefore on their overall experience of aged care. So the respective roles of the health and aged care systems in delivering healthcare to people who are receiving aged care must be clearly defined, well understood, and effectively carried out, and that's a theme that runs through the recommendations I'm about to outline.

The recommendations can be roughly grouped into these categories --- access to primary healthcare, access to specialist healthcare, in particular mental health, and then access to, in particular, dental healthcare. Then I want to address five interim measures that should be implemented, in our submission, while longer-term reforms

are being put in place; then I want to address the particular challenges in rural areas. I want to address medication management, including that topic that you've heard so much about, the overuse of antipsychotics in aged care. I want to address hospital transfers, that is the transition of people between the aged care setting and the acute care environment; and I want to address data and close this topic with a higher level set of submissions about State, Territory and Commonwealth roles and responsibilities and the clarifications thereof.

Firstly, Recommendation 62. This is the first recommendation we submit in respect to access to primary healthcare. You will see, Commissioners, that this is a far-reaching proposal for a new primary care model to improve access to people who are living in residential aged care or who are receiving aged care at home. It's a proposal for a voluntary enrolment model, also called a capitation model, for the delivery of primary healthcare services.

Commissioners, at paragraph 1015 we embark on the reasoning supporting Recommendation 62, the recommendation for the capitation model to access to primary healthcare, and we say there that with reference to the data that are available to the Royal Commission it's clear that people do receive access to general practitioners and relatively often, if they're also receiving aged care services, but there are data limitations about the nature and extent of the healthcare needs of those people receiving aged care services so it can't safely be concluded that the level of service provision actually meets those needs.

When we go to the evidence that you heard from witnesses, Commissioners, in particular I'm referring now to the December hearing held in Canberra, you will recall that the evidence was from residents, families and staff, that there are real limitations in the access that's enjoyed to general practitioners and other primary healthcare practitioners. They're either not visiting people who are receiving aged care at their own homes, or in residential aged care facilities, or they're not visiting enough, or they're not spending adequate time to provide the care that's required when they do visit, and this seems to be particularly acute in residential aged care facilities.

In our submission, part of the answer lies in attention being given to the way general practitioners are funded to provide primary care. The existing model is of course a fee-for-service remuneration model, the Medicare benefits schedule. There is also, in effect, a call-out or attendance fee that is availability based on certain criteria, but in our submission these measures are not proving sufficient for the amount and time of care needed for people receiving aged care. And there's a summary at 1017 of our inferences, suggested conclusions, drawn from the evidence you heard.

1018, the current fee-for-service model has long been recognised as in conflict with the proactive, coordinated, and ongoing team-based approaches that are needed to support the prevention and optimal management of chronic and complex conditions. In a nutshell, Commissioners, with a population who do suffer over the average more complex and chronic conditions, a more regular form and continuous form of care is

called for and that calls for a different approach to funding, not simply an approach based on fee-for-service.

So the proposed new model seeks to encourage the provision of holistic, coordinated and proactive healthcare to meet that complexity, 1019.

1020, fee-for-service remains the better model for the general population because of their more short-term or episodic needs for primary care in the main but less suited to the population I've been speaking about.

1023, in the model we propose, the Australian Government should determine the amount of the annual capitation payments that are required to provide adequate incentives to general practitioners to meet the care needs of people receiving residential care or personal care at home and we propose a tiered system based on the level of complexity and intensity and the type of care that people are receiving. The model should account for exceptional events, after-hours services and the like, and there can be fee adjustments in the event of after-hours attendances and I repeat, this should be a voluntary model. So it should always be an option for a general practitioner to choose to bring their practice into this model by seeking accreditation to be funded under this model and it should, of course, always be the choice of a person receiving aged care whether to enrol in a general practices capitation-based model, if a person who is also receiving aged care just wishes to continue to receive services that are funded by Medicare, that person has that right.

Because of that voluntariness, the program will, in effect, operate as a large-scale trial across the country, in our submission, and it should be reviewed after, say, six years to see how it's going, to see what the rate of take-up is, to see what the rate of its success may be. Doing this will enable, we anticipate, research to be done which will inform either refinement of the model or potentially broadening its scope and reviewing whether it should be made universal.

I want to now go to a second measure on primary care which we advance at Recommendation 63. This is a recommendation that is of relatively narrow compass directed to the requirements for accreditation of general practices that are imposed by the Royal Australian College of General Practitioners and, Commissioners, you will recall from the evidence in Canberra that there is an impediment in the way of general practices receiving certain incentive payments by reason of requirements in those standards promulgated by the college where the practice in question doesn't serve the entire demography of a particular community or where the practice concerned doesn't have rooms and doesn't have, therefore, a list of essential equipment stocked in those rooms.

Now the reason we've focused attention on these matters is that, as you will recall from Canberra, there are innovative, mobile general practices in gestation, and in some cases already up and running and practising but based on having rooms that are, in a way, surplus to requirements, just in order to achieve accreditation and these mobile practices are well suited, in our submission, to the provision of aged care --- I

beg your pardon, the provision of primary care to people who are receiving aged care. There should be every incentive made available to these innovative mobile general practices who specialise in providing primary healthcare to people who are living in aged care settings.

Recommendation 64, and I'm now about to embark on the reasoning and support of Recommendation 64 at point 1033 and following. Recommendation 64 is a recommendation on the topic of access to specialists and reaching back to the principles and themes that I identified at the start of this address this morning, access to specialists is particularly important, of course, given the complexity and the potential comorbidity of people receiving aged care and yet, as the data exposed in the Canberra hearing showed, there is a real problem in particular in those people living in the residential aged care settings getting access to specialists and we've recorded the key conclusions from those data at 1034, and you will remember, and we've referred to this at 1035, Commissioners, the then Secretary of the Department of Health acknowledging that the data that are available tend to suggest that there's an issue with access, I think she said there may be an issue, there is an issue, and it has to be confronted.

Now just jumping to 1039, Commissioners, you will remember the evidence was, and we led quite a bit of evidence on this, that there are a number of innovative, multidisciplinary outreach teams providing specialist services in aged care settings in a number of local hospital networks of the various states and territories and some of these are terrific, and could be a brilliant model for wider rollout across the country. What we're submitting here at 1036 and following is that the Australian and State and Territory governments should introduce local health network, that is the local hospital networks across the country that are, in effect, State and Territory administrative units relating to the administration of public hospitals and related community health, to some extent, to the extent that they're reliant on hospital resources, the Government should introduce local hospital network-led multidisciplinary outreach services providing specialist healthcare. They should be accessible to all people receiving residential care or personal care at home based on clinical need, in our submission. Now that will require intergovernmental agreement across those tiers of government, Commonwealth, State and Territory.

To be effective, those multidisciplinary specialist outreach services should, wherever possible, provide services wherever the person is residing, and they can be built on the hospital in the home model, as well as telehealth and other technology-based initiatives, and you heard evidence about hospital in the home and those other matters in the Canberra hearing.

The multidisciplinary team should include nurse-practitioners, allied health practitioners such as, for example, speech pathologist, occupational therapists, physiotherapists and pharmacists. There should also be access to a core group of relevant specialists, many of whom are going to be available as salaried or accessible specialists in the hospital settings, including geriatricians, psychogeriatricians and palliative care specialists with embedded escalation to other specialists who should

be available through those hospital resources, endocrinologists, cardiologists, infectious disease specialists and wound specialists.

Now we also submit that 24/7 on-call services should be made available through this new program of multidisciplinary specialist outreach services. That's Recommendation 64.

I'll move onto Recommendation 65, increased access to the older person's mental health services.

All the States and Territory governments, except for Northern Territory, provide a mental health service specifically for older people with severe and complex mental health conditions. In the main, these older persons mental health services are multidisciplinary and do include specialist medical, nursing and allied health practitioners. They typically provide services to older people in hospitals and community settings and are delivered by the local hospital networks.

The people who are living in residential aged care facilities should have the same access to these services as their peers in the community and that is the gist of Recommendation 65.

While older persons mental health services are run by the State and Territory Governments, the Australian Government in parallel funds a number of dementia-specific programs.

I'm at 1048, Commissioners.

These dementia-specific programs are for people receiving aged care and they include the Dementia Behavioural Management Advisory Service, the DBMAS as it was called in a lot of the evidence before you, and the severe behavioural response teams. And as you heard, the Australian Government is also in the process of establishing a specialist dementia care program with psychogeriatric clinical in-reach and also those specialist units that you heard about that are going to be fairly sparsely distributed and a bit few and far between but they're going to be, at least theoretically available, for people to be moved from residential aged care facilities at need, only in the case, of course, of very severe behavioural or psychological symptoms of dementia and inability to care for those people in residential aged care facility settings.

Now, the existence of those two services side by side has caused some issues. There's fragmentation, to some extent, causing people to fall between the gaps, as you heard in the more recent Melbourne hearing when these issues were revisited, or be referred to multiple different services until a service is provided. So in our submission, standardised eligibility criteria are needed and should ensure than an older person people is not prevented from accessing services from either of those two streams of services, the mental health care services and the dementia-specific services.

Recommendation 66 is on the topic of oral and dental health. You heard a lot of evidence, starting all the way back in Sydney in May last year when we began to open this topic about the importance of oral and dental care, not least as a key contributor to general health outcomes and the importance of avoiding mouth infection and so forth for general health purposes. Older people, I'm at 1050, are far more likely to have poor oral health. Poor oral health has obvious adverse consequences including not only the direct health outcomes but social isolation as well as functional impairment, pain and discomfort, ill-health and even death. It can affect a person's ability to speak, eat and socialise. It can contribute to tooth decay, aspiration pneumonia and mouth cancer and is linked to other chronic conditions. We've gone into those matters there.

At 1052, as we've already submitted in the program design context, oral health practitioners should be part of the enhancement of allied health that we've advanced in the program design context. They should engage in a range of preventative treatments, which we've outlined at 1052.

1053, to overcome the reduced mobility of many aged care recipients, dental services should, when needed, be provided to older people wherever they're residing. Health services can and should be delivered in residential aged care facilities as well as within the community. At a minimum, outreach dental services should be available to require a clean, well-lit area that has access to running water and capacity for portable equipment. That is the places, particularly now focusing on residential aged care facilities, where those services could be provided by an outreach dental service, those spaces within the facility should be made available so those services can be facilitated.

There are already some dental outreach services on this model operating in various aged care settings throughout Australia. This is a bit reminiscent of what I just said before about the multidisciplinary specialist outreach teams. We want to take those services and hold them up as a model for the whole country and roll them out more broadly.

The proposed scheme, 1055, would also provide comprehensive dental healthcare to older people who can't afford to fund it themselves before they have any need to access residential aged care services. Commissioners, we're aware that this is a far-reaching proposal but it's well justified and it's incidental to your Terms of Reference because of those preventative health matters that I referred to at the outset of this section.

The proposed Senior Dental Benefits Scheme would provide national consistency, avoid waiting lists and provide ongoing systemic funding for dental services. Such a scheme would be a modified version of what was proposed by the Australian Dental Association in its 2019 dental health plan. The Senior Dental Benefits Scheme should not be paid for by a reduction in funding for already overstretched public dental services. Ensuring funding is in addition to the already existing public dental

services will redirect, it will have this benefit, Commissioners, it will redirect some demand for those services and serve to reduce the wait time for people who are under 65 years old who need those public dental services, and at 1058, we've addressed some responsible public revenue constraints, that is constraints on the demand on public revenue that would flow from this, by proposing the limiting of eligibility to aged care residents and older people who receive the aged pension, or qualify for a Commonwealth seniors card, and by limiting the scope of the services, as those necessary to maintain a functional dentition, that is on, I believe this is on WHO criteria, 20 or more teeth.

I will now go to the short-term measures, the five short-term measures are in Recommendation 67. Time doesn't permit me to go through these properly and in detail. They are all important and they all should be happening while these longer-term reforms are put in place. They cover mental health treatment items provided by GPs, mental health assessments, allied mental health, that's access to psychologists in particular, and access to the aged care access incentive payment.

I'll just refer you generally, Commissioners, and commend to you and the public the justifying reasoning which is outlined under the headings in our submissions from page 319 onwards. So the comprehensive health assessments, I should have mentioned them first, pardon me. I only mentioned four of the interim items. The first is comprehensive health assessments and this is really a corner stone of looking after people's health needs because it's from assessments of this kind, particularly when you have a population who have greater than average complexity and comorbidity, that proper primary healthcare begins, or general healthcare begins. Comprehensive health assessments should be made available on a funded basis through Medicare more frequently and that's the gist of the submissions we've made there.

There's currently, in effect, a presumptive time cap placed on the availability of MBS subsidy for comprehensive health assessments which at 12 months is too lengthy. There should be more frequent availability of comprehensive health assessments and recognition of the need for them when there have been changes in health circumstances.

1064 and following, there's the argument about the access to the mental health services. There's the detail on the current level of MBS subsidisation of psychological services and the need for greater levels of access to services of those kind is addressed in those paragraphs.

There's a point at 1067, there's an existing initiative summarised at 1065 called the Better Access Initiative, and these allow Medicare benefits for general practitioners and psychiatrists to assess and diagnose someone with a mental illness and that's then the trigger for access to psychological services, the 10 MBS-subsidised psychological services, and also 10 MBS-subsidised group therapy services which might also be part of psychological therapy. But in order to enter the gateway to access those psychological services, there needs to have been entry into the eligibility

for the Better Access Initiative.

During the COVID pandemic response, which is, of course, ongoing, it's become evident that there's a lack of access for aged care residents to mental health treatment plans under the Better Access Initiative. So this is, in effect, a blockage to what was intended to be entry to that broader suite of psychological services.

Aged care residents did not get the benefit, and they should have. So we're proposing that any barriers to aged care residents using Medicare-subsidised services under the Better Access Initiative should be removed immediately.

Can I also mention at 1068, Commissioners, there has been an allocation of over $82 million over four years to the primary health networks to commission, that is directly commission by agreements, psychological services for people living in residential aged care but based on the evidence you heard at the Melbourne hearing in July, so far that program is not producing sufficient access for people in residential aged care to mental health services. That also needs to be addressed.

1074, we address here the item, the enhancement of subsidy available under MBS for allied health services including psychological services. This is, of course, very important particularly in light of the evidence you've heard about the overuse of psychotropic medication. Psychological services are a counterbalance to those sort of, if I could describe them this way, chemical answers provided to mental health issues. Psychological services should be made available on a subsidised basis to a greater extent than they are and that's addressed in paragraphs 1074 to 1077, and the aged care access incentive payment argument is set out at 1078 to 1083.

Can I just say one other thing in addition to the argument that is set out at 1078 to 1083, it's said in those submissions that the changes we propose for the General Practitioner Aged Care Access Incentive payment should remain in place at least until introduction of the new primary care capitation-based funding model described in the first recommendation I addressed.

Now, alternatively, depending on what the take-up is of that model and how that model is going, of course it would be open to the Government to leave in place the changes to these incentive payment arrangements that we advocate.

Can I go now to Recommendation 68 and the argument supporting it at 1083 to 1090, we're now moving into the area of addressing special challenges that are presented to the healthcare system in providing services in rural, regional and remote areas.

There is an existing Rural Health Outreach Fund which is designed to target funding to particular needs that arise in rural settings. It has, at present, the following areas of focus on which those grant funds are intended to be applied: chronic disease management, eye health, maternity and paediatric health, and mental health. In addition, Commissioners, we propose that an additional priority should be applied,

which is geriatrician outreach services. This is in line with a point of principle already accepted by the Australian Government, 1087. That won't, in itself, address the problems that aged care recipients face in accessing specialist services, even though chronic disease management and mental health are current priorities for that fund, and many aged care residents do suffer from those. There's, in fact, disappointingly no evidence that those needs are being addressed adequately through the fund.

So aged care generally, in our submission, should be added as a further priority area for the rural outreach fund.

At 1090 we address what the quantum of the additional funding should be and we've done our best there and we've proposed estimated additional funding of about $9.6 million annually and indexed.

Recommendation 69, and this is not just a rural, regional and remote matter. Recent experience has shown how important this topic can be because, of course, necessity has bred invention. Telehealth services should be more widely available to facilitate access to specialist services.

It's conceivable that people in aged care will receive a great deal of the support that they need from the expertise of specialists, even without a face-to-face consultation by specialists because that specialist can be in communication with clinically qualified people who are present with the person that needs the services in whatever settings they happen to be living. In particular if they're in a residential aged care facility there will be access to specialist nursing staff.

The World Health Organization defines telehealth, this is 1091, as "the use of telecommunications and virtual technology to deliver healthcare outside of traditional healthcare facilities" and, of course, telehealth has become widespread as a result of the pandemic and the Government's temporary expansion of telehealth to reduce community transmission of the virus and there's been subsidised --- more widespread subsidised support by the Government of telehealth.

In our submission, telehealth will continue to be of benefit beyond the response to the pandemic. It's a means of avoiding potential harm and distress caused by travel for frail, older people, and at present telehealth is underused by specialists and aged care providers and greater uptake needs to be incentivised.

So the Australian Government should, in addition to having introduced some telehealth MBS items in 2011, they should be expanded and to the extent that there is additional support during the pandemic, well, I can't see a submission here that we're directly submitting that those additional expanded supports for telehealth should be continued, but that's certainly an issue that deserves the attention of government.

1094, Commissioners, on the aged care provider side, there needs to be support for the ability of medical clinicians to provide telehealth by ensuring the right equipment

and staff members are available to people receiving aged care to facilitate telehealth to those people. And that's whether the person receiving aged care is in a residential care facility or is receiving personal care at home.

Aged care providers should ensure there's a qualified health professional available, present with the older person during the telehealth consultations to record the outcomes and take actions to initiate recommended changes to care. And also the AMA, the Australian Medical Association and medical colleges should also encourage their members to increase use of telehealth.

I'll go now to the medication topics, Commissioners. Recommendation 70, increased access to medication management reviews. Now, these are reviews that were conducted with --- by, or at least with a great deal of involvement by accredited pharmacists looking at whether long-term medicine regimes that have been prescribed for a person are still necessary or appropriate, including by considering changes in a person's health condition, and also considering other effects of polypharmacy including interactions between medicines that have been prescribed. Sometimes various combinations of medicines can have particularly serious side effects and certain combinations of medicines can have the effect of cancelling out the active ingredients in certain of those prescribed medications and these matters are within the particular purview of the expertise of these accredited pharmacists.

Polypharmacy, or the prescription of many medicines at the same time, is a particular issue in aged care, as you've heard, Commissioners.

Presently, the Australian Government-subsidised reviews of medication regimes, known as Medication Management Reviews, are governed by the Community Pharmacy Agreement. I'm at 1098. Under that agreement, people living in residential aged care can have a Residential Medication Management review performed by an accredited pharmacist when referred by their general practitioner. These reviews are not available for people receiving respite or transition care.

The accredited pharmacist will generate a report at the end of the review which the GP can use to develop or revise the resident's medication management plan. And there's also a similar version available for people who are living in their own homes in the community.

At present, aged care residents are entitled to only one residential Medication Management Review every 24 months unless there are significant changes to the person's medical condition or medication regimen. And they're entitled to two follow-up interviews by an accredited pharmacist no earlier than one month and no later than nine months after the initial medication review. However, these follow-up reviews are not comprehensive reviews.

In contrast, GPs can access Medicare funding for engaging in medicine review services once in a 12-month period or when there's a significant change. The different funding criteria make little sense, in our respectful submission, and cause

difficulties when accessing medication reviews. So the Australian Government should enable more frequent reviews by pharmacists. They should be able to occur at least annually and more regularly if there's been a significant change.

We also address at 1101, the anomaly whereby people receiving respite care or transition care aren't currently entitled to a subsidised Residential Medication Management Review.

Now, at 1102 we advocate the extension of a review or active monitoring and ongoing monitoring that's being performed by the Pharmacies Programs Administrator under the Community Pharmacy Agreement over this topic.

Carrying on with the topic of medication, we'll now go to Recommendation 71, restricted prescription for antipsychotics. This is a submission about the need to take concrete action to bring relevant expertise to bear on the serious problem of prescription of antipsychotics. You heard a lot of evidence about this, Commissioners, over the course of the inquiry. In short, antipsychotics are generally, perhaps this is perilous for me to enter into this expert territory, but generally great caution needs to be exercised in the prescription of psychotropics of this kind for people who may be living with cognitive decline and may be not adequately cared for and managed and therefore be exhibiting what are sometimes called "challenging behaviours".

There was evidence, including in Sydney last year, on these matters and the thrust of this recommendation is to get a psychiatrist or a geriatrician involved if there's going to be prescription of this family of psychotropic medications.

In the Interim Report, Commissioner Briggs, you and late Commissioner Tracey, identified the widespread use of chemical restraints in the purported care of many older Australians, and in response to the Interim Report, the Australian Government announced changes intended to address problems with medication management and they included changes to prescribing criteria for the antipsychotic risperidone under the PBS, and also education resources and funding for medication management programs and increased dementia training and support for aged care workers and health sector staff.

1105, of course, these measures are commendable, but in our submission, they don't go far enough to a problem that's persisted now for decades. Education and training programs need to be implemented nationally and consistently. Numbers of care staff employed in residential aged care will have to be increased, of course this is in line with our other submissions, in order to ensure more time is available for better management of the so-called "challenging behaviours", also sometimes called behaviour and psychological symptoms of dementia.

But in tandem, there should be stricter requirements for prescribing antipsychotic medicines. In the future, the system should never again be involved in, and the community should never be confronted by, this apparent resort to antipsychotics in

place of proper care of the people showing the so-called "challenging behaviours".

Under the Pharmaceutical Benefits Scheme, risperidone is only subsidised for treatment of autism in children if the treatment is under the supervision of a paediatrician or psychiatrist. In our submission, a similar regimen should be applied over the prescription of that drug in an aged care setting, and psychiatrists or geriatricians should be the only ones who can initiate that treatment.

And at 1107 we refer to how this measure will be of benefit in relieving what appears to be pressure on GPs and on residential facilities and injecting that higher level of expertise and specialisation into any decision to use that drug. We do say that repeat prescriptions should be available to be written by general practitioners but we have suggested some safeguards around those measures at the foot of 1107.

I now want to move to that point about transfers between residential aged care and acute settings, hospital care. Recommendation 72, there's a need for improved communication and collaboration between people working in the aged care system and people working in the healthcare system. The healthcare needs of older people can't be safely and properly met without improved collaboration.

You heard evidence about this, Commissioners. We've given some high-level inferences and conclusions about that.

At 1110, we've referred to deficiencies in handover processes between the two systems and we've also referred to the position in principle adopted by the governments on this matter at 1111 and this recommendation is really about implementing what's already accepted as something that should be done in principle. And we've gone into some detail about that in the remaining paragraphs, 1112 through to 1115.

Data, Recommendation 73 concerns data and Recommendation 74 is connected with this. It's a proposal for universal adoption by the sector of digital technology and also subject to the consent of each person receiving aged care My Health Record.

Of course, adoption of digital technology assists in the proper collection of data and the capability of collecting useful data because without digitisation it's administratively very burdensome to be able to capture information from the relevant records. And as you've heard throughout this inquiry, the sector remains in the dark ages when it comes to digitisation and there are many examples referred to, still, at least anecdotally in the evidence before you, I'm thinking in particular of Darwin, where aged care providers are basing their recommendations on paper records.

We've got our submissions on the detail of improving data on the interaction between the health and aged care systems at 73 and these, importantly, include two things --- the introduction of what we call an aged care identifier so that the tracking of a person who is receiving aged care and who also receives healthcare system services can properly occur and be understood, and minimum data sets, of which

you've already heard a little. These need to be agreed and implemented so that it's understood on the "collect once, use many times" maxim, what data needs to be captured.

Recommendation 74 is the one I've already flagged about digitisation and the take-up of My Health Record subject to the consent of the person concerned.

I'll now conclude this section on the three recommendations that I flagged at the outset that are high-level recommendations about intergovernmental cooperation. The first is 75, clarification of the roles and responsibilities for the delivery of healthcare as between the various governments, Commonwealth, State and Territory. Now, this will require amendment to the National Health Reform Agreement to include an explicit statement of the respective roles of those polities, those governmental entities, when it comes to healthcare providers who are delivering healthcare to people who are also receiving aged care. And there's a complex matrix that needs to be sorted out between the governments that really makes those roles and responsibilities clear, and there's something very similar that already exists in the disability sphere. We've mentioned it in that recommendation that something like that needs to be adopted in aged care.

Recommendation 76, in a way this should go without saying, but it does need saying. There needs to be explicit commitment by the State and Territory governments that the funded community services they provide to people in their communities need to be made available to people who are receiving aged care, and this touches on the point I made right at the outset about the difference in funding responsibilities as between the two systems. This can lead to undesirable outcomes, I think in the evidence perhaps on occasion the word "cost shifting" has been used. There needs to be an explicit recognition of the availability of community health services to people who are receiving aged care as well.

And our final recommendation in this part is Recommendation 77 which is the mechanism for intergovernmental consideration of the full suite of the recommendations you will ultimately be making, Commissioners, and a standing item for review of those by the Australian Health Ministers Advisory Council at the behest of the Health National Cabinet Reform Committee.

Commissioners, those are the submissions on the interaction between the aged care system and the healthcare system.

COMMISSIONER PAGONE: Yes, thank you, Mr Gray.

MR GRAY QC: I'll move now to part 3.14, which is quite closely connected with what's just been said: aged care in regional, rural and remote areas. There are only two recommendations in this part. They're both very important and you're going to hear a little bit more about the particular challenges facing aged care providers in rural, regional and remote communities when we come to the funding topic this afternoon. There are serious viability concerns that exist, in relation in particular to

residential aged care providers in these settings.

We're now focusing on certain aspects, putting funding to one side for the moment, certain aspects that need attention and that can be addressed by some relatively simple improvements to meet the challenges, the particular challenges, that aged care faces in rural, regional and remote areas.

You've heard evidence, Commissioners, about the particular needs of older people in these areas and the difficulties they have in getting access to high-quality aged care services. I'm at 1149. And just to number off some of the key themes: scarcity of local services, and we're talking primarily about aged care services but let's not also forget all of those contextual services that also contribute to the quality of the outcomes that a person receiving aged care enjoys or doesn't enjoy.

So scarcity of local services, greater travel times, particularly important when you think about that point we've just been ventilating concerning the need to get access to healthcare and those close connections between healthcare outcomes and aged care outcomes. But also relevant to the funding impost on Home Care Packages because you've heard evidence that the Home Care Packages are severely impacted by the travel expenses and there's a disparity or a lack of equity between people who live in more densely populated places compared to people who live in remoter places in that respect. Higher costs to gain access to the provision of services, difficulties recruiting and retaining service providers, a lack of access to health professionals.

People living in regional, rural and remote areas experience relative disadvantage in various ways and we have referenced some general evidence on these things. Lower incomes, poorer education, poorer housing, poorer health outcomes, including higher rates of disability, disease and injury. And all of those things can increase the need for supports in older age.

In addition to that, Commissioners, in rural, regional and remote areas, older people generally make up a greater share of the population than elsewhere in Australia. So all of those things are compounding factors on the complexity and intensity of the aged care that should be available in rural, regional and remote areas. But availability of aged care in these areas is poorer by comparison with the major cities and we've referenced the Productivity Commission report on government services on that point. And on current trends the disparity appears to be widening.

The existing legislation, as you will recall from one of the Melbourne hearings, Melbourne Hearing 2, is that there's legislative recognition of what's called "special needs", and you will remember that category of people who are defined by that expression in the Act, putting aside the terminology that's used there, let's just look at the substance.

There is reference under that provision to people living in rural and remote areas and the consequence of that is that at least in relation to the allocation of residential aged care places, and the payment of flexible care subsidies, the legislative regime evinces

an intention to identify and meet the needs of people living in those areas on a greater than general basis.

But that intention doesn't go far enough. For one thing, there's no provision there to cover the disparities I've just been adverting to in home care and the evidence before the Royal Commission, in any event, doesn't suggest that the intention in the legislation has translated into practical results in a consistent, systemic way.

The planned measures to meet the needs of people in these areas is either not happening, or if it is happening it's not working.

So in Recommendation 78, we're proposing, in effect, and you will recall this, perhaps, Commissioners, from evidence in the Mudgee hearing, proposing, in effect, a survey to identify areas where service provision is inadequate, and where supplementation of services is needed and this needs to be done on a local basis, there really needs to be quite a granular approach taken to identifying where these gaps are. And from 1 December 2021, the Government should make it clear that when people first engage with the aged care system there needs to be a recognised set of expectations about what they can expect to receive and what they won't be able to receive at a certain level of remoteness for their community.

We submit that if the Australian Aged Care Commission is established, as we propose it should be, with effect on from 1 July 2023, the Aged Care Commission would take over those functions. And we set out our reason in support of this submission and the measures that need to be taken once those gaps and deficiencies are identified at 1152 and following, and the gist of this idea is that where there are gaps, measures need to be taken, proportionate measures need to be taken in response. There should be a suite of options considered by the Government or the Aged Care Commission, once established, tailored to what's needed on a local basis. That might mean the Aged Care Pricing Authority calculating additional loadings or supplements that are needed to incentivise adequate service provision in the relevant places and probably doing that by reference to metrics of remoteness such as under the Modified Monash scale, or perhaps on a more granular basis than that.

Another option that should be available in the suite of responses is special commissioning arrangements and in particular, 1158, if there are areas where there are simply not just markets that aren't competitive but no services at all, there needs to be commissioning of services and service providers of last resort.

Information on the My Aged Care website needs to be accurate and we say verified by the governor of the system, be that the Department or the Aged Care Commission, and it needs to be very clear, in particular localities what services are and aren't available and closest places where those services are available.

The second recommendation in this section, Commissioners, is Multi-Purpose Services Program and you will remember from Mudgee the evidence about the MPS program. It's a program that's a joint initiative between the Australian and State and

Territory governments. One of its primary objectives is to provide integrated health and aged care services for regional, rural and remote communities in both residential aged care and home care settings, integrated health and age care, and that's what the "multi-purpose" in "Multi-purpose Services" refers to.

The origins of these services perhaps do more to explain what they are than that mere description I've given. These were, in the main, small country hospitals that are now jointly funded, State, Territory and Commonwealth, on the basis they will continue to provide health services to the communities they're located in as well as providing aged care services and where there are challenges of attaining sufficient scale to have either health service or aged care services, this is a terrific idea. There are 179 operational multi-purpose services across Australia at the moment. There are more in some states than others, for example New South Wales has many of them.

They are operating under a series of agreements, usually between the Australian Government, on the one hand, and the respective State or Territory on the other, and for the Australian Government's part, it provides funding to what's treated as an approved provider under a flexible care subsidy program made under the *Aged Care Act* based on the number of high-care or low-care residential places --- that's harking back to an older classification system that used to exist in the general residential aged care system --- and also the number of home care places.

The service provider can pool the subsidy that results from those places and it's, in effect, block funding not activity-based funding. The beds are paid for irrespective of whether they're filled.

Now, there's been a review by UTS, University of Technology Sydney, a team led by Professor Mike Woods who also, incidentally, was the lead commissioner on the 2011 Productivity Commission report. We go into the details of what that study found at 1163 all the way through to 1177. I won't stay now to go through that passage in detail. In essence, we've moulded our recommendations in light of what the UTS review found and one of the key points that we're driving at in these submissions is that the MPS program should be not only retained but expanded but the various wrinkles identified by the UTS review should be ironed out and the program improved and made more competitively neutral in economic and incentive terms with mainstream aged care services.

Those are our submissions on part 3.14. Unless there are any comments by the Commissioners, I will hand over to Mr Rozen.

COMMISSIONER PAGONE: Yes, Mr Rozen.

CLOSING SUBMISSIONS BY MR ROZEN QC (CONTINUED)

MR ROZEN QC: Thank you, Commissioners. Thank you, Mr Gray. The next topic

we would seek to address you on is part 3.10 of our submissions, aged care accommodation, it commences at page 271 of the written submissions.

There are two recommendations in this section which I will briefly refer to. Commissioners, where people live affects how they live. Accommodation that is well designed to meet people's needs, both now and into the future, can improve their quality of life. But people's needs change over their lives. Ideally people should plan ahead for those changes but often they do not.

This Royal Commission is authorised by paragraph (c) of the terms of reference to inquire into the future challenges and opportunities for delivering accessible, affordable and high-quality aged care services in Australia including in the context of changing demographics and preferences, particularly people's desire to remain living at home as they age. And we made some references in yesterday's submissions to that and it's an important theme that runs through all of the submissions that we make.

As acknowledged in the Terms of Reference, most older people in Australia want to remain at home as they age. Only one in six of the people who received aged care services last year received it and lived in a residential aged care facility. Most people receive aged care services in their homes.

We submit that across the country there's a need to improve access to accommodation in which people can grow older and as necessary receive aged care services. That is so whether the accommodation is owner occupied, privately rented, social and affordable housing, or residential aged care. Older people living in unsuitable housing face greater risks of falls, injury, immobility and the prospect of unanticipated entry into residential aged care. There's a clear link between the quality of housing and entry to aged care as we've heard on the evidence.

Moving to 915 of the submissions, in the last four lines, more investment in and construction of well-designed age-appropriate social and affordable housing is required. I'm talking about simple things like ramps and handrails but also far more sophisticated and complex innovations. It will help to prevent people having to move into residential aged care prematurely to access accommodation suitable for their care needs.

Overall, as we say at paragraph 916, there is a need for coordinated intergovernmental policy planning and action relating to housing and accommodation for Australia's ageing population. As a matter of priority, governments should work together to increase accessible housing, including private rental housing and social and affordable housing.

Given the focus, however, of the Terms of Reference on the delivery of aged care services, these general accommodation issues are not the subject of any particular proposed recommendations that we make. With the possible of exception of Recommendation 2 which my learned friend, Mr Gray, made reference to yesterday,

the integrated long-term care strategy which, as was noted yesterday, needs to have a focus on housing as part of a comprehensive approach to the care needs of older people.

The proposed recommendations in this part of our submissions are specifically directed to the design of residential aged care buildings. The designs of those buildings must be accompanied by an effective model of care delivery to ensure safe and high-quality care for aged care residents. Other submissions including submissions on quality and safety of care and workforce and training that we made yesterday are relevant. Another example of the way the package of recommendations that we're proposing needs to work together. The environment is as important as the staff that are working in the environment and the training that they have.

Principles of accessible and dementia-friendly design should now be the expected norm for new or substantially refurbished residential aged care buildings. We made reference yesterday to the statistics about the prevalence of dementia amongst the residential aged care population, and it is only expected to grow in future.

Residential aged care services should also transition from institutional settings to smaller, lower density, congregate living arrangements integrated in a local community. Commissioners, together with me and members of the staff, you will recall visiting Korongee in Hobart last December when we were there for the hearing, and it is an example of a dementia village, at the cost of some $25 million which recently opened and it is an example of the sort of way in which accommodation can be constructed that's tailored to the specific needs of people with dementia diagnoses with memory boxes, outside rooms and a whole range of other important features.

I said that about transitioning to lower-density congregate living.

The first recommendation we propose is Recommendation 57 which is on page 273 of the submissions. There are three steps to the transition to more appropriate residential aged care accommodation for older people. The three steps are essentially an information step, an encouragement step, and then a step which will mandate design and we've structured it in that way to assist the sector to give advanced notification as far as possible of the proposal to introduce mandatory requirements by taking what we consider to be a responsible four-year proposal.

The first part of that is in (a), the development and publication by 1 July 2022 of a comprehensive set of national aged care design principles and guidelines on accessible and dementia-friendly design for residential aged care, with the features that we've identified. The second part is a year later, by no later than 1 July 2023, there should be a program introduced by what will then be the Australian Aged Care Commission, to promote adoption of the national aged care design principles and guidelines in design and construction of residential aged care buildings. The program should include education, including the sharing of best practice models,

which could involve models such as Korongee or others, and also a program of financial incentives as detailed in (ii) of paragraph (b).

The third step in this recommendation is advancing to the National Federation Reform Council by 1 July 2025 a proposal for amendments to class 9c of the National Construction Code to require the adoption of accessible and dementia-friendly design for new residential aged care buildings or those proposed to be substantially refurbished according to specifications informed by the National Aged Care Design Principles and Guidelines. We make the point that we've known for many years now what dementia-friendly design looks like.

This is a classic example of where Australia can learn from experiences overseas, but we've been very slow to do that and we think it's very important that this area receives the priority that it deserves.

Commissioners, the second recommendation that we make in relation to accommodation is on page 276 of the document, it's Recommendation 58. And it concerns capital grants for small home models of accommodation. The evidence before this Royal Commission is that the trend is in precisely the opposite direction. The trend is towards larger, more institutional-type residential aged care. That's a product of the market in operation, essentially, of the lack of steering by the system governor that's allowed residential aged care accommodation to grow in size, particularly in the last ten years, and it would seem that unless there is some policy intervention, those trends will continue and those trends are contrary to at least some of the evidence before this Royal Commission about the appropriateness of smaller-scale accommodation as providing greater quality of life and better quality residential aged care.

Recommendation 58 is intended to be just that type of policy intervention. We note at paragraph 932 of our submissions that there is a Rural, Regional and Other Special Needs Building Fund which exists and provides support, as identified, for capital grants for construction of residential aged care facilities but we submit that the criteria for access are too narrow at present, and need to be broadened and that will broaden access to the fund and the fund itself should be increased in size. We make those submissions in Recommendation 58 that the expansion by 1 January 2022 of access to the fund should provide additional capital grants for building or upgrading residential aged care facilities to provide small-scale congregate living.

We note the terms of section 7 of the Grant Principles at 58.2, and at 58.3 we propose that a capital grants program for building or upgrading residential aged care facilities to provide small-scale congregate living should continue after the introduction of the new Act. We note some of the evidence there about the importance of smaller-scale accommodation at paragraphs 926 and 927.

Commissioners, at paragraph 932, in the fourth line, we note that an alternative approach to this could be to establish a separate capital grants program, specifically for projects of this kind, catering mostly for residents within one or more of the

disadvantaged groups described in section 7, subsection 2 of the grant principles, or yet another way could be the provision of financial support for a transition to small-scale congregate living which would involve the payment of a supplement to approved providers for every resident living in a building providing small-scale congregate living. This is paragraph 933 of our submissions. Such a payment might be said to have the benefit of compensating for additional capital and labour costs associated with a small home model of care. However, it would not necessarily direct financial support to areas of greatest need, as we note.

If I could just make one observation in closing that in our submission it is important to consider in relation to this otherwise desirable trend to move to smaller-scale accommodation, and that is that one of the benefits of larger-scale providers may be the infrastructure necessary to develop the workforce, the human resources infrastructure, the training infrastructure, the access to the sort of facilities that might be needed to provide up-to-date and appropriate technologically informed training to employees.

So it's a factor to bear in mind in relation to what is an otherwise desirable trend to see smaller-scale accommodation. The answer to that might be that smaller-scale accommodation doesn't necessarily have to be provided by smaller-scale providers. It could be that larger-scale providers could still benefit from those sort of economies of scale that I've referred to but do so whilst providing smaller-scale accommodation along the lines we've discussed in this part of the submissions.

Commissioners, that's all I wish to say under topic 3.10. If I could move to part 3.11 of our submissions on page 279. This part of our submissions is concerned with younger people in residential aged care.

As we note at paragraph 934, Commissioners, aged care is not intended for younger people by definition. Their needs are not the same as the needs of older people. No younger person should have to live in residential aged care but too many younger people do and too many have done so for too many years. Commissioner Briggs will recall the Melbourne 1 hearing before Commissioner Pagone's appointment, where we'd perhaps heard, amongst what has been a lot of very moving evidence in this Royal Commission, perhaps the most moving evidence of all, singling people out is always risky but I would just briefly refer to two of the witnesses that we heard from in the Melbourne 1 hearing. The first was Mr James Nutt to whom I made brief reference to yesterday who found himself in residential aged care at the age of 22 and for the purposes of our hearing, embarked on what could only be described as an odyssey of travelling from his home in Newcastle to Melbourne to give evidence, had all sorts of difficulties getting his wheelchair on to an aeroplane. Ultimately, through his perseverance and courage, he was able to do that with the great support of his support workers and I thanked him outside the hearing room for going to all that trouble and he said, "No trouble at all, Peter. This is the most important day of my life, to have the opportunity to get young people out of aged care is something that I've been wishing to do for years."

The other witness that I would want to make brief reference to also demonstrated remarkable courage, Lisa Corcoran, 43-year-old, a young woman who gave evidence about her experience living in residential aged care in terms that can only be described as very, very moving. She was asked by Counsel Assisting, Ms Bergen, what her goals were and memorably, and this has received quite a bit of media attention, she told us that her number one goal is to "get the fuck out of the nursing home", and it resonated with everyone in the room and demonstrates the great passion that people, young people who find themselves in residential aged care feel about their circumstances. One can't help be moved by that.

Commissioners, the statement that there are too many younger people in residential aged care and that they oughtn't be there is recognised by the Australian Government as we note at page 935. In response to the Royal Commission's Interim Report, the Government committed itself to ensure that apart from in exceptional circumstances, no person under the age of 65 would enter residential aged care from 2022, no person under the age of 45 would live in residential aged care from 2022, and no person under the age of 65 would live in residential aged care from 2025.

These commitments are commendable, they must be achieved and they must stay achieved. We note that stated intentions must translate to sustainable results. And importantly, this has not happened in the past.

For decades, the Australian Government has accepted that younger people should not have to live in residential aged care but younger people have still continued to find themselves living in residential aged care. Past initiatives have not delivered, certainly not in any enduring and comprehensive way and we note the extensive evidence that was adduced in the Melbourne 1 hearing on that topic.

We note that as at 30 June this year, there were 4,860 younger people living in residential aged care in Australia. Of these, 3,978 were aged between 55 and 64, but importantly, there were 110 that were aged between 35 and 44 and 20 people under the age of 35 living in residential aged care.

To achieve its commitments, the Government must work actively to ensure that all younger people who are living in residential aged care can find suitable alternative accommodation before 2025. Reduction of the number of younger people living in residential aged care, particularly those who are aged between 55 and 64, should not depend on younger people turning 65 years or dying while in residential aged care and it's one of the very, very sad facts of this evidence that the way the numbers have been kept in check in the past is by either the early death of the younger people in residential aged care or ageing out, as it's called, when they turn 65 and they're no longer part of the statistics.

Commissioners, the big game changer here is the NDIS scheme, as we heard in the hearing. It presents a significant opportunity to stop younger people having to live in residential aged care by providing the sort of assistance that is needed for alternative accommodation and support in the community. It's important to recognise, however,

that the NDIS will not be the solution for everyone. There's a sizable minority of younger people who live in or are at risk of entering residential aged care who are ineligible because they don't have a disability as defined to become NDIS participants.

The Government has clearly indicated its commitment to stopping younger people having to live in residential aged care. That commitment is commendable. The actions since the Royal Commission's Interim Report by the Government have delivered some encouraging early signs but as we note at paragraph 941 there have been false dawns before. Fulfilment of the Government's commitment will require dedicated, continuing and systematic action and Recommendation 59 is our proposed way of holding the Government to account.

So we base the recommendation around the stated commitment by the Prime Minister on 25 November 2019, it's Recommendation 59, and we recommend that the Government put in place the means to achieve, monitor and report on progress towards that commitment by taking the various steps that are set out in Recommendation 59. I won't read through all of them. But there are essentially four components to our recommendations.

The first concerns the assessment stage. As you heard in the evidence in Melbourne 1, that's the gate keeper, if you like, the assessment by the aged care assessment teams is what ultimately leads to people entering residential aged care in the first place. For that reason, we note at paragraph (d) of the recommendation that what should occur is that the assessment, there should be a referral assessment by the agency most appropriate for the assessment such as the NDIS and not an aged care assessment team or aged care assessment service for any younger person who is at risk of entering residential aged care. That's a very important threshold reform, in our submission.

Because so many of the younger people who enter residential aged care do that as a result of being discharged from hospitals, it's important that there be hospital discharge protocols with State and Territory governments to prevent discharge into residential aged care of younger people. It really relates to the point that my learned friend, Mr Gray, was just making about that interface between the health system and the aged care system. This is a practical example of where that has been failing people.

There is a need for the development, funding and implementation with State and Territory governments programs for short-term and long-term accommodation and care options. And we make submissions about both transitional accommodation from paragraphs 970 through to 975, and also longer-term accommodation from 976 through to 989, and I won't read through those submissions at the moment, but they seek to detail the evidence that was led about this topic at the Melbourne 1 hearing.

We submit that the Government should require the National Disability Insurance Agency to publish an annual Specialist Disability Accommodation National Plan

setting out priority locations and proposed responses, particularly in thin markets, and we make reference to the need for greater Specialist Disability Accommodation in paragraph (h) and importantly, funded, dedicated and individualised advocacy services. You will recall we heard from a number of advocacy groups that have been very active for years in relation to this topic and we see them as being a very important part of the solution here. As is collecting data, you will recall that there are inadequacies in the data in relation to this topic, as with so many parts of our aged care system.

There are two final aspects to our recommendation which are important. Firstly, we recommend that the responsible Minister report to the Parliament every six months about progress towards achieving the announced commitments. That's a very important part of the accountability mechanism that we submit ought to be put in place to ensure that governments which have a tendency, understandably, to be distracted by other matters as they arise, that this focus remains in place to ensure that the commitments that were made are, in fact, carried through.

Finally, Commissioners, and this is a difficult aspect of our recommendation, but the evidence that you heard in Melbourne suggests that for some people, maybe Aboriginal and Torres Strait Islander younger people, perhaps people living in regional, rural areas where they want to be living close to family, residential aged care may ultimately be the best option.

What we submit in paragraph (l) of the recommendation is that a person --- a younger person should only ever live in residential aged care if it is in their demonstrable best interests of that person and importantly, it's independently certified to be such by someone with suitable skills, training and knowledge of the person and in those limited and exceptional circumstances we give three categories of people who might be younger people for whom residential aged care is, in a practical sense, the best option.

We see those as being exceptions and limited ones but they are important if the approach to this question of policy is to be informed about what's really in the best interests of individual people and at the end of the day that should be the sole criterion for the application of the policy.

Commissioners, they're the recommendations that we submit, or the recommendation that we submit you ought to make in relation to younger people in residential aged care.

The next topic that I would like to address is topic 3.12, which is a related topic of aged care for people with disability. It's at page 295 of our submissions.

Commissioners, by paragraph (b) of the Terms of Reference, the Royal Commission is authorised to inquire into how best to deliver aged care services to people with disabilities residing in aged care facilities. A matter reasonably relevant to that inquiry is how best to deliver aged care services to people with disabilities living in

their homes.

For the purpose of this inquiry, the Royal Commission is also required to have regard, among other things, to the interface with other services accessed by people receiving aged care services including disability services.

As we note at paragraph 991 of the document, the establishment of the National Disability Insurance Scheme transformed the way in which disability services are provided in Australia. The NDIS is justifiably described on its website as the most important social reform in Australia since the introduction of Medicare. We would like to think that the reforms to the aged care system, as a result of this Royal Commission, might rival that in years to come.

It has changed, for the better, the lives of hundreds of thousands of people with disability by providing them with the reasonable and necessary supports that they need to live an ordinary life. However, like any statutory scheme, it's got its boundaries, and the intersection between the NDIS and the aged care system is what we are focusing on in this part of our submissions.

We note at 992 that the NDIS does not provide those supports to people who acquire a disability after they turn 65. Nor does it provide supports to people with disability whenever acquired who had already turned 65 when the NDIS came into operation in their local area. That includes people with lifelong disabilities.

Nor, importantly, does the NDIS provide supports to people with disability who first receive aged care services on a permanent basis after turning 65. So if you're a member of the scheme before you turn 65, and you turn 65 and start accessing aged care services, that impacts on your ability to be supported through the NDIS.

Despite the landmark contribution made by the NDIS to the lives of people with disability, many people with disability aged 65 or over are prevented from accessing the NDIS and obtaining the benefits of an individualised NDIS plan of supports. In Australia, there were, in 2018, 1.9 million people with disability who were aged 65 years and over. However, a report by the Australian Institute of Health and Welfare in 2019 estimated that only around 15,000 people aged over 65 would have access to the NDIS and its benefits when the NDIS roll-out was completed in 2020.

We submit, and don't take this to be controversial, Commissioners, that, at 994, we say the NDIS discriminates against older people on the basis of their age. In the absence of any relaxational removal of the age requirements for the NDIS, which is not a matter within the Terms of Reference and is therefore not something for this Commission's inquiry, other government programs must step up to provide analogous benefits for those with disability aged 65 and over and who cannot access the NDIS.

To that end, we propose two recommendations in relation to this category of people. The first is at Recommendation 60, which you will find immediately after paragraph

1001. Recommendation 60 is in the following terms: by 1 July 2024, so significant lead-in time, every aged care recipient with a disability or disabilities regardless of when acquired, should receive through the aged care program the daily living supports and outcomes including assistive technologies, aids and equipment, equivalent to those that would be available under the National Disability Insurance Scheme to a person with the same or substantially similar conditions.

So the mere entry into the aged care system of a person who previously enjoyed such benefits under the NDIS shouldn't mean they no longer continue to enjoy those benefit. We would want to have an equivalent support for such people provided through and funded by the aged care system.

We note at 1002 that the disability services and the aged care systems are different both philosophically and operationally. Discreet Commonwealth legislation separately governs each program area, each area has its own responsible Minister. Disability services and aged care are financed differently and each offers a different range of services. The NDIS is not means tested whilst aged care services involve consumer contributions. Aged care services are presently rationed whilst the NDIS is not and there are strict age requirements for the NDIS but not for aged care. And we refer to the evidence that has been received by the Royal Commission in relation to these topics. We note, for example, the schedule of supports available in the NDIS is more comprehensive than what is presently available in aged care.

We note, however, at 1004 that as a matter of principle we submit that people with disability should not experience disadvantage because they access supports and services from the aged care system instead of the disability services system. That accords with one object of the proposed new Ageg Care Act, that is to provide for a system of aged care based on a universal right to high-quality, safe and timeless support and care to assist older people to live an active, self-determined and meaningful life. The aged care program should provide people with disability receiving aged care with daily living supports and outcomes equivalent to those received under the NDIS, as I've noted.

The second recommendation complements the first. Like our recommendation in relation to younger people in residential aged care, we think a form of regular reporting by responsible Commonwealth Government agencies is important to provide the public with the confidence that the recommendation we propose here, if made by the Royal Commission, and implemented by the Government, is, in fact, implemented both in accordance with the letter but also the spirit of the recommendation.

To that end, Recommendation 61 proposes that by 1 July 2024, the Disability Discrimination Commissioner and the Age Discrimination Commissioner should be required, as part of the new national disability strategy, to report annually to the Parliament on the numbers of aged care recipients with disabilities who are 65 years or older and their ability to access daily living supports and outcomes including assistive technologies and others that are equivalent to those available under the

National Disability Insurance Scheme.

We note, Commissioners, that the ten-year National Disability Strategy, which currently ends this year and as we make these submissions, the Australian Government is developing a new National Disability Strategy. We submit that the new Strategy should continue to give effect to the human rights of people with disabilities, in accordance with Australia's human rights responsibilities under the UN Convention on the Rights of Persons With Disabilities and we note at paragraph 1007 that under the existing strategy, the Australian Human Rights Commission has an important role in ensuring the strategy upholds the human rights of people with disability. That should continue and this proposed reporting mechanism that we raise should become part of that and part of that responsibility of the Human Rights Commission, the two roles that we identify.

Commissioners, they're the submissions that we would make under 3.12. Mr Gray is about to commence other submissions. It may be an appropriate time for a break if that is suitable.

COMMISSIONER PAGONE: Yes, we will adjourn for 15 minutes.

ADJOURNED **[11.09 AM]**

RESUMED **[11.25 AM]**

COMMISSIONER PAGONE: Yes, Mr Gray.

CLOSING SUBMISSIONS BY MR GRAY QC (CONTINUED)

MR GRAY QC: Thank you, Commissioner. So far in our submissions we've covered points that can be distilled as answering questions such as: what should aged care be? Who should deliver it? Where and in what ways should it be delivered? Now, we come to the point how and what should be paid for it? And how should it be paid? The funding for aged care are the sinews required for the activity that's constituting the essential services that need to be provided. It's absolutely indispensable that the funding be right otherwise the services will be inadequate. Also the ways in which the funding's made available can have profound incentive effects on service delivery.

In earlier sections of our submissions, as you know, we've been providing supporting reasoning for an independent pricing mechanism. Independent pricing is a crucial reform but it will take some years to implement. It needs to be preceded by measures for greater accountability for the expenditure of public funding for high-quality care

and the other purposes for which it's paid. This topic of funding is at least a two-way street. Independent pricing, we anticipate, will result in greater funding and that funding will be made available to aged care providers but it's made available for particular purposes and there need to be a suite of measures ensuring greater public accountability for the ways in which the money's spent. This will involve, in our submission, improved reporting and transparency and that improved reporting will also provide an opportunity for better regulatory oversight of risks to continuity of aged care and to its quality because financial risk is a key indicator that there might be problems in continuity and quality of provision of aged care.

The measures for greater accountability are simpler to construct and should be implemented sooner than the independent pricing function and they should be in place before independent pricing begins.

In part 3.15, entitled proposed funding arrangements and outline of financing options, we advance 20 Recommendations, five of these are for interim steps and 15 of them are for longer-term reforms of funding arrangements. On financing options, as we've indicated previously, Commissioners, we are not advancing firm particular recommendations, but we are outlining at the back of this part where our consultations have led us in consideration of financing options, and they include both financing of the capital requirements of residential aged care providers and longer-term system financing including public financing options.

Commissioners, 1180, the aged care sector in recent years has been under significant financial pressure. The services of evidence for this are referenced in that paragraph and the causes are identified, the probable causes are identified in the paragraph that follows and in the detail that follows in succeeding paragraphs.

The evidence on the financial pressure in question comes from certainly experts, expert observers of the sector including accountancy experts, the lenders, the banks, the approved providers themselves, the Department of Health itself, and, to some extent, research that the Royal Commission has obtained. All of this material consistently indicates that the financial performance of approved providers has been deteriorating over a period of several years and, more disturbingly, the continued viability of a significant number of residential care providers is now doubtful under current funding levels and arrangements.

The risk of financial failure is particularly acute in regional, rural and remote areas. There's a particular set of concerns we raise stemming from a deterioration in occupancy levels in Victorian residential aged care facilities because of the events of recent months and the effect, no doubt, of the pandemic, accompanied by what was a pre-existing trend away from the payment of accommodation charges by way of lump sum deposits towards daily payments. As you will recall, Commissioners, residents in aged care facilities have an option to pay either by a lump sum deposit or a daily accommodation payment. We will be going into some detail on that topic in a minute.

The factors we've identified are summarised in 1181 and as well as inflexible and outdated funding models contributing to this, we've identified indexation arrangements. I need to say a bit more about that than I said yesterday in connection with system design to explain what the index arrangements are and what's been the result of inadequacies in those arrangements.

But first, I'll just outline the evidence on financial viability that's available to you. Commissioners, I'm now at 1182 and 1182 refers in particular to the survey that's conducted by accountancy firm StewartBrown, it's quite a broad-based survey of approved providers. It's been conducted for many years so it does provide a good picture of trends over time and the lead manager of that survey work is Mr Grant Corderoy who gave evidence to you in September in Sydney. As you will recall him saying, Commissioners, Mr Corderoy identified 2012 as a point when the sector began to experience declines in financial performance that coincided with a freezing in the then indexation that was routinely being applied up to that point. And as you will recall from other evidence, and as I'm going to go into in a minute, even the indexation arrangements that had existed up to 2012 were inadequate by comparison with growth in wages in the sector.

So taking those points a little further, 1183 contains a series of references from the September funding hearing corroborating Mr Corderoy's conclusions from the various other sources of evidence that's available. 1184 summarises the position for regional, rural and remote residential care providers. As I said a minute ago, the concerns are particularly acute for those providers even before any effects of the pandemic we see in the last line there, that by December 2019 there was a disturbing figure of 44 per cent of outer regional and beyond facilities experiencing a cash operating loss, 40 per cent of all of the facilities in those bands of remoteness experiencing a cash operating loss, and that's according to the survey data collected by StewartBrown.

The general point about the deterioration in financial performance is not only the preserve of StewartBrown, the Aged Care Financing Authority has also been identifying this trend for some time and has produced a special report on the particular plight of regional, rural and remote providers.

Commissioners, 1185 and following there's a consideration of the viability supplement which is the current funding mechanism that is meant to provide redress for different costs, differential and higher costs faced by providers in these rural areas. I won't go into the detail of the analysis here but essentially there have been two increase, one of which might, on the present policy settings, be temporary and just intended for the duration of the COVID pandemic.

It appears that those increases have been insufficient to really cover the additional costs and other challenges that are faced by these providers.

1188, there's a particular point here arising from the evidence of Mr Ansell of Ansell Strategic relating to the reliance of the residential care sector on refundable

accommodation deposits, those lump sum deposits I mentioned a short time ago. These are a form of cheap or, really, free capital, interest-free capital, that are available to providers but the ability of providers to repay those deposits upon the discharge of the particular resident or the death of the particular resident depends on there being some degree of replenishment of that capital from newly admitted residents so occupation levels are very important in the equation as to whether there's going to be a capital adequacy risk or a liquidity problem arising from the need to repay these deposits and Mr Ansell has been keeping an eye on this matter, he's been preparing reports and providing them to the Department of Health. He's concerned that, in particular, under the present pandemic conditions, there are problems with the replenishment rate, particularly in Victoria. He draws attention to those in his evidence.

There's a point made in 1189 which is of great importance and that is something I alluded to right at the outset but I should emphasise it. We're not just talking about money here. If there's financial pressure on a provider, that can induce risks to the quality of people's care and even the safety of the care they receive.

Providers exiting a market in usual circumstances is something that the system should contemplate and provide for. The system governor, or the entity responsible for actively managing the system, on our submission, the future Aged Care Commission, should, of course, keep a very careful eye on the viability of providers and any financial pressures they're under, just as it should keep a very careful eye on the quality outcomes for the people in that provider's care, and there may well be providers who are consistently poor performers. In respect to those providers, the governor should provide an orderly exit for that provider without any harm being done to the people in that provider's care.

Sudden exits from the market, sudden financial failures in particular, obviously would have very serious consequences for the people who are being cared for by that particular provider but also they might have serious consequences for the availability of care in the particular area in general. This is more of a concern in rural and remote areas and it's a concern where you have a greater proliferation of smaller operators, because the evidence before you, Commissioners, from the September hearing was that small single-site operators are currently at particular financial risk in the current environment.

1190 and 1191 refer to evidence the Royal Commission obtained from two firms; one an accountancy firm BDO and the second a report of returns at a high level from economic consultants Frontier Economics. BDO considered that there are limitations in the way financial data is reported by the sector to the Department of Health and they prevented it from reaching firm conclusions about what they call true returns, that is true profitability if one takes into account the entirety of what might be regarded as the aged care business, that a particular provider provides because one might have to take into account, for example, in the case of a corporate group, elements of operations relevant to aged care that are conducted by other entities and are not necessarily transparently known from the form of reporting that's provided to

the Department of Health.

Notwithstanding that limitation, BDO went onto analyse the returns of the sector and of the various segments of the sector in a report provided to the Commission, to the Royal Commission, that is, based on those data reported to the Department of Health and they found that certainly in the top quartile of for-profit providers, there are providers making a good return in recent --- including in recent financial years, notwithstanding what I said earlier about the general deterioration in sector-wide financial performance over those years, and there's some detail about that at 1191.

Frontier Economics also, at a high level and up to financial year 2017, acknowledging that there was variation in the returns of the various providers, gave the opinion that because substantial investment in the sector in that period of 2015-2017 had occurred, that suggested that returns for many providers did cover their cost of capital in these years and they inferred returns for the sector at least in those years that were reasonable returns.

There is great variation in performance, that's clear, and the fact that some approved providers appear to be making adequate returns doesn't, in our submission, diminish the force of the evidence that there are many who are not and that's probably particularly of concern in those more sparsely populated areas I referred to a minute ago.

The Secretary of the Department of Health, Dr Murphy, told the Commission, this is at 1192, that the system is under financial pressure at the moment and definitely does need some financial resetting.

I'll now go to the details of this point I've mentioned, indexation. At 1194, there is reference to a detailed paper analysing government expenditures on aged care over recent times, in recent decades, and a lot of the analysis at 1194 and following draws on that paper.

There's been an indexation approach that, in effect, has involved a significant discount by reference to a complicated equation that has diluted the effect of increases in the minimum wage over those years, and it's really over two decades, and there's been, in effect, an erosion of what would otherwise have been real subsidy-level increases over that time, estimated, this is at 1194 in the following terms, between the financial year 1999-2000 and financial year 2018-19 subsidy levels increased by 70.3 per cent whereas provider input costs increased by 116.3 per cent.

Now, there's been increases, no doubt, because of the ageing of the population over that time, in average acuity of the cohort of people receiving aged care and probably particularly residential care, and as a result of that, the Australian Government has been paying, in aggregate terms, more money, and also average real increases in average care subsidy per resident per day, based on average acuity assessments under the aged care funding instrument.

Mr Mersiades who is Director of Aged Care at Catholic Health Australia, he is also, incidentally, Acting Chair of the Aged Care Financing Authority, but he wasn't giving evidence in that capacity. He has characterised that as frailty drifts, a gradual increase in the average acuity of residents. The effect of this has been to compensate for inadequate indexation, on one view, although, to the extent that the acuity assessments are accurate, one might say that greater funding was required because the acuity was greater.

At 1196 there is an acceptance by the Australian Department of Health of the insufficiency of the indexation approach that has been taken.

I'll just move on from here. At 1197, that's really where the consensus ends. 1197 begins a passage explaining how the Department of Health has viewed the conduct of residential care providers in making claims based on assessments of greater acuity driving higher levels of funding for residential aged care over the last decade or so. The Department of Health's position is that in 2012 the Australian Government paused indexation for 12 months and made changes to the ACFI tool, the Aged Care Funding Instrument tool which I mentioned yesterday, that's the tool for classification of people based on assessment of need to particular funding levels. And that those changes were made to, on the Department's claim, address concerns of overclaiming and to bring growth more in line with estimated, sustainable funding levels.

Now, this is a controversial topic. I took it up with Dr Murphy in the September hearing. The sector has, in essence, been concerned that what the Government has done in light of those concerns has created funding volatility and has resulted in inadequate funding for residential aged care. The Government, for its part, has been concerned that the claiming behaviour of at least some providers, and perhaps a significant number of them, has been beyond its expectations and in some ways blameworthy although when I asked Dr Murphy about that, he said he didn't blame the providers for what they'd done. He said they were really driven, in essence, that they were somehow driven to overclaim.

All of this is dealt with in some detail in paragraphs 1198 through to 1209. I don't have time now to go through it in detail but it's a very important part of the submissions. There was, in effect, a repeat of history in 2016 when over an, in effect, 24-month period, there were further indexation pauses and further changes to the claiming criteria and the classification criteria under the instrument because of similar fiscal pressures and similar concerns by Government about claiming behaviour.

These matters are really examples of the sort of thing that one can draw from the Cabinet Memorandum that I tendered yesterday, Exhibit 22-1. As that Memorandum noted, Government, through the Health Department, has its hands on all the levers of control of funding, including eligibility criteria which link needs assessments to particular levels of classification and therefore of funding for individuals. And

what's happened in 2012, and again in the 24-month period following decisions in 2016, which is summarised in 1198, is that the Government has taken two steps. It's paused what, on any view, was probably inadequate indexation altogether, and it's also, perhaps just as concerningly, or even more concerningly, intervened in the criteria by which individuals are classified to particular levels of need and funding.

These are examples of the sorts of things that can happen if the governor of the system is subject to the sorts of day-to-day fiscal pressures that Ministers of executive government are under and if there's a direct link between general governmental fiscal considerations and the particular levers of governance for assessment of eligibility of individuals to receive funding in the aged care system.

I'll now go to the urgent interim measures that we recommend. There are five of these, as I mentioned at the outset. The first is Recommendation 80. It's amendments to these indexation arrangements that I've alluded to. The recommendation at 80 explains - I beg your pardon, the reasoning at 1210 and 1211 explain the reasoning for the new proposed indexation arrangements. In paragraph 80.1 inside the recommendation, there's a proposal that rather than adopting indexation based on a diluted form of movement in the minimum wage, there should be more attention given to the actual composition of the residential care workforce and that drives one to a 45 per cent and 30 per cent attribution to personal care workers and nurses respectively and to other goods and services that drives one to a 25 per cent attribution of the consumer price index. All of those metrics should not be diluted in any way but should apply directly as building blocks in the indexation formula.

The next recommendation is Recommendation 81 and the supporting reasoning is at 1212 to 1217. And a similar approach is taken to derive the building blocks of the new indexation formula that's proposed in Recommendation 81 for home care, based on our best estimate of the composition of the workforce combined with the minimum award rates in the Aged Care Award and in the Nurses Award, both instruments are dated 2010.

The next at 1218, we mention the Commonwealth Health Support Program and we know that there's, in effect, been little growth in those rates, in those grant agreements for some time. We haven't made a recommendation specifically about this. Further data would be needed but we've raised that as a point of interest and a point for further investigation. And we've proposed a different weighting for the wages component compared with the other goods and services component due to data in one of the Aged Care Financing Authority reports.

We've then moved to a recommendation, Recommendation 82, on immediate changes to the basic daily fee and this is a recommendation Mr Rozen mentioned yesterday. It's a very important recommendation for an interim increase in the basic daily fee of $10 per resident per day for all residents on condition that the relevant approved provider for the particular residents should first undertake, in writing, to the Government, that the provider will conduct an annual review of the adequacy of

the goods and services it has provided to meet the basic living needs of residents, and in particular, their nutritional requirements throughout the preceding 12 months and a written report of that review, and that the report will set out the provider's expenditure to meet basic needs of residents including any nutritional needs and changes in that expenditure, and that the governing body attest that the annual review's occurred and give the report and the review to the new Aged Care Commission or, before its establishment, the Administrative Implementation Unit that we're recommending at the end of our submissions in Recommendation 123.

In the event of a failure to comply with those transparency requirements, the provider will be required to repay the additional funding that they've received. That debt can become a set-off against future funding entitlements.

Provided those conditions are met, in our recommendation that's something that should begin very, very soon. We see no reason why it shouldn't be ready to go only a few months after the final report is delivered. So we've proposed the date of 1 July 2021.

There's a focus there on nutritional needs. There isn't a hard requirement to spend the money on nutritional needs, or, indeed, a hard requirement to spend the money on particular basic needs, but there must be transparency.

Next, Recommendation 83, changes to the viability supplement, that's the supplement mentioned in the session just before the break for rural providers to address increased costs for them --- I beg your pardon, not before the break, just earlier in my submission. That should be an interim arrangement until independent pricing is ready and it should simply incorporate arrangements for the existing increases in the viability supplement to continue, pending the commencement of independent pricing.

Next Recommendation 84. Immediate funding for education and training on the basis that this will be funding on a reimbursement model. So it involves an automatic accountability check that the funding is going to the right place and Mr Rozen referred to this during his workforce submissions.

The details of it are on page 371, eligible education and training should at least include Certificate III in Individual Support and Certificate IV in Ageing Support, and continuing education and training courses including add-ons which we understand are known as skill sets and micro-credentials relevant to direct care skills including but not limited to dementia care --- dementia is so important to every aspect, almost every aspect of our recommendations literally and this is another example of where it needs to be given better focus --- palliative care, oral health, mental health, pressure injuries and wound management.

I'll now go to the longer-term reforms and as, Commissioners, you will well appreciate, independent pricing and what we're calling the Aged Care Pricing Authority are a centre piece of the reforms that we recommend. In the passage that

follows under the heading Aged Care Pricing Authority on page 372, we make two recommendations one about the particular functions of the Pricing Authority. You will remember from the system design section that we've already proposed a recommendation for its establishment, and now we go to the detailed functions of the body.

The second recommendation is a recommendation about requirements being imposed on approved providers to participate in and cooperate with the activities of the Pricing Authority. This is a critical matter because the authority can only work with the information it's got. It needs detailed data on which to perform its cost studies and cost studies will be of the essence of its performance of pricing functions and that's, of course, as you can see from its name, one of its core functions.

It's not its only function, on our submission. At 1242, we've referred to that core function of costing studies and pricing, at 1242(b), but we recommend that you recommend that this body should also have additional functions which go well beyond traditional pricing functions into the broader topic of advice and assistance to the Aged Care Commission to develop funding models that are properly tailored to particular economic circumstances. This is a very variegated, distributed market, as we know, or distributed system. In fact, there isn't a workably competitive market in many locations and in many service lines. It's of the essence to have expert assistance in developing funding models that are tailored to particular needs, including local needs, or the needs for services that meet diverse requirements.

And (c), 1242(c) is where we raise the broader role of considering forms of regulation, economic regulation, including price regulation, that may be appropriate to protect the consumer, the consumer here being the person who needs aged care and that aged care is going to be either paid for by a user contribution from them, or by a subsidy paid on their behalf by Government. Either way, there's going to be a price charged by the provider for the services given to that older person.

In many cases, that older person will be vulnerable to price gouging, unless there is some appropriate form, appropriately tailored form of intervention, economic regulation by the Aged Care Commission on the advice of the Aged Care Pricing Authority. Alternatively, the Aged Care Pricing Authority might have a direct regulatory role.

Price caps are limitations on the prices that can be charged, relevantly here between an approved provider and the person who needs care or Government, if Government is paying the subsidy, and those price caps are one form, a fairly extreme form, of economic regulation, or a fairly heavy-handed form of economic regulation. There are various other options that are available.

So all of these matters are traversed in Recommendation 85 and in the supporting argument at 1233 all the way through to 1259. I won't spend too much more time on this but I will just say that one of the points raised in the evidence, of course, this is at 1245, is that the Independent Hospitals Pricing Authority could be considered as a

model for the independent pricing functions which should be performed by the Aged Care Pricing Authority, and you had this evidence from a number of sources, including from Professor Woods. You also had evidence from the IHPA's CEO, Mr Downie, and there are certainly things to be learned from the approach that the IHPA takes to its costing and pricing of public hospital services. It has a detailed approach to classifying groups of services by reference to need characteristics for particular people, for the conditions of particular people on admission into hospital and for working out what the reasonable prices are by reference to costs data for providing care for an admission episode for those people.

But there are huge differences between hospitals and aged care. Mr Mersiades drew attention to some of them. In aged care you're looking at a long-term proposition, long-term care and you're looking at quality of life. He also mentioned personal private contributions which are required as well, so that gets into that territory of the regulation of prices and the protection of people who may be vulnerable to price gouging because they may not have the ability to switch providers in any realistic way and they may be left with no choice but to pay a price they're asked to pay, that therefore being a justification for some form of economic regulation.

Another important point, Commissioners, is touched upon at 1246. Should the pricing function be determinative or merely a recommendation to the Australian Government? And there are arguments each way. Dr Murphy, the Secretary of the Department, expressed concerns about the Government being locked into delivering a price. But in a way, Commissioners, that might be the point. It might be important that the Government be locked into delivering a particular price determined by experts on the best available information and I hark back again to the sorts of themes one sees in that Cabinet memorandum. It may be desirable to remove the levers of control over these matters well away from the day-to-day concerns, including fiscal concerns, of executive government.

The economists you heard from included Professor John Piggott and Professor Henry Cutler. There's some evidence from them at 1249 on arguments for a determinative price setting function, including addressing this problem of volatility of provider revenue. That volatility can be caused by policy changes and Professor Cutler made points about the increased costs to the system through increased investment costs, including borrowing costs, if there is volatility and unpredictability in future revenue streams.

There's also some points made, this is very important to get submissions on this, Commissioners. At 1251, we've made some points about how should the funding be appropriated and made available. We've proposed a special appropriation of funding consistent with this vision for a new aged care system being a demand-driven system. That seems the best approach. We've also proposed for the Australian Aged Care Commission a corporate Commonwealth entity structure with a governing board, one member of whom would be the presiding commissioner who would be a direct appointment by the Governor-General. The structure should, of course, be the subject of close scrutiny and we welcome and invite submissions in particular on that

structure and on the best form of appropriation or other aspects of funding arrangements that might be administered by that body or by an alternative body.

We've then got a passage, from 1252, on economic regulation. I've already touched upon the role that economic regulation can play. I won't go into that any further, but we commend that passage to you as well, Commissioners.

The second recommendation, as I outlined a little earlier, is all about ensuring that data will be available for the Authority to deliver independent pricing and perform its other functions. A short-term amendment to the Accountability Principles will be required to require the participation of the approved providers in cost data reviews. They should begin under interim arrangements straight away. We shouldn't wait until there's formal statutory establishment of the new authority. The interim implementation unit should begin that work and maybe they will need to draw on the expertise of the IHPA in building capability in that regard.

There's then a passage under the heading "Specific funding arrangements for particular services" which covers four recommendations. This is beginning at page 381. I can move through this fairly quickly. These are all reflections of submissions that you've already seen in the program design section.

Firstly, there's the recommendation which is, in effect, the funding aspect of the submission we've already made about the grant-funded categories of services, which will be available to people in aged care generally, and most particularly to people who are at home and in the community, social supports, respite and assistive technology and home modifications. As I said, some of those services will be available to people in residential settings as well.

There's then a reference back to the point about there being still some work to be done before there's a final conclusion reached about the appropriate assessment classification and funding mechanisms for care at home. That's just, in effect, a place holder there at paragraph 1267.

We then go to residential care and at Recommendation 88, we've recommended, as I outlined or foreshadowed yesterday, that there should be casemix-adjusted activity-based funding for residential aged care and that AN-ACC, Australian National Aged Care Classification, is the forerunner in that respect and it's currently in trial and might meet with refinements but those matters seem, really, completely uncontroversial on the evidence that you've heard.

And there are some additional submissions we make about augmentations, temporary augmentations, perhaps, of that model, if it's adopted, at 1277.

The next recommendation, 89, is about that tipping point between care in the community and at home and the commencement, if you like, of care in a residential aged care facility. This is a difficult point. There's currently a disparity between the care component of the funding that might be available to a person in a residential

setting, under the instrument called ACFI, and the highest level of home care that's available to a person receiving a home care package, and there's no attention given to any form of assessment of the funding that would be available to a person receiving home care if they were assessed in a residential setting.

There are good reasons why there should be an exercise done of that kind. There should be every encouragement given to people who can viably, economically remain at home, remaining at home because that is the overwhelming preference of Australians. And there should be, in effect, cost neutrality or competitive neutrality established with respect to the care component of the subsidy that Government makes available for people in home care on the one hand and residential settings on the other.

So we've made a submission that there should be parity in the form of a ceiling for amounts payable for care at home referable to the amount that that individual would receive if they were assessed as receiving care in a residential setting. That's 89.

We then conclude that section with Recommendation 90, which is simply an addition to the assessment principles that we find, in our respectful submission, a persuasive addition. It's making a change to the principles so that a provider is not going to be incentivised in ways in which the current assessment framework might do to emphasise the dependencies of a particular person, or the deterioration in their condition, but rather the approved provider will be incentivised to do everything they can to enable the improvement of the person in care and the attainment of greater levels of independence by that care. And the way to achieve that is to make sure that the provider isn't going to receive less money if the person is enabled and achieves greater levels of independence.

There are two ways in which this is done. If a reassessment determines that a person is entitled to a higher level of funding, provided the approved provider can demonstrate they'd been providing care at that higher level, then the provider should be eligible for a back payment to the date of the reassessment and secondly, a resident shouldn't be required to be reassessed if their condition improves under the care of a provider. So if they've been assessed as needing care on a particular level based on a particular level of dependency, but they actually achieve more independence for a time, then the provider should still be able to retain the funding that's provided at the higher level of need.

We then, under the heading "Accountability" at the foot of page 388, move to three recommendations which are designed to improve the measures for accountability for the funding that's provided for aged care. They are the reporting of staffing hours, and that's an important measure to complement the recommendations we've made through submissions Mr Rozen made in February and which he again returned to and refined yesterday on mandatory staffing levels and mixes of different skill categories.

Recommendation 92, the payment of a accruals basis at home which will, in effect be an accountability measure. And Recommendation 93 the adoption of standardised

statements on the services delivered by providers of home care. These have been confusing on the evidence to date, and they need to be standardised and made easier to understand.

We've then got six recommendations on the reform of co-contributions and means testing. The theme --- I won't read out all six of these but the theme here is there should be simple, notional co-payments for certain categories of grant-funded services. That should not include respite care. In respite care, there should only be payment for the ordinary costs of living as determined by the Pricing Authority from time to time.

In residential care, we're proposing that in line with the principle of the universality of the entitlement to receive aged care, there should be no contributions required for the care component of funding in residential care anymore. That will require a change to the status quo. We submit that that's justified in line with the principle of the universality of aged care. And that's Recommendation 98.

There will still be payments required from people for the basic daily fee to meet daily living needs, and for accommodation and these are means tested and there is a safety net. Details appear in the submission.

When one comes to the accommodation means testing arrangements, they're sorely in need of reform. You heard evidence about the inequitable impact on disposable income when one has regard to particularly the lower end of the wealth spectrum, at the point at which people become liable to have to make contributions or to pay for their accommodation. That's a matter that needs reform.

I now go very briefly to not making any recommendations on topics of financing but to just outline where our thinking has got to as a result of the consultations that have been performed.

We've got to start with work that was commissioned by the Office of the Royal Commission from Deloitte Access Economics. I will ask the operator to put some images up on the screen and to stream them to the public as we go.

Deloitte Access Economics modelled a baseline of projected increases in the funding requirement of the aged care system if there are no changes made to the system as a result of this Royal Commission. They appear in the report in detail. There's a chart summarising those on the screen at present.

We'll just go to the next slide now. This is the beginning of a three-page table that's included in Deloitte's report. Deloitte did modelling on the basis of a suite of reforms which were the subject of information and instructions provided by the Office of the Royal Commission to Deloitte. This is just the start of that table, table 4.1. It's an important table.

There was then, in part 4 of the report, modelling of a series of outcomes based on

those reforms. Two very important aspects of the reforms are a move to what Mr Rozen has described as three-star staffing by a certain point in time. We're saying that should occur by 2022 and four-star staffing by July 2024, two years after the move to three stars.

Deloitte's modelling takes into account increases to the four-star position and we'll go to the next slide, please, operator. Deloitte models the move to four stars and its impact on workforce requirements and wage prices. We'll go to the next slide, please.

In this table, over a series of points in time, 2030, '40 and '50, Deloitte models by particular employee category the gross FTE, full-time equivalent, workforce requirements implied by the reforms we recommend over and above the increases in workforce requirement which would be required anyway on the baseline scenario that was modelled by Deloitte.

I can just tell you, Commissioners, that if we go to 2050 and we look at the overall workforce requirement estimated at 363,530 people, or FTE, full-time employee equivalent, people in 2050, on the baseline modelling that was done, that figure would have been 316,518 people. So we're talking about the addition of about almost 50,000 more people to the workforce required by 2050 if the reforms recommended by the Royal Commission are in line with Counsel Assisting's submissions and then are implemented by Government.

Now, as I have said in one of these --- as Counsel Assisting have said at 1317, the cost of this corresponds to --- the cost of this and the other reforms that are models corresponds to about a 0.5 per cent additional --- I beg your pardon --- additional outlay in gross domestic product by 2050 which is about another third of what the projected budget for aged care would have been in the absence of the reforms.

Thank you, operator, you can stop streaming those.

The financing task is therefore a very significant one. Aged care in Australia is currently financed by a mix of pay-as-you-go public financing source through general taxation and private contributions in the form of means-tested fees and co-payments for certain services. It has never been financed from a dedicated and committed source and there's no guarantee that governments will make available sufficient funds to meet future needs.

The Royal Commission released Consultation Paper 2 in the middle of this year, or in June, and it examined various options based on a review of models for financing of aged care in Australia and overseas. That consultation paper attracted a diverse range of submissions and there's a taste of those in the written submission we provided to you, Commissioners. As you know, in the hearing four weeks ago, you also heard from a number of very eminent witnesses. The Hon. Paul Keating, the Hon. Peter Costello, Dr Kenneth Henry, Professors John Piggott, Michael Sherris, Naoki Ikegami, and the Secretary of the Australian Department of Treasury,

Dr Stephen Kennedy, and his colleague, Ms Jenny Wilkinson, among others, on these matters.

All of that material is going to be, no doubt, taken into account very carefully as you prepare your final report. We don't propose to advance any particular recommendations now on any of this material, but what emerged from it includes exciting potentials to secure a more sustainable and reliable source of public financing for aged care. This could have benefits in instilling and building community confidence in the reliability of the system in the same way as, for example, the institution of a Medicare levy has led to public confidence, one might argue, in that system. Even in the absence of formal arrangements for hypothecation of that levy to the particular purposes of funding healthcare services.

In the paragraphs that follow, 1322 through to 1328, we outline some preliminary ideas on the topic of a hypothecation of a potential future levy, dedicated to the purposes of funding or contributing to the public funding and financing of the aged care system. There are a range of issues that need to be thought through and there are other options that could be formulated to help achieve the desired system in which we can all have confidence, for example additional insurance and savings products linked to current superannuation and retirement income arrangements, really merit detailed consideration and they could combine deferred annuity in aged care insurance products, for example. They could be voluntary or there could be some aspect of incentive or even compulsion attached to products of that kind.

All of these considerations should inform your recommendations on this topic in the final report, in our submission, Commissioners.

Capital financing, I won't say anything about this. There's a detailed written submission which, in effect, is something by way of a preliminary or interim report on a consultation process that has been taking place over recent weeks. Capital financing here referring, as I mentioned a little while ago, to the means by which approved providers of residential care services should obtain the capital they need to invest in the replenishment and replacement of their capital assets which are critical to providing residential care.

That's the end of our submissions on part 3.15.

COMMISSIONER PAGONE: Thank you. I understand Commissioner Briggs would like to add something on this topic.

COMMISSIONER BRIGGS: Thanks, Commissioner Pagone. Just a very short comment in relation to the comment you just made, counsel, about not making a recommendation on future capital funding for the sector. I'd encourage you to give further consideration to that as we go forward because it's a very important issue, particularly with the future of RADS under consideration and it would be helpful if we could make clear recommendations to the Government in our final report. So thank you.

Thanks, Commissioner.

MR GRAY QC: Thank you.

COMMISSIONER PAGONE: Yes, Mr Gray.

MR GRAY QC: Can I turn to part 3.16 entitled "Prudential regulation and financial oversight". This is a section of our submissions covering ten recommendations.

Many of these recommendations, in particular a recommendation to empower the future governor of the system, on our submission, the Aged Care Commission, to implement a regime of more rigorous financial reporting. Many of these recommendations, like that one, are complementary to the accountability measures that I mentioned at the outset of my submissions on the preceding part.

There were really two principles that flow through this section of our submissions and they reflect two policy goals, which are perhaps related but really merit distinct consideration. And by far the most important, in my submission, is the point I alluded to about an hour ago. Financial performance, and in particular pressure of a financial nature on a provider can be a red flag that that provider is running into difficulties which might imperil the continuity of the care the provider provides or even the safety the carer provides.

It's here that there is an inextricable connection between the need to monitor the financial performance of providers, and do so closely, and in as timely a fashion as possible, and the need to also keep a close eye on the quality outcomes that are being delivered to people in care. The two should be considered together and they should be conducted under the same roof in close consultation with each other. If there are separate offices responsible for those functions, then that might be understandable but there needs to be very close connection between those respective employees or officers and ideally it should be happening within the same organisation.

The current state of affairs is that prudential regulation has ostensibly been recently transferred from the Department of Health to the Aged Care Quality and Safety Commission, but responsibility for the analysis of financial risk that might be posed by particular providers is not necessarily in the hands of the Aged Care Quality and Safety Commission as I understand the current state of the evidence. It seems to be a matter of ongoing discussion and perhaps debate between those two entities. I think there's agreement in principle between them that there should be close consultation between them on these matters, but they aren't being exercised by the same organisation.

When you think about the administrative responsibilities of the Department, you can see the reasons why the Department would want to retain hands-on responsibilities for financial risk analysis. That's because the Department is providing the funds, the Department is also directly commissioning some providers, the Department is

managing the system and administering the program. It's very important to understand what the financial reports of providers are saying in order to discharge those responsibilities properly and to know about impending financial failures and so forth. But this is a topic on which one can see a strong argument for a union, a consolidation of system management functions with quality regulatory functions. Provided, of course, all of those functions are exercised separately from direct executive government control. You wouldn't have safety and quality regulatory functions ever directly exercised under ministerial control. You'd always have to have those in a separate institution.

The second important theme running through these recommendations is connected with the Refundable Accommodation Deposits, which you just mentioned, Commissioner Briggs. These represent about $30 billion in assets that are --- I beg your pardon. $30 billion in liabilities that are owed by approved providers to the residents who have deposited them as a condition of their entry into residential aged care and they have to be repaid in due course upon the discharge or death of the resident concerned.

They're therefore an interesting item in accounting terms. One might regard them as current liabilities because they might have to be repaid at short notice. One might, however, think that that's an accounting treatment that's liable to create distortions in usual accounting analysis because the likelihood is that people are in residential aged care for, on average, almost three years, many people are going to be in there substantially longer than that. There will be a certain statistic that one can infer about the likely average time at which deposits are going to have to be repaid, and the larger the data set that one's dealing with, the smoother it should be, according to the law of large numbers and statistics.

So all of these things are complicating factors in how one treats the liabilities repayment of residential accommodation charges that have been paid in the form of an interest-free refundable accommodation deposit, but they have to be confronted.

They are of particular concern to the Commonwealth because the Commonwealth guarantees their repayment to the person who has deposited them, or to their estate, in the event of the financial failure of the provider concerned.

The prudential regulation regime to date, I'm at 1351, Commissioners, has been primarily focused on the risks surrounding those deposits that's been something that's been, no doubt, close to the heart of Government because of that guarantee scheme. Now, the focus needs to shift and broaden to cover that very important first principle that I spent some time outlining. That it's really, if anything, more important from a system governance and potential quality regulation than monitoring perspective to keep track of financial risks that particular providers might be incurring so that one can have as much notice as possible of financial pressure which might be having effect on safety and quality of care.

At 1355 we outline the current features of the prudential and reporting regime. We

refer in the passage from 1356 to the multiple reviews that have already taken place about, in effect, deficiencies in and the need of reform of the prudential regulatory function. This is a topic, like many others, in aged care that's already received a great deal of attention and yet there hasn't been the reform that's been recommended.

Most recently, there's been a report by Ms Kate Carnell into a matter which, you Commissioner Briggs, and also Commissioner Tracey looked into in Brisbane last year concerning Earle Haven. Ms Carnell was separately commissioned to report into that and she made recommendations. It raised some concerning issues about the potential risks of the outsourcing of the entire management of care provision by particular services and it's led to some prudential regulatory recommendations. We don't differ from what Ms Carnell's said on the topics we address.

The next set of recommendations you see are all in line with the themes I've just been developing. Recommendation 100, this is about empowering the Aged Care Commission to work out the detail of a more rigorous regime for prudential regulation and effective financial reporting.

Recommendation 101 touches on the establishment of different and more rigorous prudential standards. Recommendation 102 is a detail of that concerning liquidity requirements. You will recall the evidence from the hearing last month from Mr Corderoy on the report that StewartBrown has provided to the Department of Health at the Department's request on the tightening of the prudential and reporting regime and StewartBrown's recommendation that the regime should be built around a focus on liquidity requirements because that has been the most reliable flag for problems in the past.

Recommendation 103 also touches on the complementary topic of capital adequacy, a point that Mr Corderoy subordinated to liquidity requirements in terms of its importance. But it's nevertheless a point that is available as a potential red flag raiser and it's a matter that should be incorporated in the construction of the new prudential regulatory regime.

Recommendation 104 is that signature recommendation for empowering the new commission to require approved providers to submit regular financial reports. The frequency should be far greater than the frequency of the reports that have currently been required which are annual. The contents of those reports, although there's been a number of different reports required, the contents of them has left something to be desired, something that BDO observed, and I mentioned in passing when we were looking at the evidence of the performance, financial performance of the sector in that report that BDO had provided. That's the content. Frequency is also important because at present they're only required on an annual basis and then the evidence is they come in in the October following the relevant financial year and then are subjected to a first-pass assessment and don't really get detailed scrutiny until I think it's early in the next calendar year. So one has the potential, therefore, a deterioration to have occurred in the financial position of a given provider but nothing will be known by those responsible for financial risk monitoring until almost potentially two

years later. This is clearly not acceptable and a more timely reporting regime is required.

Recommendation 105 is an important recommendation and a new departure, if it's accepted. It's a proposal for continuous disclosure of matters we're referring to as "material information" that comes to the attention of approved provider that relate to its ability or affect its ability to pay its debts as and when they become due and payable. That is intended to be a more stringent trigger than applies under general insolvent trading provisions. It's, for example, meant to focus the attention of the approved provider on questions such as whether its forecast revenues have fallen materially below what was expected and/or its forecast expenditures have increased materially above what was expected so as to raise a material prospect that it may become insolvent down the line.

We submit that a more stringent trigger point than the trigger point that applies under general law for insolvent trading is required here because of the public interest and the public importance in the continuity of the provision of high-quality care under subsidy arrangements that are funded by the Commonwealth.

And the second limb of the continuous disclosure requirement at (b) is about material information that affects the ability of the provider, or any contractor providing services on its behalf, and that's, in effect, picking up that theme that arises out of the Earle Haven case. The ability of those entities to provide or continue to provide aged care that is safe and of high quality to individuals to whom it is currently contracted or otherwise engaged to provide aged care, and upon material information under either of those limbs coming to the possession, coming to the knowledge of the approved provider there must be an immediate disclosure to the Commission.

Now, I'll move to Recommendation 106 and 107 and deal with them together. Before I do that, I'll just mention very briefly that Recommendation 108 is a recommendation I alluded to a short time ago in speaking about recommendations made by Ms Carnell arising out of the Earle Haven matter and I won't say anything further about that. We've explained it in detail at 1443 to 1448.

Moving then back to 106 and 107, these are a suite of proposed recommendations for improving the ability of the regulator to address matters arising in connection with financial risks. There need to be, in our submission, a broader range of powers available to the regulator and, of course, on our system design submission that would, in due course, be the Aged Care Commission. We need to have in the tool kit, if I can use that expression, available to that regulator, the ability to impose directions akin to the directions that APRA, the Australian Prudential Regulatory Authority, has under the *Private Health Insurance Act*, and they include matters concerning the use and treatment of funds entrusted to entities because those refundable deposits are of a similar nature to funds that are entrusted to private health insurers. And the power to impose civil administrative penalties, enforceable undertakings and sanctions and we've set out details on the supporting reasoning in the paragraphs that follow, Commissioners, 1420 through to 1434.

In line with and complementing the expansion of the tool kit for the regulator, attention needs to be given to the capabilities of the regulator. There's a deficit on the evidence in those core accounting skills, financial analysis skills, that are so critical to really understanding what financial reports are saying and getting inside them and identifying risks that they present. We've set out our detailed submissions on the review of prudential capacity that should occur and, in broad terms, the description of the capacities that are going to be required in the future by the regulator.

Now, they're the submissions we wish to emphasise in our oral presentation on 3.16.

COMMISSIONER PAGONE: Thank you, Mr Gray. 2 o'clock? Adjourn to 2 o'clock.

ADJOURNED **[12.47 PM]**

RESUMED **[1.59 PM]**

COMMISSIONER PAGONE: Yes, Mr Gray.

MR GRAY QC: Thank you, Commissioner. The next part of our submissions is part 3.17 entitled "Effective regulation" and the focus here is on the regulation of quality and safety.

For a Royal Commission required to focus on quality and safety why are we leaving regulation of quality and safety to last in our submissions? It's because if the system has to resort to and rely upon sanctions, and other punitive or serious consequential actions following up on failures to provide safe and high-quality care, then that's a system that's failing. The system shouldn't have to resort to the stick, it should be able to rely on a system of incentives and the overall framework in which funding is provided and culture is generated and education is provided to ensure that high-quality care is the result.

Just as prevention is better than cure, incentives are better than sanctions.

We've been addressing questions such as what is high-quality aged care? Who should be providing it? What should be paid for it? How should it be provided? How should the providers who deliver it be governed? How should the system set up to ensure all these outcomes be governed? If all these things are working right, we shouldn't need the ultimate form of accountability for safe and high-quality aged care.

But there needs to be a credible deterrent at the very least, that failures, particularly

failures that harm the interests, health or wellbeing of people receiving aged care will be met with serious consequences, and in this sense, effective regulation is essential.

It's been frequent review and somewhat piecemeal reform on this front over some time. During the currency of this inquiry, there's been probably the most movement of all on this front, culminating in the concentration of most regulatory functions in the hands of the Aged Care Safety and Quality Commissioner and her Commission.

A milestone in the development of these steps was the review conducted in 2017 into the Commonwealth responses to failures at the Oakden Older Persons Mental Health Service. In 2017 those failures were examined in detail by Ms Carnell and also by Professor Ron Paterson ONZM, and of course the Royal Commission heard from Professor Paterson in its Brisbane hearing last year.

In a way, returning to this topic now is to close a circle of sorts in that the Royal Commission heard from two very important witnesses in its very first substantive hearing in February 2019, Mrs Barbara Spriggs and her son Mr Clive Spriggs, and they recounted their experiences following the mistreatment of Mr Robert Spriggs at Oakden. And the persistence of the Spriggs family in pressing their complaints, in spite of all obstacles was one of the triggering events for this very inquiry and let's hope it will result in lasting change.

Recommendations made by Ms Carnell and Professor Paterson in their review about improvements in aged care regulation, have been implemented, in our submission, in a slow and haphazard way and almost three years after the report was handed down, key aspects of those recommendations remain to be implemented.

The current regulation of the quality of aged care, in our submission, remains inadequate. Professor Paterson put it this way, "the regulation of aged care in Australia has paid lip service to the welfare of care recipients. The system fails to ensure the provision of safe, high-quality care and pays insufficient attention to the quality of life of aged care users".

A shift in the system for regulation, along with the broader cultural and systemic shift we advocate is needed.

Again, I return, as Mr Rozen has done, as well, to the point about putting people at the centre of the system. We've spoken about those people. They're not limited to the people receiving care, they extend to the workforce, the relationships between the workforce and the people receiving care, the close supporters of the people receiving care, in particular their informal carers and other friends and family who are closely involved in communication and advocacy for people receiving care. Their voices need to be heard and that should be central in the reconstruction of the system for the monitoring of quality and safety and for its regulation.

Where issues with provider performance are identified, the regulator needs to be equipped with the resources and the powers needed to respond in a proportionate

manner and it's only in these ways that regulation will come to act as a genuine deterrent and a general deterrent.

There needs, at the upper end of that regulatory pyramid, the Braithwaite model, with which you're familiar, Commissioners. There needs to be the likelihood of the imposition of strong sanctions where serious breaches have occurred and it's only if there's the prospect of genuine accountability of providers, and we say that should include too personal accountability for those in key positions in providers, that there will be the change that's required.

I want to address a series of some 14 recommendations in this part of the submission. Four of these are on that need for more rigorous consequences and powers. Three of these are on the theme of ensuring that the voices of those people at the centre of the system are heard and acted upon, and an aspect of those recommendations, Commissioners, leads to a somewhat different topic, a topic which might really be regarded as going beyond quality and safety monitoring and regulation, and we debated, amongst ourselves in the counsel team as to where to locate these recommendations.

These are recommendations that go beyond monitoring of quality and safety and extend to creating incentives for the improvement of quality standards on a system-wide basis. They include ensuring that more information about good performance as well as bad performance is disseminated throughout the system with the beneficial effects that that could have on consumer choice and on norm setting for other providers. And then we'll conclude with submissions on following up where things have gone wrong, where there's reporting of serious incidents acting on coronial reports and addressing the approval regime for providers, their suitability, fitness and propriety, and the capabilities of the regulator.

So starting on page 433 with the heading "Consequences for breach of the general duty", we have here two follow-up recommendations, Commissioners, that relate closely to the general duty which Mr Rozen has already outlined to you, and, again, one would locate these recommendations alongside the general duty or one could see them more as part of a framework of consequences for serious breaches and we, for the purposes of these final submissions have chosen the latter course.

The first recommendation, 109, provides for a civil penalty for certain contraventions of the general duty. The general duty is in broad and normative terms and rightly so, and it refers to ensuring that safe and high-quality care is provided. The definition of high-quality care will be ambulatory over time. As practices improve and as learning is developed, standards will, we anticipate, be refined. For the purposes of this civil penalty provision, there is, in effect, detail fleshed out on the concept of high-quality care by making a link with the standards of quality and safety that are imposed at the time, presumably under subordinate instruments made under the aged care legislation of the time.

So, the new act should provide that on application by the Aged Care Commission to

a court of competent jurisdiction, the followings are contravention attracting a simple penalty: a breach by an approved provider of the general duty, accompanied by the breach giving rise to harm or the risk of harm to a person to whom the provider is providing care, or, and this is in the case of omissions to give care, to a person to whom the provider is engaged under a contract or understanding to provide care. And there's a third, in effect, definitional requirement. The failure, if it's a failure alleged to be a failure to provide high-quality care, is taken to occur if and only if there's been a failure to comply with one or more of the then applicable quality standards.

There's a provision, a follow-up provision for accessorial liability for directors, key personnel and any other person who is knowingly involved or aids, abets, procures or induces in the familiar language, and that person is a person defined as being involved in the contravention.

1458, Commissioners, please note this point. This is a reference to a coronial inquest and report. In findings into the matter of the death of Dorothy Baum, who was a resident of an aged care facility who was living with dementia and who died after being physically attacked by another resident, the coroner in that matter concluded there had been a gross dereliction of proper management on the night in question, and I'll just omit the next two lines and go to the concern expressed by the coroner about the aged care framework not producing an outcome commensurate with the seriousness of the events that had occurred, and the coroner's concluding comments including the concern that:

> *.... senior management and the governing bodies of aged care providers should be subjected to a system of personal accountability when standards of care are not met. Only by adopting a scheme in which there is some personal risk to those involved in the management of aged care providers at the highest level, could the public be confident that an event such as the appalling treatment of Mrs Baum in life and then in death could not happen again.*

These are powerful points which we enlist in support of the recommendations we propose.

Again, Commissioners, 1459, there's support to be derived through our recommendation in the Aged Care Quality and Safety Commission's own advisory panel's options paper supporting the imposition of legislated financial penalties on directors or key personnel in appropriate circumstances where an approved provider is not operating to the expected standards.

And 1460, supportive evidence from officers of the Department of Health has been given to the Commission, including a remark by one officer to the effect that having options of this kind would be "amazing".

I won't outline the rest of the submissions but we commend them to you including the parallels to be drawn with work, health and safety legislation and environmental

protection legislation.

The next recommendation, also a follow-up in respect of breaches of the general duty, Recommendation 110, would confer a private right of compensation for certain contraventions of the general duty, and this will be familiar from other legislation, including the *Competition and Consumer Act*. Where there's been a contravention, it should be permissible upon application of the regulator to a court of competent jurisdiction for a compensation order to be made but in addition, and this is the private right of action, a person who has, or is acting on behalf of the person who has suffered loss and damage as a result of a contravention, should be able to bring a private right of action for damages, for loss and damage arising from that contravention and should be able to rely on findings or admissions in any earlier proceeding about the contravention in question.

I'll go now to the next heading, I'll skip over the supporting reasoning at 1463 to 7.

The next heading is "Wider range of enforcement powers". There's one recommendation here of far-reaching scope. I've already opened this point about the need for a wider range of enforcement powers and I've mentioned in the context of prudential regulation the advisability of recommendations on this topic in that context. This is similar.

Can I just mention, in particular, paragraph (c) of Recommendation 111. It would propose a power to appoint --- I beg your pardon. (C) is in similar terms to an existing sanctioned power but a little wider. It's a power to impose a sanction to be applied on a noncompliant provider revoking the provider's approval unless the provider agrees to the appointment of an external administrator or manager. I said a little wider, it's in fact very substantially wider.

The current power which resembles this power only relates to the appointment of an adviser or a manager of a service. This would be an administrator or a manager of the provider itself.

Can I also draw your attention, Commissioners, to the extensive power in 111(b) which is a power of direct appointment, direct appointment, of an external administrator of a provider or of specific assets or undertakings of a provider which might, for example, include a particular residential aged care service or a home care service.

We have set out our supporting reasoning in 1473 to 1479. We've included in subparagraph (a) of the same recommendation a proposal about a broader suite of powers drawn in familiar form to the *Regulatory Powers Act*. The external manager point is addressed at point 1475 and following, and our justifications for recommending the conferral of such a far-reaching power is set out in the paragraphs that follow.

We turn now to the related topic on which is one recommendation of a strengthening

of the investigatory powers of the quality regulator and we're recommending that this take place as an augmentation in the near future of the Aged Care Quality and Safety Commission's powers. These recommendations, along with a lot of other recommendations that have intended to be of ongoing effect, these are intended to apply not only as an interim measure but also to continue on under whatever new structure the aged care system has in the future and as you know, Commissioners, our submission is that the very important work of the Aged Care Quality and Safety Commission would be carried on by subsumed into the Australian Aged Care Commission. So those powers would be available to the Australian Aged Care Commission once it's up and running.

These powers are intended to, in effect, mirror the sorts of powers that the Commissioner of Taxation has, for example, in respect of the administration of taxation laws. That was a point picked up in the prudential regulation section as well. This should be the ability, where there are prudential concerns, for example, or even where there aren't prudential concerns, for the regulator to be able to, in effect, randomly investigate or audit.

Now the powers here are needed, in our submission, to fill out some existing powers which are currently quite circumscribed as to the topics on which they can be exercised. So paragraph (a) of Recommendation 112 would round out existing powers the Quality and Safety Commissioner has in respect of conducting inquiries, including requisitioning documents and conducting examinations, but extend those powers beyond the currently enumerated topics into inquiries about complaints or reported serious incidents and there would also, in our submission, be broader powers to enter and search premises of residential aged care facilities and also, in effect, the back room offices of home care services. We are not recommending that anything like that be exercisable on private premises on which home care is being provided.

Now, I will move to the next heading, "The people at the heart of the system must be heard". And there are two ways in which this needs to occur, in our submission, and then there's a follow-up provision about protection of people who raise issues.

The two ways in which this needs to happen are through an expanded use of what had been referred to as consumer experience, interviews and reports. These are a very important measure to gauge what the people who are actually receiving services or their close supporters know and think about the services they're receiving. There is no better source of information about potential risks to quality and safety than asking the people who are living with those services day by day what is going on. And there are some measures in place at present along these lines. They are essentially, in effect, variable by the Aged Care Quality and Safety Commissioner according to her capabilities and her judgment of conditions at the time. They've waxed and waned a little in the scope in which they've been employed and deployed.

We submit that centrality in quality and safety monitoring should be cemented into the system and there should be the measures in Recommendation 113 ensuring, in

particular for example, that interviews should comprise at least 20 per cent of the people receiving care of a particular service when there's a quality review or a review audit of that particular service. That those outcomes --- the reports of those interviews should be taken into account in regulatory decision making, including those important key decisions on accreditation. And that there should - this is (d), that there should be, in effect, all-year-round online real-time avenues for providing information of the kind that is captured in those interviews and those reports. It shouldn't just be a one-off that happens to occur whenever perhaps a cyclical accreditation occurs which might be only every three years.

Now, 113(c) is in a slightly different category and this is a segue into the topic I mentioned at the outset about lifting quality by publishing the results of consumer feedback. There's a sort of a two-way element there. There's a negative incentive of a kind, that is if the reports are no good, then the provider is provided with an incentive to ensure that that never happens again and they need to lift their game. But perhaps even more importantly, there's a positive incentive involved there and that is that information about well-performing providers will be disseminated out through the national information service into the system so that other providers can take note, there be a normative effect, at least theoretically, one would hope, in practice, on lifting standards throughout the system if this is done right.

Now, I'll come to the other quality incentive elements of what we propose in just a minute but before going there, I will finish off on raising the consumer voice and giving it that centrality in the system.

Recommendation 114 is improve complaints management. Now there's quite a lot of detail in Recommendation 114 and I refer back to the persistence of Mrs Spriggs in pressing her complaints. Complaints are absolutely of the essence of ensuring that things are picked up, hopefully in a timely way and matters that raise systemic concerns are nipped in the bud.

We've made submissions already about the functions of the Aged Care Commission, at least in writing, I didn't spend a lot of time on it in oral submissions and I don't have time now, but we have developed the features of the complaints scheme in such detail in this submission and that's a scheme that would be operated by a dedicated Assistant Commissioner of the Commission. It's essential that the complaints scheme have a powerful advocate within the system. It's also essential, in our submission, that it be connected with both quality and safety monitoring generally, because it's a very important source of intelligence and also systemic review for the reason I just identified about nipping issues in the bud.

The Inspector-General has an important role here and we anticipate that the Inspector-General will receive, either on referral from the complaints scheme or directly, complaints that raise systemic issues and will monitor systemic issues and the performance of the complaint scheme more generally.

Now, I need to move through this so I won't --- I just commend to you,

Commissioners, the supporting reasoning at 1504 through to 1515 and that discussion of the complaints scheme concludes on the need to be transparent about what the complaints scheme is telling the Commission about the system. There should be more detailed information than is made available at present, deidentified, of course, about trends in issues. The reports could contain information at a provider level. They shouldn't, unless a complainant has consented, of course, reveal who the complainant is.

The role of advocates is then picked up at 1519 and this closes a loop on Recommendation 7 which I outlined to you yesterday when I was addressing system design. Advocacy needs to be strengthened. Its reach isn't yet broad enough, it doesn't appear to have the funding it requires, I addressed you on that. Advocates need to be sufficiently resourced and available to provide support to people who wished to make official complaints.

There's been information recently, of course, published by --- it was commissioned by the Office of the Royal Commission but it was a study conducted by NARI. Mr Rozen spoke about it yesterday, the National Ageing Research Institute, Inside the System: aged care residents' perspectives. It's at the foot of page 447, Commissioners.

Disturbingly, while there were quite a number of respondents to the NARI survey, with respect to residents of aged care facilities, not a single resident had made a complaint to the Aged Care Quality and Safety Commission and even when one takes into account complaints made on a resident's behalf by close proxy, only about 1.8 per cent of concerns which had been harboured by a resident, led to an official complaint to the Commission.

Now, what one might think, oh, well, it's possible to draw comfort from that. In fact, you can't draw comfort from that because the same survey indicated there was a very high level of dissatisfaction with the internal handling of complaints that had been made to providers. So if you put those two things together, you have a disturbing picture of near apathy, or perhaps ignorance, on the part of residents and those closely supporting residents, about the avenue of taking an unresolved complaint forward to the regulator, or to the complaints scheme.

Now, protections for the people who have raised issues, absolutely critical. Recommendation 115, a lot of evidence before the Royal Commission has referred to fear of reprisals. There couldn't be a cohort conceived of that is more vulnerable to the possibility of adverse action being taken to them outside, perhaps, just a few limited examples of people in other forms of institutions.

People living in residential care are completely vulnerable, at least they perceive themselves to be completely vulnerable, to treatment by the people associated with the provider of residential care and they must be given the greatest possible protections for whistleblowing, and this is subject to Recommendation 115, and that should extend into the rest of the aged care system regardless of care setting.

And guidance can be drawn on whistleblower protection from the National Disability Insurance Scheme context, 1525. If the whistleblowers are official, in effect, people employed or official position, they need to be protected from the prospects of administrative action, civil litigation and, of course, even at least, theoretically, criminal prosecution, if they're raising a matter concerning quality and safety of aged care.

I now go to that area I've alluded to once or twice about incentives for quality improvement. That's Recommendations 116 and 117. 116 is about graded assessment and performance rating and, Commissioners, you've heard us speak about this briefly before. It's the proposal that the assessment of the delivery of aged care against the aged care quality standards on a binary basis, that is a met/not met basis, is inadequate to incentivise the delivery of improved performance and even excellent performance over and above those minimum standards, and it also tells the provider little and even more importantly, the broader public and people who might need aged care services nothing at all, really, apart from the bare fact that the provider has or hasn't met a minimum standard. This needs to change and it can change quite simply, a graduated spectrum of outcomes can be readily conceived and should be introduced into the practices of the Aged Care Quality and Safety Commissioner when she and her staff assess the compliance of aged care providers with the standards, or against the standards.

That should feed into, this is Recommendation 117, the star ratings performance information scheme that has been talked about for so long.

At present, there's a totally inadequate dot ratings, so-called dot ratings scheme in place. That tells the public nothing more than, in effect, the compliance history and the current status of compliance of that provider with the minimum standards. It's essentially just an iteration of the binary met or not met regime.

Star ratings, that is at least five stars, we would say, based on the extent to which the provider is meeting or exceeding or performing below the relevant standards, is going to be of critical importance in informing the public so that they can make proper consumer choices about services, therefore at least theoretically where there's competition, where there's workable competition, driving quality up, and also about creating a normative effect on lifting performance throughout the system.

Finally, Commissioners, I want to say something briefly about what happens, what are the consequences when things have gone wrong. There's serious incidents and there's coronial reports. I don't need to say anything about our final submission on capabilities of the quality regulator. That's right at the end in Recommendation 122 and we simply rely on our written submissions for that one. It is self-evident that a capability review and improvement of capability is required.

Serious incident reporting is Recommendation 118. As you've heard in the hearings, Commissioners, there is a need for --- and as Mr Rozen has mentioned in the quality

and safety submissions, there's a need for the serious incident regime to pick up suspected and alleged assaults, even if they're perpetrated by somebody who is suffering a cognitive impairment. This is a glaring omission in the scope of the regime at present and needs to be --- the regime needs to be augmented in its scope. There might be all sorts of systemic things that need to be done in order to improve the conditions in which care is provided by particular providers, yes, or system wide to deal with a possibility that there are very widespread assaults being perpetuated, which we know nothing about, because they're not being reported.

The coronial response recommendation is Recommendation 119. It's a recommendation that the Commission be required to maintain a publicly available register of those coronial reports involving the death of a person in an aged care setting as, in effect, a transparency measure to ensure that there are responses made to the recommendations in reports and those responses as well should be made publicly available. There needs also to be a round-up on an annual basis in the form of an annual report to the Inspector-General on those matters.

I'll move now, unless there are any comments by the Commissioners, I can move now to the topic of transition and implementation, which is the subject of part 2 --- I beg your pardon, part 3.18 of our submissions and this is the final part of that body of our submissions in part 3.

There have been numerous inquiries and reviews, as you know, Commissioners into the state of aged care in our country over the years. Background paper number 8 is a very handy and detailed compendium of the history of those reviews. It tracks government implementation, or non-implementation and it shows that implementation has been patchy. Where there have been responses, in some cases they've come months or even years after the relevant review, and when one reads those responses carefully, one sees that some of them only partially address recommendations, sometimes under the guise of some fanfare that the recommendation will be implemented. One needs to look very carefully at the detail when it comes to government responses to recommendations of inquiries into aged care.

Our recommendations in these submissions, of course, call for sweeping reforms to the system in order to address what we have identified as persuasive, systemic problems. Undeniably reforms of this magnitude are going to require a lot of careful planning and very careful implementation over a lengthy period. This has to be done deliberately and with relevant safeguards and monitoring and we would say also with reporting of progress.

It's going to require genuine commitment by the Government and even with such commitment, implementation of changes of this kind can be disrupted by many factors, some of which might be completely unforeseeable. More foreseeable potentially disruptive factors are attributable to the interdependencies that exist between some of these reforms.

If there's delay in the implementation of a particular earlier reform that's a precondition for the commencement of implementation of another one, then obviously there's going to be a knock-on effect as a result of any problems encountered in delaying the first. But I return to the point about unforeseen disruptions and I'm going to hark back now to some of the things I submitted to you yesterday when speaking to you about system design and the academic literature on complex systems.

There clearly will be unforeseen disruptions or there will be unforeseen consequences of particular interventions because so many of the actors in this system are autonomous and are simply going to be guided by their own perception of self-interest. They might well react to certain interventions in unforeseeable ways. All of this makes it critical to build flexibility into the plans for implementation of these reforms.

One thing that's clear is there must be clear accountability for implementation, in particular, responsibility for implementation of particular identified steps, measurable outcomes for progress on those steps, a system of monitoring what is happening, and making transparently publicly available what the progress has been and what the plans are for the future.

The implementation must be monitored constantly, reviewed regularly, and it will require that commitment from Government to continue.

The attention of the political leadership may well shift in the future with crises, elections, fiscal pressures and other pressing challenges, but securing Government and ministerial engagement for seeing the change through will be essential.

We submit the following basic recommendation should be made by you, Commissioners. Firstly, Recommendation 123, there's a recommendation for measures to get the implementation running, up and running, and for this to happen quickly, well before the commencement of the new act. The new act will take time, drafting legislation is a difficult business. And it needs to be done with care and attention and instructions about operational matters. So we understand that.

But pending the establishment of a new act, and the --- I beg your pardon, the commencement of the act and the establishment under that new act of the Australian Aged Care Commission, in our submission, an administrative unit or a body should forthwith be established by the Australian Government and we say this should happen through the Australian Department of Prime Minister and Cabinet so that it's happening at the apex of the system, that is of the broader governmental system, and that unit should be properly staffed and resourced to implement and direct implementation of the Royal Commission's recommendations.

We've been referring to that unit or body as the Implementation Unit throughout these submissions.

Pending the formal establishment of the Office of the Inspector-General under the new act, we say an officer should be appointed to that role essentially under temporary administrative arrangements and that should happen very soon. And the officer should monitor the implementation of recommendations and report to the responsible minister and to the Parliament at least every six months on the implementation of the recommendations.

We outline some submissions at 1585 and following in support of those recommendations and we outline some key principles at 1590 to 1593, and I won't read those out.

At 1594, we then refer to the desirability of a careful implementation through a phased approach and the need to formulate an implementation plan having all those features that I outlined earlier including clear responsibilities and measurable goals.

At the same time, while the goals should remain fixed, the goals should remain fixed, the plan needs to retain sufficient flexibility to be capable of the adaptations I alluded to should the need arise during implementation.

Now, at annexure A of our submissions, we've set out a seven-page document, it's quite dense, I am going to spend a little bit of time on it now, which is, in effect, a chronological arrangement of some of the most important recommendations, in fact most of our recommendations here, not all of them, but this is the sort of approach that is needed, it's included in these submissions to elicit responses from interested persons, stakeholders and Government. In our submission, it sets out ambitious, yes, an ambitious program but a practically workable program for transformation of the system and in the shortest possible time, that's part of the ambition in the program.

It begins with a phase of four to five months of, no doubt, very intense activity to try to achieve by only four to five months out from the final report the measures that appear on first page, including, obviously, the establishment of the implementation unit. The conferral, and this will require legislation, of the functions Mr Rozen spoke about concerning setting of quality standards and review of quality standards by the Australian Commission, that other body that currently specialises in healthcare standards, the adoption of graded assessment by our present Aged Care Quality and Safety Commissioner, and I have just been speaking about that, graded assessments. Urgent action on the home care waiting list and on the additional funding, the $10 per resident per day of the basic daily fee. The beginning of those high-level intergovernmental mechanisms which we advocate, the first step here being the National Cabinet Reform Committee on Ageing and Older Australians should be established in this period and it should begin that work on an integrated long-term support and care plan or strategy for older people. That is, as we said, in our submissions yesterday, a long-term project. But there will be dividends from setting up a higher level intergovernmental body of that kind, dividends outside the integrated long-term care strategy because it will provide a forum for improvements of the way all of those different services interact to improve the position of older people in Australia more generally. You can't just regard aged care on its own in a vacuum. You have to take into account all of those interdependencies with those

other areas and services.

Another step during this period of very intense activity will be the establishment under temporary ministerial arrangements of the Inspector-General role.

Next, there should be mechanisms put in place to achieve the Australian Government's commitment to bring an end to younger people having to live in residential aged care in all but those very exceptional circumstances Mr Rozen spoke about at the end of his address on that point.

Amendment to the Quality of Care Principles to limit the use of restrictive practices further, along the lines of the review process we've mentioned. Expansion of the mandatory indicator program such as it is, as Mr Rozen said, as of only recently, there are three mandatory indicators. They were voluntary before that. They're fairly limited. There is a commitment to at least expand them out to five but there's no detail on what one of those additional indicators, or medication management will look like. That all needs to happen and happen urgently in this first phase.

There should be the commitment of those incentives Mr Rozen spoke about and that support for Aboriginal and Torres Strait Islander organisations to be assisted to expand into aged care delivery. The Aged Care Workforce Council should be given more resources and refreshed in the manner Mr Rozen spoke about. Existing employment programs and initiatives for potential Aboriginal and Torres Strait Islander aged care workers need to be reviewed and aligned to the needs of the sector to care properly for people of Aboriginal and Torres Strait Islander background. This is all still in the first phase.

Expansion and transformation of the Community Visitor Scheme into that expanded aged care volunteers visitor scheme that we've addressed. A new program to assist providers to improve their governance arrangements should commence in this period and internal governance of aged care providers, it's a topic, of course, that Mr Rozen addressed. Its importance is difficult to overstate. Leadership has to come from those people because they do have direct responsibility for the outcomes of the care they provide.

Completing the rest of the points under this phase we have measures for improvement of healthcare access of various kinds. We've got the medication management point, we've got the Rural Health Outreach Fund point, we've also got those indexation, those urgent interim indexation improvement measures that I outlined earlier today. We've got the increase in education and training with reimbursement available to providers on proof that they provided that training, and the standardised more readily comprehensible formats for home care statements.

So there's a lot to be done but all of that should be achievable with adequate resources being put into those measures in the first phase. They're, of course, just the foundation for what will follow. There should be a movement to the accruals basis in arrears in about the following quarter, and then in the following six months some

more of those health access improvement measures that I outlined to you this morning should take place. MBS, primary and allied healthcare service items, specialist services via telehealth and the measure about the need for involvement of a psychiatrist or geriatrician in respect to the prescription of antipsychotics.

Then the next major phase, Commissioners, is about nine to ten months out from the final report at the end of 2021 or the beginning of 2022. These are matters that you and the public obviously can read in the document. I won't read them out now. I won't conduct that sort of granular exercise of going through each one of them for the remaining phases because the document speaks for itself but I wished to do so in respect of that first phase of activity that's needed to really get the implementation plan off on the right footing.

And the next major phase, which is within six months after that, in mid 2022, is a consolidation of a number of more complex measures for training, for the providing services properly tailored for people of Aboriginal and Torres Strait Islander background, career pathway development, there are a host of issues which we address in this phase that are important to consolidate the capabilities that are going to be needed in the new system.

And then the next major phase, six months on from there, I'm now at the top of page 5, will be at around the end of 2022, beginning of 2023. This is a very important phase, all of them are important but you can see a number of really critical initiatives that should be available by this time, including the dementia post-diagnosis pathway that's so critical for the support of people living with dementia, yes, and also for those who care for them, the informal carers of people living with dementia about whom and from whom you have heard a lot of evidence, Commissioners. We'll never again hear the sort of evidence we heard from Mrs Cameron concerning how she felt, so bereft and left on her own after her husband's diagnosis with dementia. There needs to be a clear pathway available for people in that situation, including linkages with all the support services that are presently available and that should be available into the future in enhanced form.

This period in 2023 is going to include, by about the middle of 2023, the establishment of those key elements in the institutional framework that we outlined to you, the Aged Care Commission, the pricing authority, there are going to be important consolidating measures in the year between mid 2023 and 2024 in order to get the system ready to support the launch of a new demand-driven, unrationed aged care program in mid 2024. That's really the critical date by which all the capabilities need to be in place, mid 2024. That's on page 6.

And at that point, in our submission, the new system, or the new program reflecting the universal entitlement to aged care based on assessed need needs to be in place. The aged care provision ratio needs to be replaced essentially with a demand-driven program. Minimum staff --- I should have mentioned in mid 2022 there will be that first progression to three-star general average staffing levels in residential aged care. Two years on in mid 2024 there needs to be a fully costed and priced funding regime

supporting four-star average staffing levels in residential aged care and that should be ready by mid 2024 and it should be funded on beyond that point. Of course it will need iterative refinement as the understanding of what we mean by high-quality aged care is refined over time and as we work out more and more accurately what the cost of providing that is but this is when the new system needs to commence, mid 2024.

The other matters covered in the implementation plan are follow-up measures to ensure constant measuring and refinement. And it's in these years following mid 2024 where there needs to be constant monitoring and refinement. It's here where the benefits of having independent system governance will come into their own. By this time we will be more than four years out from the final report of the Royal Commission, and public memories of what this Royal Commission has seen and what the findings of this Royal Commission have exposed will be growing dim. It's at this time, when independent governance, governance in the interests of the people who need aged care services and are receiving aged care services will come into its own, and that overriding goal of independent system governance needs to be given a focus that is not distracted by the fiscal pressures of the government of the day. That's not a criticism of the Department's role. A department is an emanation of the executive government. A department is intended to act under the direction of the Ministers of the day and the Ministers of the day are, of course, doing their job when they consider fiscal pressures that apply to the government of the day.

So it's completely understandable that if a department has governance of the system, that that department, or any of its officers, will be properly performing their role if they take instructions from the minister who is responsible for that department, and if those instructions are informed by fiscal pressures. That will be an example of a department acting as it is intended to act. It's just that that isn't in the interests of the governance of a system of essential human services as sensitive as aged care.

The governance of a system like that should be exercised in the interests of the people who need the services.

It's for those reasons that we submit an independent body is going to come into its own in these years when memories grow dim about what this Royal Commission has seen. It's for that reason that we're recommending independent governance, independent of ministerial direction so as to avoid repeating the mistakes of the past, and I'm referring there to the volatility introduced and the mistrust which developed between the sector and government as a result of indexation pauses and changes to eligibility criteria in 2012 and 2016.

As the Cabinet memorandum I tendered yesterday, Exhibit 22-1 shows, government has its --- government presently has its hands on all the levers of control of aged care expenditure and can even alter service delivery benchmarks, and for that matter, eligibility criteria. Those are all options available to government to deal with fiscal pressures of the day. The governance of the system needs to be removed from the influence of those sorts of considerations.

Commissioners, I will now turn to part 4 of our submissions, which is entitled "Aged care and support in 2030 and beyond". The recommendations that we propose are intended to reform aged care in Australia over the coming decades. If fully implemented, these proposed recommendations should bring about significant, wide-ranging, long-lasting and beneficial changes. They should lay the groundwork for a vision for aged care in 2030 and beyond. Some core components of the vision that we have for 2030 beyond are now set out in the written submission and I will, in effect, go through each of those elements of the vision. I'm at 1599.

Aged care should be and should also be about older people receiving support and care, the people who support them, that is their families and their informal carers; also the workforce, personal care workers, nurses, allied health and medical practitioners and the others who support and care for those older people.

In 2030, that, of course, should be the case and there should be a framework for a system that carries that on as the central guiding mission of the system. It should be a statutory framework for aged care that emphasises the centrality of those people in relationships. That framework will, on our vision, enshrine and protect the rights of older people to high quality, safe, and timely support and care to assist them to live active, self-determined and meaningful lives.

The statutory framework will be administered and regulated chiefly by a strong and independent Australian Aged Care Commission. Pricing and standard setting will be undertaken by bodies removed from and independent of the Commission. The Commission's performance of its functions will be scrutinised and reviewed by an independent Inspector-General of Aged Care.

Independent pricing of aged care will mean for the first time that funding will be set at levels designed to enable provision of high-quality care. This begins with defining what's needed to raise aged care to that level and then working out what the reasonable costs of providing that will be, including staffing costs, of course, and then setting funding levels to cover those costs. This will be the principal purpose and function of the new aged care Pricing Authority once it is established. Its pricing task will be an iterative process which will have to be refined over time.

The paramount consideration in the administration of the statutory framework will be the safety, health and wellbeing of people receiving aged care. The focus of aged care will be maintenance of independence, autonomy and choice. That focus will inform the delivery of aged care to older people. Support and care in the home will be the norm for aged care through to end of life. Wherever care is delivered, it should be personal and relationship-based rather than transactional or institutional. All aged care will be well adapted to providing safe, high quality and empathetic dementia care.

Residential aged care will chiefly provide aged care services for older people with the most complex, acute, and special needs, including those needing advanced subacute care, advanced palliative care and advanced dementia care. Greater

numbers of smaller, congregate living arrangements will be available for people living in residential aged care. Residential aged care facilities will meet accessible and dementia-friendly design standards.

Delivery of aged care centred on the person will involve greater recognition and provision for diversity of circumstances and needs of older people. It will recognise and make culturally safe provision for the distinctive requirements of Australia's Aboriginal and Torres Strait Islander people. People receiving aged care will have access to locally based care finders to assist with accessing aged care and other systems in accordance with their individual needs and preferences.

There will be a larger, better trained, valued and regulated aged care workforce. Residential aged care providers will have to meet mandatory staff-to-resident ratios taking into account their case mix of residents. The ratios will be adjusted to ensure they are at a level required for the delivery of high-quality and safe care. Providers will be funded accordingly.

Aged care staff providing personal nursing and allied healthcare will be remunerated at comparable levels to their counterparts working in the health and disability service systems.

Personal care workers will have mandatory minimum qualifications and undertake ongoing training and professional development activities. Nursing and allied healthcare staff will be subject to professional registration. All staff will receive better training in dementia care. High level infection control will be the norm in residential aged care overseen by trained infection control officers.

There will be greatly improved access to allied and other health professionals in accordance with assessed need. Preventative and restorative care delivered by multidisciplinary teams will be expected. People receiving aged care will have far better access to general practitioners, specialists, dentists and pharmacists at their place of residence, whether that be at home in the community, or in residential aged care.

Outreach services will deliver healthcare to people who are unable to travel to visit health professionals. There will be system and data interoperability of information systems used by providers and the healthcare system to facilitate continuity of care. There will be a shared understanding of the respective and joint responsibilities of providers and health professionals to meet the care needs of people receiving aged care.

People with disability receiving aged care will have access to services that would otherwise be available to a person with similar conditions under the National Disability Insurance Scheme. And save for very limited exceptions, where it is demonstrably in the best interests of the person receiving care, there will be no younger people in residential aged care.

There will be no planning limits or rationing of entitlements to receive aged care for people who are assessed as needing it. Wherever practicable, appropriate local aged care options will be available for all older people across Australia. Funding of aged care will be driven by individual care needs, independently assessed in a convenient and timely manner through an integrated assessment process which provides access to all aged care services a person might need.

Providers will be governed accountably and skillfully by fit and proper key personnel. Providers will have a duty to provide high-quality care so far as reasonable. They will have to meet clear regulatory standards for high-quality care and to report on measurable performance indicators of clinical care and quality of life outcomes. Reporting on quality indicators will inform assessment by the Australian Aged Care Commission of performance of providers against benchmarks.

In meeting regulatory standards, providers will provide best practice oral care, medication management, infection control, pressure injury prevention, wound management, continence care, falls prevention and information control. A failure to meet those standards will attract timely and proportionate regulatory consequences. There will be a strong and effective regime for ensuring sound financial and prudential management by providers, in order to provide timely warning to the Australian Aged Care Commission of risks to the continuity of high quality and safe care to the people for whom a provider is responsible.

The Australian Aged Care Commission will act as a proactive regulator of providers. It will have more powers and greater preparedness to use them. There will be zero tolerance for abuse and neglect. There will be effective means of redress for people who are receiving aged care services who are no provided with high-quality care. Complaints to the Commission will be carefully considered and promptly acted upon.

Information on care-related spending, outcomes, provider performance and pricing will regularly be reported to the Australian Aged Care Commission, and it will be made available in appropriate form to the public, subject to individual privacy considerations. Accountability of the Australian Aged Care Commission is an important aspect of these recommendations and they need to provide data transparently so that others may hold them accountable.

The information to be disseminated by the Commission will include a star rating system for providers which will provide publicly available, transparent information to inform real choice.

The Australian Aged Care Commission will have responsibility for aged care data collection and management, including a national aged care data set. There will be dedicated, sizable and ongoing research into aged care, innovation, and its translation into practice.

By 2030, steps should be under way for the aged care system to be integrated with

other systems administered by the Australian and State and Territory governments for the provision of healthcare, housing and welfare supports for older people and other services in a comprehensive long-term care system for older people.

HOUSEKEEPING

MR GRAY QC: Commissioners, before concluding, there are a couple of housekeeping points. There are a series of exhibits, numbered 22-2 to 22-9 which I understand, Commissioners, you've received in chambers.

COMMISSIONER PAGONE: Yes.

MR GRAY QC: They should now be made available to the public as public exhibits in the inquiry.

COMMISSIONER PAGONE: Yes, thank you, Mr Gray.

MR GRAY QC: Thank you, Commissioner. I'm instructed or I'm informed they're on the website now.

COMMISSIONER PAGONE: Thank you.

MR GRAY QC: In addition, yesterday you made a direction in the terms that I'd anticipated at the outset of our oral address, that is that responses to these submissions that I've just made and that Mr Rozen has just made, and that we've published in written form on the website, are invited from any interested person and that all responses are to be made on the form for responses which has been published on the Royal Commission's website. They are to be provided by 4.00 pm Australian Eastern Daylight time on 12 November 2020. And you, Royal Commissioners, have indicated that no extensions to this deadline will be granted.

COMMISSIONER PAGONE: I think, Mr Gray, for the benefit of certainty, I should indicate that I think the direction was extended so that the subject matter extends also to the matters that were raised during the course of these two days to pick up the matters that Commissioner Briggs specifically asked to deal with.

MR GRAY QC: Thank you very much, Commissioner.

COMMISSIONER PAGONE: I think you're looking at an old version of the direction.

MR GRAY QC: Thank you.

Could I just add a note of thanks, Commissioner, to the staff here in Melbourne for working on what is, in Melbourne, a public holiday.

COMMISSIONER PAGONE: Yes, of course.

MR GRAY QC: Thank you very much.

COMMISSIONER PAGONE: Thank you, Mr Gray.

MR GRAY QC: If the Commissioners please.

COMMISSIONER PAGONE: Before I make a couple of wrap-up comments and thank people, Commissioner Briggs, I understand there are some matters you wish to say as well. Perhaps over to you first. Commissioner Briggs, I think you're on mute still, we can't hear you.

CONCLUDING REMARKS BY COMMISSIONER BRIGGS AO

COMMISSIONER BRIGGS: Thanks very much, Commissioner, and thanks, Senior Counsel, for the submissions you've made to us over the last two days which I found very thought provoking and very helpful.

I really appreciate the work that's gone into them and I would like to acknowledge gratefully all those supporting you to this point. Thank you, everybody.

On this, our 99th day of hearings, and after two years, the Royal Commission's work is coming to its climax and, I, too, want to take this opportunity to reflect and comment on where we've come from and where we might end up.

There's much more to a Royal Commission than sitting in judgment and writing a very large report. So much of what a Royal Commission does is about giving people a voice, hearing their stories and exposing individual and systemic failures that collectively undermine public confidence.

The power of the court system is exemplary in seeking out the truth and the inquisitorial style of Royal Commissions makes them not just spellbinding but effective mechanisms to consider long-term policy reform.

Our counsel are the public face of the Royal Commission, but they walk alongside the policy and research people, the solicitors and the corporate support staff who work in the backgrounds of the Royal Commission to deliver jointly the direction and the recommendations that Commissioner Pagone and I will ultimately hand to the Governor-General next February.

All of these people work around the clock and none of it is easy or simple. If it was, you wouldn't need a Royal Commission in the first place.

Royal Commissions are expensive and major exercises which are hard to coordinate and certainly challenging to lead. I apologise to those of you who I have let down in the process. I'm doing my best but we're all only human.

Commissioner Pagone and I, though, are very conscious that Royal Commissions are a crucial part of our democratic processes and strongly supported by most Australians and so it is with this Royal Commission.

On this, our very last public day, I would like to thank the Australian community for letting us into their lives. I would like to thank all those who appeared before us, whether it was in community meetings, in hearings, in workshops, in round tables, or in briefings right across Australia. It has been wonderful to bear witness to the depth of commitment and engagement shown by many and to their experience and their desire to see reform.

In a very real way, we have moved forward together and, counsel, I'm confident that we will change the landscape of aged care in Australia.

I understand that our Interim Report "Neglect", was a shock to many in the sector because it presented the aged care system from the point of view of older people. It turned out to be a watershed moment for those using the aged care system and their families along with the many fine people working in the system because it represented the aged care system they knew which showed it was in need of major reform. At that time we had no inkling that around the corner a devastating health pandemic would further expose the system leaving over 680 aged care residents dead, and firmly establishing that the aged care system was, indeed, broken and in need of significant repair, and realignment around older people themselves.

After two years of evidence, it's clear to me that we have an underfunded system that demonstrably fails to meet community standards of health, personal care, and sustenance for a generation of people who are used to just making do. The system is not good enough for them and it is unimaginable that future generations will stand for it as it is. It is unacceptable to us all.

As you've said, counsel, the aged care system is going to require a lot more money before the community can have confidence that it will deliver high-quality care consistently and universally. It will need more money because aged care has been seriously underfunded, because demographics and expectations are changing in a way that will require a lot more services and a better quality and range of services because technological changes will drive costs up because universal entitlement to care as proposed by counsel will cost more because fair access to healthcare and disability services will also cost more and fundamentally, because treating our older people well is purely and simply the right thing to do. Everyone knows it and it's about time we did it.

It will come as no surprise to many who have followed this Royal Commission over the last two years that we think it's time to put older people first. As you said,

counsel, we need a new act that is fit for purpose and delivers on the promise of high-quality and safe aged care. We need aged care providers, healthcare professionals, the states and territories and the Australian Government to work together to provide the best possible care and support services for older Australians.

We need a new program system that is personal and helpful, easily accessible, maintains health and wellbeing, delivers entitlements to care based on assessed needs and rights and is better funded to ensure that everyone genuinely has access to high-quality aged care. It should respect older people's wishes to be cared for and supported at home until such time as this is no longer an option. We need better standard setting and better regulation to protect older people against poor quality care and to ensure that taxpayers' money is used appropriately and properly accounted for.

We need dedicated research and effective data collection sharing arrangements that can inform better quality aged care. We need to ensure that young people with disabilities are not inappropriately put into aged care and that older people with disabilities receive their fair share of services commensurate with their entitlements.

We need a skilled, compassionate and appropriately trained and paid ongoing workforce that helps to provide not only great care but also a good quality of life.

We need both provider boards and the Department or the Commission to drive better leadership and a shift in organisational culture in all parts of the aged care system. We need everyone in the community to pull together to support older people to live happily and actively contributing lives and to find both tried and true and new ways of doing that. It will be great if younger people led the way and showed us how.

We need ambition and enthusiasm within the aged care sector to turn this system around. Let's see some stars in transformation who champion those kinds of changes we recommend. And we need governments to move forward collectively, to fund and make sure that the Australian aged care system is one that we can be all justifiably proud of and have confidence in.

The current aged care system is sadly a poor reflection on us. Our final report will be a report for all of us. I'm sure that it will make a real difference to the lives and circumstance of older Australians, and to each and every one of us as we age.

It's been a very great honour and extraordinary privilege to serve as a Royal Commissioner into aged care, quality and safety. I would like to thank everyone who has made it possible for me to serve and who has helped us along the way, especially my chairs and fellow commissioners. Your arrival, Commissioner Pagone, brought a healthy contest of ideas and a sharp focus on our recommendations and time frames and I thank you for that, in particular.

Of course, we still have a few things to sort out and I am sure we will do so.

Our report will be out in late February, counsel. I hope everyone takes the time to

read it. All of our futures depend on it. Thank you, Commissioner.

CONCLUDING REMARKS BY COMMISSIONER PAGONE QC

COMMISSIONER PAGONE: Thank you, Commissioner Briggs, for those concluding remarks.

I should add one or two things myself. Of course, as I'm sure the public understand, there is still quite a bit for us to do. This is the 99th day of public hearings but our work doesn't stop here. We now need to digest the nearly 500 pages of material that was presented to us by counsel and the vast amount of material that sits behind that that is informative of your recommendations to us about what we should do and, of course, there are still responses that may come pursuant to the direction that was made yesterday which may have a big impact on the way that we proceed and think.

So I thank you for that.

I might just take a moment or two to reflect a little bit about the Commission and then possibly say one or two personal remarks myself.

This, as you've heard, is the 99th hearing day of the Commission that's been running for sometime now. It began on 8 October 2018 when the Commission was established by letters patent, the first letters patent appointed Hon. Justice Joseph McGrath and Ms Lynelle Briggs AO as Royal Commissioners, with Justice McGrath as chair. He regrettably stepped down but on 6 December 2018, the letters patent were replaced with the late Hon. Richard Tracey AM RFD QC as chair.

On 13 September 2019, I was appointed as Royal Commissioner, and unfortunately Richard Tracey died on 18 October 2019. I'll come back to that in just a moment.

On 31 October 2019, Commissioner Briggs presented the Governor-General with the Interim Report that she and Commissioner Tracey had prepared and which has had a significant impact in the public debate.

On 30 September this year, Commissioner Briggs and I presented to the Governor-General a special report with the response to COVID-19 in aged care which, as is well known, notorious and was mentioned a moment ago by Commissioner Briggs, devastating and had a dramatic impact particularly in aged care facilities.

Our final report will include an appendix which will list the many people who have been working with us as advisers or as employees. There are many people.

Before I mention some of them, however, might I bring to the forefront the huge number of people from the community who have willingly given time and

information and assistance to us in this work. In my case, it has been so far just over a year but it's been for a lot longer. People have allowed us into their homes, their hearts, their emotions, their fears. It has been an extraordinary experience to have gone through and listened to the many stories that so many people, indeed I think everybody has. I've not been able to go to a meeting, when one could go to meetings, of course, of friends, relatives, dinners, without somebody coming up and wanting to tell me a story about their experience in aged care. It's a system that affects every Australian in every walk of life and in every place and we have been truly privileged to have had so many people tell us their stories in the way they have at times in a very heart-wrenching way.

It would be impossible to mention any of you in particular, you have all been absolutely wonderful and we thank you deeply and sincerely for that assistance.

Now, then, there have also been those that have assisted in a more formal way. Aged care providers, government, experts, a whole range of people whose expertise, whose knowledge, whose experience and whose wisdom we have been able to draw upon. It is a remarkable experience of a kind that I have certainly never experienced before in my years as a judge or before that as a practitioner. It is a unique experience of enormously humbling proportions. We thank you for that.

But let me mention a few of the people closer to home. Mr Peter Gray QC and Mr Peter Rozen QC whose faces you have seen over the last couple of days popping up and down, who have assisted us and led an extraordinary team of counsel in preparing not only the submissions that you've heard over the last couple of days, but in all of the hearings that have taken place.

The work they have done and the leadership they have shown has been extraordinary. I can assure you this is not something I say lightly. Giving an endorsement of that kind to practising barristers is not something one should do lightly but they have been truly great leaders. The bar can be very proud of them and we are very fortunate to have them.

They were aided, before my time, by Dr Timothy McEvoy before his appointment in March 2019 to the Family Court of Australia. I'm pleased there's been no more such appointments in recent times because we would have lost a great team.

To them added Mr Richard Knowles appointed Senior Counsel during his time working for the Commission, Mr Paul Bolster, Ms Erin Hill, Ms Brooke Hutchins, Ms Eliza Bergin, all of whom have done a wonderful job in the hearing and also outside of the hearing. A lot of the work that's done, the public does not see. It is no less important. On the contrary, probably more important than the lead roles that those who get up in front of the cameras and the court need to perform. We thank each of those.

There's also the Office of Solicitor-General, the Australian Government Solicitor lead by co-solicitors assisting, Ms Louise Amundsen and Mr Rodger Prince. They,

too, have led an extraordinary team of people behind the scenes, each of which have been truly wonderful, reliable, dedicated, hardworking of a kind both Commissioner Briggs and I know very well. They've been on tap at all hours of the day and night and have always been entirely helpful.

The staff of the Royal Commission. There's a Policy and Research Branch led by Ms Sara Samios who has led a team of people that have been extraordinarily helpful in our deliberations and I know how much time and effort has gone into the work that she has done in coordinating that and making that work mesh in with what you've seen the lawyers do publicly.

There's the Operations Branch led by Mr Dan Cox and before him Mr Scott Brooks. Within that branch is Ms Tara Philip who leads the team that has made it possible for us to conduct our hearings including virtual hearings during the COVID-19 pandemic which, of course, continues. Many of you will have heard me praise Ms Philip on a number occasions. No doubt she feels embarrassed every time I do but we could not have worked without the efforts that she has made behind the scenes in making sure that everything works, that microphones don't stop, that cameras continue and that it's all going very well.

The official secretary, Dr James Popple who has been a powerhouse of support and stability, always there, also always available at times around the clock and Dr Popple, we thank you for your patience, perseverance, assistance constantly.

The electronic court facilities have been provided by Law In Order and I'm delighted to say that Law In Order has been in order and working well. There are some in the room, we thank you very much for your efforts. It is a testament to the efficiency of your work that we go on air and we are able to perform as we are intended to perform.

Hearings have been conducted all around the country. Adelaide, Sydney, Perth, Brisbane, and Melbourne. Some have taken place in the Commonwealth Law Courts and we need formally to thank the Hon. Justice James Allsop, Chief Justice Allsop AO and the Hon. Justice Will Alstergren for enabling us to use the facilities when we have done so.

The Supreme Court of the Northern Territory in Darwin where the Hon. Michael Brandt, the Chief Justice, was our host, the county court in Melbourne where Chief Judge Peter Kidd was our host and commercial venues in Broome, Cairns, Mildura, Mudgee, Hobart, Canberra, and Adelaide and I think in Sydney we also had the Fair Work Commission more recently we were able to hold hearings.

It would be remiss of me, however, if I didn't just say a few words of personal thanks and gratitude, and perhaps one or two reflections about the Commission.

I would never have thought that I would have been chairing a Royal Commission let alone on aged care. When I was approached for this task, the now late Richard

Tracey was still with us, and I had anticipated my role to be somewhat different than it has become. I did not expect it to be as it has. The learning curve has been steep. I knew something about aged care in different capacities but to understand the complexities of the aged care system in Australia has been very demanding, very time-consuming and without the assistance that we've had would have been, for me, impossible.

Then, of course, COVID-19 hit and that made the process even more complicated and personally more difficult. So to that extent, I need to repeat my gratitudes but to make them personal gratitudes for the dedicated and hard-working team, all of who have been respectful, always available. There have been some robust moments, as there should be, but it has always been worthwhile.

I'd like to think that we are now in the home stretch. As I looked out the window earlier on in Melbourne, it doesn't quite look like the Spring Carnival season but then Melbourne can often not look like that even when it is spring. However, spring and summer is a time when thousands of flowers bloom and hopefully with that context we may be able to feel enlivened and enriched as we embark upon what I hope will be the home stretch in this very important task.

It is an important task because the challenges are very great. The challenges are great because they arise in all sorts of ways that are sometimes difficult to deal with. We have seen many failures and many shortfalls. But the ones that are most difficult to overcome are the failures when the things are working as you would expect them to be working, as Mr Gray said a few moments ago. Good people, well intentioned, doing the best they can can cause the biggest problem to fix the system without a complete overhaul.

That is why that memorandum that counsel referred to yesterday and today of 1997, was so important. We might just ask the operator to put up paragraphs 4 and 9 of that memorandum because what we see in that memorandum is Government working as it's supposed to be working. It's a wonderfully candid, helpful memorandum to Government. In paragraph 4 we're told helpfully that residential care is not a demand-driven program. And then we're told about capping, capping was put in place. And that paragraph ends by saying it has saved billions since its introduction and continues to do so. The system is working well. The ministers are being informed candidly and helpfully. But we see in it also that it comes at a cost.

Paragraph 9 is another illustration of that, if the operator could possibly go to paragraph 9 where the memorandum helpfully tells the Minister about the growth being unavoidable. And then there's an alternative to a demand-driven system.

It's the last sentence that struck me:

> *However it necessarily results in higher average dependency and thus higher unit costs of care for those who do get access to the system.*

Those that have the lever of government do have these instruments. They can do these things, it comes at a cost. There are savings to be sure, but one of the consequences of the savings is a diminution in care and a worsening of conditions, a higher average dependency and thus a higher unit of cost.

We might take that down. Thank you, operator.

Aged care has had lots of reform talked about in the past. It's been reformed at times in the past and it has had many reviews. Over a year ago, in what, for me, was my very first session of the Commission, Uncle Brian Campbell finished his evidence. We thanked Uncle Brian Campbell for the evidence he gave, and then he said, "Excuse me, could I ask one question?" And I said, "Of course." Uncle Brian Campbell said this, "I've sat with Royal Commissioners into deaths in custody, I've sat with the Bringing Them Home hearing, right, and out of all of them hardly anything gets done and is this one going to be the same?" Well, I indicated that I hoped this would not be the same, it might be one where we might get things done and indeed, I went onto say, "I'm pleased you've asked that question, Uncle Campbell, and we might put that in the report when it comes out, the need for something to be done and that people like you come to these Commissions to share your stories so that something gets done."

You know, we've all heard the well-known expression about the more things change the more things remain the same. There's a variation of that expression that, given my ethnic background I can happily say comes from a Sicilian writer, which has a cynical twist to it. In the book The Leopard, the twist is this: If we want things to stay as they are things will have to change. What we don't want this Commission to do is to bring about changes for things to remain the same.

Mr Gray, it's customary for judges to end a hearing by saying they're indebted to counsel. Indeed, it's so common that's often said in a formulaic way. But that's not said in a formulaic way on this occasion. We are indebted to counsel, and I mean all of you, Mr Gray and Mr Rozen. We will consider your submissions carefully. My attention was drawn overnight to a report of yesterday's hearing in which the word "courageous" was put as a description of the submissions. The writer of that report said that it wasn't being used in a complimentary way. Let me use it in a complimentary way. The submissions are, perhaps, courageous because they cause us to ask about what system we want and what system will best serve the future, whether it's a system that has the features that you've recommended or others. Might I, in that respect, simply join with Commissioner Briggs in seeking responses to the various matters that you've raised with us and to ask the question: is what we have as good as we can get?

Thank you, we will adjourn.

HEARING CONCLUDED AT 3.45 PM

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